CLINICAL SERVICES PLAN

This program description represents a compilation and description of current core programs and services directly operated by Genesee Health System (GHS). GHS Mission, Vision, and Values statements form the guiding philosophy for these services. This plan is continually reviewed at the program level and annually reviewed/revised at the organizational level.

Genesee Health System is both the public community mental health entity for Genesee County, as well as a service provider of the Region 10 PIHP, a four county comprehensive mental health and substance abuse services network. All emergent and non-emergent referrals to Medicaid covered specialty supports and services come from the Access Center/Liaison services, where they are first screened for both eligibility and level of care prior to referral. Additionally, non-specialty outpatient mental health, outreach, navigation, and Medicaid Flint Water Waiver referrals are processed outside of the PIHP Access route.

Mission:

Supporting recovery, prevention, health, and wellness of the body, the mind, and the community.

Vision:

GHS will take positive action to promote hope and health by recognizing the interconnectedness of the body, the mind, and the community. We will do this by drawing out and strengthening the natural systems of support inherent to all communities so that individuals achieve the lives they desire. We will use a relationship-based model of care to empower the people we serve and all members of our community to be the drivers of their own health and wellness goals. We will support those who need it with highly-qualified caring professional teams able to respond to needs across all spheres of life: physical, mental, social, and spiritual. We believe that recovery is possible, worthwhile, and achievable for everyone.

Values:

- Welcoming, accessible, responsive services
- Providers who understand the need for relationship
- Inclusiveness founded upon the inherent worth and dignity of every member of the community, with respect and appreciation for diversity of opinions, preferences, and life choices
- Delivery systems that integrate physical and behavioral health care
- Accountable, transparent stewardship of the public’s trust
- Good corporate citizenship, partnership, and leadership across the community’s many networks of services and supports, both public and private
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CENTRALIZED INTAKE
Description
Screening for specialty mental health services and supports is conducted by Region 10 PIHP Access Center. Adults assessed to have serious mental illness and/or intellectual/developmental disabilities and children with serious emotional disturbances and/or intellectual/developmental disabilities are scheduled promptly with an intake at GHS’ centralized Intake Department. The department is located at GHS’ main campus of 420 W. Fifth Avenue, Flint, MI. The Mental Health Professionals and Care Specialists are supervised by a Licensed Master Social Worker and the Medical Clerks are supervised by a Senior Secretary. Intake appointments are scheduled as soon as possible but always within 14 days of the initial request and within 3 business days if being discharged from a psychiatric hospital. Same day and next day appointments are also available for urgent requests. Assessments are performed primarily in the office at the main campus but occur when necessary in community settings as well.

All consumers are greeted by welcoming clerical staff who verify insurances, address financial considerations and link them to trauma-informed clinicians who; through a detailed and supportive face to face assessment process, allow individuals and families to tell their story, discuss advance directives, develop initial treatment goals and begin their recovery journey. The Intake Department has the capacity to accommodate individuals who present with Limited English Proficiency, diverse cultural backgrounds, visual impairments and mobility challenges. Any needed interpretation services are provided promptly at no cost to the individual or family via either live or video interpretation.

Consumers, guardians and families meet with a Care Specialist to provide a full orientation to the program, inform them about crisis services, Customer Services and provide them with information about their rights and responsibilities and other health and safety information in a way that is understandable to the person and family served. Individuals and families are provided with written and/or electronic materials including a Your Rights booklet, Customer Handbook and other pertinent agency and community resources. Children and families are provided a separate waiting area equipped with child appropriate materials.

Assessments are completed by qualified Mental Health Professionals who are trained in co-occurring disorders, trauma-informed and integrated care concepts as well as a Culture of Gentleness. The biopsychosocial assessment involves a comprehensive and strength-based interview process used as a clinical framework to determine treatment needs for the individual, develop an individualized plan of care and to subsequently provide appropriate interventions and safe and effective services. Consumer preferences are highly valued and treatment goals are consumer driven, person-centered and based on the individuals strengths, needs, abilities and preferences. The written assessment document consists of a presenting problem, detailed history of all aspects of the individual’s life (current and historical), mental status exam, risk assessment, level of functioning, clinical interpretative summary and recommendations. Based on the assessment process and pertinent external sources as appropriate, diagnostic impressions including co-occurring disorders are made by the clinician at this time. LOCUS scores are completed following the assessment of all adults and CAFAS, PECAFAS or DECA scores are completed for children. The clinician and individual work to together in completing an Initial Treatment Plan which allows the primary program to assist the person served to begin working on what is most needed and important to the individual and family at that time.
PROTOCOL FOR INTAKE SERVICES

SUBJECT
L. Tompkins - Vice President of Clinical Operations
K. Baxter, Senior Clinical Director

Proper coordination is conducted to ensure the best likelihood of effective engagement with the primary provider, allowing the individual to derive the most benefit from treatment. Before leaving the Intake Department, all eligible individuals are scheduled an appointment for ongoing services as soon as possible but always within 14 days of assessment, unless otherwise requested by the consumer or guardian. If the individual has been discharged from the hospital, they will have been given an appointment with a psychiatrist within 5 calendar days of discharge from the inpatient unit.

Intake clinicians are trained in eligibility requirements consistent with the Michigan Mental Health Code, Medicaid Provider Manual and contractual obligations. If, following a comprehensive face to face mental status examination and assessment, it is determined that further completion or acquisition of testing results is necessary, individuals are connected with initial services with the goal of further evaluation; and a prompt eligibility review determination is made by qualified personnel at this time. In the event, an individual is determined not to meet eligibility for SMI, SED, or I/DD, he/she is given an Adequate Notice of Denial and Due Process rights are fully explained.

Individuals who meet eligibility requirements but do not have a Medicaid Product are wait listed if sufficient General Fund dollars are not presently available to serve them. The waiting list is monitored no less than quarterly and individuals are placed in specialty services as they obtain Medicaid or monies are available to serve them per contract requirements. A Care Specialist assists all individuals without Medicaid in the Medicaid application process. Individuals are provided with community resources available to them in the interim and are given information on how to access crisis services in the event of urgent or emergent needs.

Special Populations
Children who have received a score of 12 or more on the SCQ or 3 or more on the MCHAT, through a screening at the PIHP, are referred to Intake for a biopsychosocial assessment and are promptly linked to a support coordinator/case manager to coordinate the compilation and/or completion of all necessary testing and documentation to determine eligibility; and referral if appropriate, for the Applied Behavior Analysis (ABA) benefit through GHS Autism Center. Children who are deemed not eligible for ABA services are referred for specialty services that meet medical necessity; or are issued Advanced Notice with explanation of appeal rights if no eligibility exists.

Crisis Management/After Hours
The GHS Crisis Line number, which is given to all consumers and families that present at Intake, provides consumers and the community with 24-hour crisis telephone support and, when needed, referral to mobile, face-to-face crisis intervention by the Crisis Intervention and Recovery Team (CIRT). The purpose of CIRT is to mitigate crisis, prevent hospitalization, and link individuals to the safest services and supports available, which includes coordination with existing GHS supports and services the following day. CIRT is available 24 hours a day, 7 days a week, serving GHS consumers and all residents of Genesee County in need of immediate assistance in defusing mental health, substance abuse, and/or family crises and accessing medically necessary services and supports. CIRT can also be accessed directly by Genesee County community providers, agencies, and safety net partners on behalf of consumers or others in distress to ensure timely after-hours crisis support. Persons will have access to
services regardless of their living environment, physical condition, or disability. Interpreters or other communication assistance are provided as necessary, including TTY availability.

ADULT SERVICES

Assertive Community Treatment (ACT)

Description

ACT is a set of intensive clinical, medical, and psychosocial services provided by mobile multidisciplinary treatment teams. It provides acute, active, and ongoing community based psychiatric treatment, assertive outreach, rehabilitation, and support. This includes services and supports essential to maintain the consumer’s ability to function in community settings, including assistance with accessing basic needs through available community resources such as food, housing, and medical care, and providing supports to allow individuals to function in social, educational, and vocational settings. Services are based on the principles of recovery and person-centered practice, and are individually tailored to meet the needs of the individual.

The ACT team provides assistance to individuals to maximize their recovery and ensure consumer-directed goal setting. The team provides support to consumers to gain hope and a sense of empowerment and assistance in helping them become respected and valued members of their community.

ACT services are often used as an alternative to hospitalization. These services are provided in the individual’s home or other community location according to the consumer’s preference and clinical appropriateness. Treatment groups may be provided onsite.

Admission Criteria

ACT services are targeted to individuals who are diagnosed with Serious Mental Illness (SMI), which may include personality disorders, who require intensive services and supports, and who, without ACT, would require more restrictive services and/or settings. Specific criteria include:

- Persons with SMI with difficulty managing medications without ongoing support, or with psychiatric symptoms despite medical adherence.
- Persons with SMI and a co-occurring substance use disorder.
- Persons with SMI who exhibit socially disruptive behavior that puts them at high risk for arrest and incarceration, or those exiting a county jail or prison with a history of SMI.
- Persons with SMI who are frequent users of inpatient psychiatric hospital services, crisis services, crisis residential or homeless shelters.
- Older persons with SMI with complex medical/medication conditions.
- May have disruptions of self-care, limited ability to attend to basic physical needs, serious impairment in interpersonal functioning, and/or significantly diminished capacity to meet
educational/occupational roll performance expectations.

Discharge Criteria
Discharge from ACT occurs when there is cessation or control of symptoms. Recovery must be sufficient to maintain functioning without support of the ACT team as identified through the person-centered planning process.

- The person served no longer meets severity of illness criteria and is able to function with the level of support available in a less intensive service.
- The team, despite deliberate, persistent, and frequent assertive team outreach attempts including face-to-face engagement and legal mechanisms that have been documented over a significant period of time, cannot locate the person served.
- The person served and the team members mutually agree to termination of services.
- The person served moves outside the county area. In such cases, team members assist the individual in securing appropriate treatment in the new location. When feasible, the team maintains contact with the person served until service transfer is arranged and finalized.

Transition Criteria/Process
ACT is committed to assisting persons served to move from one level of care to another and to obtain specialized services to support their recovery. This may include short-term inpatient hospitalization or crisis residential when symptoms escalate and transfer to other services such as Case Management and/or Medication Management when they have progressed in their recovery.

Transition to different or additional programs is completed with active participation of the consumers and their guardians. Transition planning may include friends, family, and other individuals and services as appropriate or permitted by the individual. Throughout treatment and during the person-centered planning process, there are discussions regarding the needs and desires of the consumer, additional supports and services that may enhance recovery, and planning when a different level of care would be appropriate.

Although most all services are provided by the ACT team, ACT consumers may add Dialectical Behavior Therapy (DBT) or Family Psycho-education (FPE) based on their needs and preferences.

ACT Goals

1) ACT services will demonstrate continued improvement and increased conformance with the MDCH’s ACT Field Guide requirements.
• ACT will develop an action plan based on the MIFAST results.

Special Populations

The ACT team addresses the co-occurring substance use disorders of consumers within the team service delivery. The team is licensed to provide substance abuse treatment and utilizes the Integrated Dual Disorder Treatment model (IDDT), a SAMSHA evidence-based practice.

IDDT assists in helping individuals to identify substance use and its effects; recognize the relationship between substance use, mental illness, and psychotropic medications; develop motivation for decreasing use of substances; develop coping skills and alternatives to substance use; help achieve and encourage periods of stability; and help access and utilize self-help and/or support groups, including the on-site dual diagnosis support group. Services are offered in a positive atmosphere and are adapted to individual's stage of recovery. The team has one substance use specialists to assist other team members in providing interventions in an integrated fashion.

Persons served who are dually diagnosed with SMI and Developmental Disabilities (DD) can be served by the ACT teams. Team members actively consult with GHS programs that serve individuals with DD; several ACT team members have experience in working directly with developmentally disabled individuals.

For deaf or hard-of-hearing consumers, access to interpreter services is assured through the scheduling of an interpreter through the Communication Access Center. In those instances where foreign language assistance is required, GHS has at its disposal the use of Voices for Health, via telephone. Foreign language interpreter services are provided on a case-by-case basis.

Crisis Management/After Hours

Although ACT consumers are able to access GHS’s 24/7 crisis services, the ACT teams provide their own 24/7 crisis coverage (including a psychiatrist). If an ACT consumer reaches the crisis phone number or the Crisis Intervention Response Team (CIRT), ACT is contacted directly to provide crisis support.

Program Resources

The ACT program is a multidisciplinary team that consists of a Masters-level supervisor (team leader), seven ACT Specialists, two nurses, two Certified Peer Support Specialists, and one medical clerk.

The psychiatrist and the psychiatric nurse practitioner are an integral part of the team, providing oversight, clinical support, and consultation for each person served; attending team meetings; and providing clinical consultation and supervision to the team. The staff to consumer ratio is no more than 1:10; i.e., a maximum of ten persons served to each member of the team. The ratio includes the
team leader, the nurses, and the Qualified Mental Health Professionals (QMHPs). The Certified Peer Support Specialists substitutes for one full-time equivalent QMHP to achieve the ratio. Clerical support staff and the psychiatrist do not count in the ratio.

The ACT team leader is a qualified behavioral health practitioner who possesses knowledge and competencies that meet the needs of persons served. The team leader also provides direct service and clinical guidance to the team. Team offices are located to ensure ease of communication among team members. Medical records are available to team members at all times and in any location through the use of CHIP, the electronic web-based medical record.

ACT offers flexible hours and personnel availability based on the needs of persons served, and has the ability to adjust intensity of care and treatment as clinically indicated. Team members have access to agency cars for outreach use. The team meets with the individual where he or she feels most comfortable, without compromising safety.

The ACT program received Substance Abuse (SA) licensure for Outpatient, Case Management, and Integrated Treatment from the MDCH in September 2007. Ongoing personnel training and resource development continue to take place, with a special focus on the dually diagnosed population (SMI/SA).

ACT is located at 420 W. Fifth Avenue, Flint, MI, in the GHS main campus. Although most ACT services are provided in the community, the building itself is handicap-accessible, easy to get to, and situated near public transportation.

Service Modalities
ACT services and interventions are consistent with and balanced by medical necessity and the preferences of the individual while utilizing person-centered principles and recovery. The goal is to maximize independence and progression into less intensive services. Consumers with co-occurring substance use disorders will have both mental health and substance use disorders addressed in their individual plans of service.

ACT is a team-based service that includes shared responsibility for service delivery in order to provide continuity of care for persons served. Case management services are interwoven with treatment and rehabilitative services and provided by all team members.

Frequent monitoring of, and response to, medications is a core component of the service to support the use of medications as part of the recovery plan. ACT teams are expected to address co-occurring substance use disorders of individuals within the team service.

The ACT team meets Monday through Friday. The meetings are attended by all staff members on duty. The status of each consumer is briefly reviewed and documented daily. This documentation
includes clinical information regarding all consumers discussed and all staff members present. During this meeting the daily schedule is organized and contacts are planned.

The ACT program is an individually tailored combination of services and supports that vary greatly in intensity over time based on the consumer’s needs and conditions. Services include availability of multiple daily contacts and 24 hours a day, 7 days a week crisis support.

Adult MI Intensive Case Management (Mental Illness and Co-occurring)

Description

The MI Intensive Adult Case Management program provides goal-oriented, individualized supports for persons with SMI, and co-occurring substance use disorders or chronic health conditions, who are eligible for specialty mental health services and supports. The primary services provided are targeted case management, which includes provision of the following six elements: assessment, planning, linking, advocacy, coordination, and monitoring. The medical necessity criteria for these services are defined in the Medicaid Provider Manual.

Key Aspects

- Master’s-level staff to perform the initial and ongoing assessments and initial plan of service.
- Traditional individual case management/supports coordination model, with team support to deliver services.
- A person-centered planning framework, with the goal of improving each individual’s recovery potential and minimizing relapse/return to more restrictive settings.
- Services are provided in a variety of settings, most often in an individual’s natural setting.

Admission Criteria

- Adults with SMI, and/or co-occurring substance use disorders, and/or chronic health conditions including multiple functional impairments affecting their daily lives.
- Demonstrated inability to access and/or coordinate needed services and supports.
- Increased use of emergency psychiatric or crisis services, repeated hospitalizations, and/or partial hospitalizations.
- May be involved with the police, courts, MI-DHHS, or Protective Services.
- May demonstrate difficulty in being a part of their household or community including housing problems, evictions, and emotional disturbances at home or in the community.
- May have poor management skills of co-morbid chronic health conditions, which creates complications that interfere with their recovery.
- May have demonstrated little to no success participating in traditional office-
based outpatient services.

- Have a high level of vulnerability and inability to independently access and/or sustain involvement with needed services.
- The individual and/or their legal guardian are willing to accept and cooperate with supports coordination services.

**Discharge Criteria**

- Demonstrates the ability to function in most major life domains (e.g., work, school, social, self-care, etc.) without requiring the direct assistance of case management/supports coordination.
- There are sufficient natural support systems in place to support ongoing functioning in the community.
- Demonstrates the ability to move to a less restrictive setting.
- Goals have been met to the satisfaction of the person served, guardian, and/or family.
- May require minimal support from only a single source or services.
- Individual/guardian/family requests alternative services.
- Requires long-term nursing home placement or prison.
- Moves outside the county area.

**Transition Criteria/Process**

The MI Intensive Case Management program is committed to assisting persons served to move fluidly between service levels to meet their identified needs. Transition between targeted case management and supports coordination is a matter of degree, and services can be increased or decreased by the staff as needed. Transition within the program or to alternative or additional programs is completed with active participation of the consumers and their guardians/natural supports.

Transition planning may include friends, family, and other individuals as appropriate or permitted by the consumer. During the person-centered planning process and throughout treatment, there are discussions regarding the needs and desires of the individual and, in addition, the supports and services that may enhance recovery to support a decreased level of care.

Individuals engaged in recovery may also complement targeted case management with pharmacy assistance/med drop program, DBT, FPE, or Peer Support Services. Individuals may also transition from Case Management/Supports Coordination to other community programs and supports.

**MI Intensive Case Management Goals**

1) An over-arching goal is to have all consumers with a mental illness and/or co-occurring condition offered an evidence-based practice that meets their needs.
   - Additional case management staff will be trained in Family Psycho Education (FPE) to increase the numbers of groups provided to consumers.
• Case management staff will be trained in Motivational Interviewing.

2) Staff work with persons served to ensure they receive primary and preventative healthcare while continuing to support their behavioral health needs in an integrated service approach.

3) In order to ensure program efficiency, staff will provide face-to-face services to consumers for a minimum average of two hours and 45 minutes a day each month.

**Program Resources**

The Adult MI Intensive Case Management program is staffed by one Manager, 1 Masters-level staff, 1 Bachelors-level staff, and one registered nurse providing case management, and 1 clerical/support staff. The targeted case managers are licensed social workers in the State of Michigan. Although not required for the position, one staff is credentialed in substance use counseling. In addition, two full-time peer support specialist positions are available to the program on an individual referral basis.

The programs are located at 420 W. Fifth Ave., Flint, MI. Hours of operation are from 7:00 am to 6:00 pm Monday through Thursday and 7:00 am to 5:00 pm on Friday.

**Service Modalities**

Services and supports are designed to assist consumers to develop and implement strategies that are person-centered and goal-oriented. The use of assessments, planning, linkage, advocacy, coordination, and monitoring facilitate the following:

- Identify and meet basic needs (i.e., food, housing, medical care, health and safety), linking and coordination with GHS and community supports such as the Food Bank, Salvation Army, senior centers, GCHC, etc.
- Attend mental health, substance use, or medical and dental appointments (psychiatric and primary care physician), and provide skill building and/or CLS to facilitate follow-through with recommendations.
- Use of the Genoa Medication Assistance Program to educate and develop medication compliance.
- Linkage to professional consultative services including, but not limited to, nursing, behavioral/psychological, OT, PT, speech, and dietary consultants.
- Build and support links to natural community resources and community agencies such as the Michigan Department of Health and Human Services (MDHHS) Adult and Child Protective Services, Social Security, and the court system (Mental Health Court);
linkage to skill building to increase effective communication skills at work sites, day programs, and in schools to support continued help and community inclusion.

- Resolve crisis situations in coordination with GHS and community resources, including CIRT.

Crisis Management/After Hours

The GHS Crisis Line provides our consumers and the community with 24-hour crisis telephone support and, when needed, referral to mobile face-to-face crisis intervention by the Crisis Intervention and Recovery Team (CIRT). The purpose of CIRT is to mitigate crisis, prevent hospitalization, and link individuals to the safest services and supports available, which includes coordination with existing GHS supports and services the following day. CIRT is available 24 hours a day, 7 days a week, serving GHS consumers and all residents of Genesee County in need of immediate assistance in defusing mental health, substance abuse, and/or family crises and accessing medically necessary services and supports. CIRT can also be accessed directly by Genesee County community providers, agencies, and safety net partners on behalf of consumers or others in distress to ensure timely after-hours crisis support. Persons will have access to services regardless of their living environment, physical condition, or disability. Interpreters or other communication assistance are provided as necessary, including TTY availability.

Adult Case Management/Supports Coordination - MI

Description

The MI Adult Case Management/Supports Coordination program provides goal-oriented, individualized supports for persons with SMI, and co-occurring substance use disorders, who are eligible for specialty mental health services and supports. The primary services provided are targeted case management or supports coordination, which includes provision of the following six elements: assessment, planning, linking, advocacy, coordination, and monitoring. The medical necessity criteria for these services are defined in the Medicaid Provider Manual. Individuals with greater needs who require more elements of service receive targeted case management, and those with less intense or fewer needs receive supports coordination.

Key Aspects

- Master's-level staff to perform the initial and ongoing assessments and initial plan of service.
- Traditional individual case management/supports coordination model, with team support to deliver services.
- A person-centered planning framework, with the goal of improving each individual's recovery potential and minimizing relapse/return to more restrictive settings.
- Services are provided in a variety of settings, most often in an individual's natural setting

Admission Criteria
• Adults with SMI, and/or co-occurring substance use disorders including multiple functional impairments affecting their daily lives.
• Demonstrated inability to access needed services and supports.
• Use of emergency psychiatric or crisis services, repeated hospitalizations, and/or partial hospitalizations.

• May be involved with the police, courts, MI-DHHS, or Protective Services.
• May demonstrate difficulty in being a part of their household or community including housing problems, evictions, and emotional disturbances at home or in the community.
• May have poor management skills of co-morbid chronic health conditions, which creates complications that interfere with their recovery.
• May have demonstrated little to no success participating in traditional office-based outpatient services.
• Have a high level of vulnerability and inability to independently access and/or sustain involvement with needed services.
• The individual and/or their legal guardian are willing to accept and cooperate with supports coordination services.

Discharge Criteria
• Demonstrates the ability to function in most major life domains (e.g., work, school, social, self-care, etc.) without requiring the direct assistance of case management/supports coordination.
• There are sufficient natural support systems in place to support ongoing functioning in the community.
• Demonstrates the ability to move to a less restrictive setting.
• Goals have been met to the satisfaction of the person served, guardian, and/or family.
• May require minimal support from only a single source or services.
• Individual/guardian/family requests alternative services.
• Requires long-term nursing home placement or prison.
• Moves outside the county area.

Transition Criteria/Process
The MI Adult Case Management/Supports Coordination program is committed to assisting persons served to move fluidly between service levels to meet their identified needs. Transition between targeted case management and supports coordination is a matter of degree, and services can be increased or decreased by the staff as needed. Transition within the program or to alternative or additional programs is completed with active participation of the consumers and their guardians/natural supports.

Transition planning may include friends, family, and other individuals as appropriate or permitted by the consumer. During the person-centered planning process and throughout treatment, there
are discussions regarding the needs and desires of the individual and, in addition, the supports and services that may enhance recovery to support a decreased level of care.

Individuals engaged in recovery may also complement targeted case management or supports coordination with DBT, FPE, or Peer Support Services. Individuals may also transition from Case Management/Supports Coordination to other community programs and supports.

Adult Case Management/Supports Coordination Goals

1) An over-arching goal is to have all consumers with a mental illness and/or co-occurring condition offered an evidence-based practice that meets their needs.
   • Additional case management/supports coordination staff will be trained in Family Psycho-education (FPE) to increase the numbers of groups provided to consumers.
   • Case management/supports coordination staff will be trained in Motivational Interviewing.

2) In order to ensure program efficiency, staff will provide face-to-face services to consumers for a minimum average of two hours and 45 minutes a day each month.

Program Resources

The MI Adult Case Management program is staffed by 3 supervisors, 20 Bachelors-level and 5 Masters-level staff providing case management, and 3 clerical support staff. The positions include both mental health therapists and targeted case managers/supports coordinators, with the latter being licensed social workers in the State of Michigan. Although not required for the position, two are credentialed in substance use counseling. In addition, two full-time peer support specialist positions are available to the program on an individual referral basis.

The programs are located at 420 W. Fifth Ave., Flint, MI. Hours of operation are from 7:00 am to 6:00 pm Monday through Thursday and 7:00 am to 5:00 pm on Friday.

Service Modalities

Services and supports are designed to assist consumers to develop and implement strategies that are person-centered, and goal-oriented. The use of assessments, planning, linkage, advocacy, coordination, and monitoring facilitate the following:

• Identify and meet basic needs (i.e., food, housing, medical care, health and safety), linking and coordination with GHS and community supports.

• Attend mental health, substance use, or medical appointments (psychiatric and primary care physician), and dental and provide skill building and/or CLS to facilitate follow-through with recommendations.
• Linkage to professional consultative services including, but not limited to, nursing, behavioral/psychological, OT, PT, speech, and dietary consultants.

• Build and support links to natural community resources and community agencies such as the Michigan Department of Health and Human Services (MDHHS) Adult and Child Protective Services, Social Security, and the court system (Mental Health Court); linkage to skill building to increase effective communication skills at work sites, day programs, and in schools to support continued help and community inclusion.

• Resolve crisis situations in coordination with GHS and community resources, including CIRT.

Crisis Management/After Hours

The GHS Crisis Line provides our consumers and the community with 24-hour crisis telephone support and, when needed, referral to mobile face-to-face crisis intervention by the Crisis Intervention and Recovery Team (CIRT). The purpose of CIRT is to mitigate crisis, prevent hospitalization, and link individuals to the safest services and supports available, which includes coordination with existing GHS supports and services the following day. CIRT is available 24 hours a day, 7 days a week, serving GHS consumers and all residents of Genesee County in need of immediate assistance in defusing mental health, substance abuse, and/or family crises and accessing medically necessary services and supports. CIRT can also be accessed directly by Genesee County community providers, agencies, and safety net partners on behalf of consumers or others in distress to ensure timely after-hours crisis support. Persons will have access to services regardless of their living environment, physical condition, or disability. Interpreters or other communication assistance are provided as necessary, including TTY availability.

Adult Case Management/Supports Coordination—I/DD

Description

The Adult Case Management/Supports Coordination program provides goal-oriented, individualized supports for persons with I/DD, who are eligible for specialty mental health services and supports. The primary services provided are targeted case management or supports coordination, which includes provision of the following six elements: assessment, planning, linking, advocacy, coordination, and monitoring. The medical necessity criteria for these services are defined in the Medicaid Provider Manual. The Habilitation Supports Waiver, a special designation and funding source from the State of Michigan, provides for services as intensive as case management. The level of outreach and supportive services varies on medical necessity and the individual’s response to interventions.

Key Aspects

• Master’s-level staff to perform the initial and ongoing assessments and initial plan of service.
• Traditional individual case management/supports coordination model, with team support to deliver services.
• A person-centered planning framework, with the goal of improving each individual’s recovery potential and minimizing relapse/return to more restrictive settings.
• Services are provided in a variety of settings, most often in an individual’s natural setting.

Admission Criteria
• Adults with I/DD, including multiple functional impairments affecting their daily lives.
• Demonstrated inability to access needed services and supports.
• Use of emergency psychiatric or crisis services, repeated hospitalizations, and/or partial hospitalizations.
• May be involved with the police, courts, DHS, or Protective Services.
• May demonstrate difficulty in being a part of their household or community including housing problems, evictions, and emotional disturbances at home or in the community.
• May have poor management skills of co-morbid chronic health conditions, which creates complications that interfere with their activities of daily living.
• Have a high level of vulnerability and inability to independently access and/or sustain involvement with needed services.
• The individual and/or their legal guardian are willing to accept and cooperate with supports coordination services.
• For Habilitation Waiver Supports Coordination, must meet the standard for Habilitation Waiver as established in the Michigan Medicaid Provider Manual.

Discharge Criteria
• Demonstrates the ability to function in most major life domains (e.g., work, school, social, self-care, etc.) without requiring the direct assistance of case management/supports coordination.
• There are sufficient natural support systems in place to support ongoing functioning in the community.
• Demonstrates the ability to move to a less restrictive setting.
• Goals have been met to the satisfaction of the person served, guardian, and/or family.
• May require minimal support from only a single source or services.
• Individual/guardian/family requests alternative services.
• Requires long-term nursing home placement.
• Moves outside the county area.

Transition Criteria/Process
The Adult Case Management/Supports Coordination I/DD program is committed to assisting persons served to move fluidly between service levels to meet their identified needs. Transition within the program or to alternative or additional programs is completed with active participation of the consumers and their guardians/natural supports.
Transition planning may include friends, family, and other individuals as appropriate or permitted by the consumer. During the person-centered planning process and throughout treatment, there are discussions regarding the needs and desires of the individual and, in addition, the supports and services that may enhance recovery to support a decreased level of care.

Individuals with DD may complement targeted case management or supports coordination with attendance at day programs, work programs, and a variety of community supports and services.

**Adult Case Management/Supports Coordination I/DD Goals**

1) The over-arching goal is to support and enable each consumer to attain the highest level of independence, productivity, and community inclusion.

2) In order to ensure program efficiency, staff will provide face-to-face services to consumers for a minimum average of two hours and 45 minutes a day each month.

**Special Populations**

*Habilitation Supports Waiver Program 1915 (c) (HAB Waiver)*

One special population of persons with DD is those individuals certified as Habilitation Supports Waiver (HSW) recipients. HSW services are enrollment-based, and eligibility is focused on those persons with DD who, without waiver services and supports, would return to an Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) level of care. Supports coordination is a core and integral service within the HSW. The level of outreach and supportive services will vary based on medical necessity, yet is typically long-term, considering the ongoing cognitive and medical needs that persons who qualify for ICF/MR. The medical necessity criteria for these services are defined in the Michigan Medicaid Manual. This program supports those persons with DD who require the most intensive level of care, with the intensity level equivalent to targeted case management.

**Program Resources**

The Adult Case Management/Supports Coordination I/DD program is staffed by two unit supervisors, 21 Bachelors-level staff providing case management and supports coordination, and a secretarial support staff person. The positions include both mental health therapists and targeted case managers/supports coordinators, with the latter being licensed social workers in the State of Michigan.

The program is located at 420 W. Fifth Ave., Flint, MI. Hours of operation are from 7:00 a.m. to 6:00 p.m. Monday through Thursday and 7:00 am to 5:00 pm on Friday.

**Service Modalities**
Services and supports are designed to assist consumers to develop and implement strategies that are person-centered, and goal-oriented. The use of assessments, planning, linkage, advocacy, coordination, and monitoring facilitate the following:

- Identify and meet basic needs (i.e., food, housing, medical care, health and safety), linking and coordination with GHS and community supports such as the Food Bank, Salvation Army, senior centers, etc.
- Linkage to professional consultative services including, but not limited to, nursing, behavioral/psychological, OT, PT, speech, and dietary consultants.
- Build and support links to natural community resources and community agencies such as the Department of Human Services (DHS), Protective Services, Social Security, and the court system (Mental Health Court); linkage to skill building to increase effective communication skills at work sites, day programs, and in schools to support continued help and community inclusion.
- Resolve crisis situations in coordination with GHS and community resources, including CIRT.

Crisis Management/After Hours

The GHS Crisis Line provides our consumers and the community with 24-hour crisis telephone support and, when needed, referral to mobile face-to-face crisis intervention by the Crisis Intervention and Recovery Team (CIRT). The purpose of CIRT is to mitigate crisis, prevent hospitalization, and link individuals to the safest services and supports available, which includes coordination with existing GHS supports and services the following day. CIRT is available 24 hours a day, 7 days a week, serving GHS consumers and all residents of Genesee County in need of immediate assistance in defusing mental health, substance abuse, and/or family crises and accessing medically necessary services and supports. CIRT can also be accessed directly by Genesee County community providers, agencies, and safety net partners on behalf of consumers or others in distress to ensure timely after-hours crisis support. Persons will have access to services regardless of their living environment, physical condition, or disability. Interpreters, including foreign language, and other communication assistance are provided as necessary, including TTY availability.

Other Adult Services Initiatives

**Deaf and Hard of Hearing Adults**

Case managers who serve deaf and hard of hearing consumers strive to provide effective mental health services, recognizing that mental health issues must be understood within the social, cultural, and linguistic contexts of the deaf community. These staff are deaf and/or uniquely familiar with the deaf community and family, and competent in use of American Sign Language. Genesee County is the home of the Michigan School for the Deaf, which has drawn, and continues to draw, persons with severe hearing impairments to our area. If needed, sign language interpreters are provided via contractual interpreter service agencies, at no cost for any service that the consumer is eligible for. Services are provided both in the community and in program offices.
**SUBJECT**
L. Tompkins Vice President of Clinical Operations  
K. Baxter, Senior Clinical Director

**PROCEDURE MANUAL**
Program/Service Structure Clinical Services Plan

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**Adult Mental Health Court**
GHS provides an array of Jail Diversion services to the residents of Genesee County, one of which is the Mental Health Court. This service, which is part of post-jail diversion services, screens individuals within the county jail and our catchment prison for mental health-related needs. Mental Health Court is designed to divert individuals with mental illness from jail and reduce repeat incarceration among participants by enhancing the criminal justice system’s response to mentally ill and co-occurring disorder offenders.

**Family Psycho-education (FPE)**
The evidence-based FPE program involves a partnership among consumers, family members, natural supports, and staff. FPE groups assist individuals and their families to learn ways to work together to support recovery by solving the problems that interfere with recovery. GHS currently has two FPE groups.

By providing ongoing training for additional staff and a Certified Peer Support Specialist to become proficient as facilitators, GHS will continue to achieve successful outcomes and build a supportive network for recovery and wellness.

**Motivational Interviewing**
GHS provides clinical training for staff in Motivational Interviewing/enhancement techniques and skills. This is a proven evidence-based practice that has demonstrated an increase consumer engagement and retention for individuals with mental health and substance use disorders. There are two certified Motivational Interviewing trainers (under the Wyoming Protocol) who provide a curriculum consisting of modules/stages that focus on engagement skills (the overall spirit of Motivational Interviewing), basic skill sets, decisional balance (pros/cons), and OARS (open-ended questions, Affirmation, Reflective Listening, and Summary).

**OBRA**
OBRA is a multi-disciplinary mental health service available to residents of Genesee County who are coping with a mental illness or developmental disability. Its two-fold purpose is to provide clinical support to the consumer who is suffering from an active psychiatric disorder, and target the prevention of unnecessary hospitalization and/or nursing home placement by timely resource coordination and psychotherapeutic intervention.

OBRA is staffed by one full-time OBRA coordinator who is a master-prepared social worker, one full-time OBRA specialist who is a Masters-prepared social worker, one full-time RN, and one part-time medical clerk under the OBRA supervisor. Services are delivered in the community. The treatment team provides clinical consultation to the nursing home’s treatment staff. Primary care professionals, including the attending physician and the facility’s social work and nursing personnel, activity and recreational therapists, and other members of the interdisciplinary nursing home treatment team work in consultation with the OBRA team to ensure the consumer is in the appropriate level of care,
receiving services appropriate to his or her condition, and receiving them in the appropriate location. Consultative support is also made available to concerned family members and significant others with the permission of the consumer. When requested, training is provided to nursing home staff to assist them in understanding mental health disorders in older adults.

Peer-Delivered Services
Peer support specialists provide services to support, mentor, and assist individuals in order to promote greater community inclusion, participation, independence, recovery, resiliency, and/or productivity. Peer support specialists are mental health staff with unique backgrounds and skills based upon their experience in utilizing services and supports. They seek to gain the trust and respect of the individuals they serve based upon their shared experiences with disabilities and associated services. GHS employs seven peer support specialists to support individuals from various programs within GHS including Adult Case Management/Supports Coordination, Community Housing, and DBT. Services may include vocational assistance, housing assistance, treatment planning, self-determination, selecting and employing support staff, accessing entitlements, developing wellness plans, alternatives to guardianship, crisis services, and support and guidance for advocacy and support groups.

Self-Determination
Self-determination is not a type of service, but an approach to structuring the way supports and services are made available to the individuals who need them. The central tenet of self-determination is that persons requiring support from the public mental health system should be able to define what they need in terms of the life they seek, have access to meaningful choices, and have control over their lives via direct management of their supports and services. A key element of self-determination is ensuring that the individual has the opportunity to direct a fixed amount of resources, based on the person-centered planning process, to purchase chosen services and supports. This involves a system change to assure that services and supports for individuals are not only person-centered, but person-defined and -controlled. Through the self-determination process, individuals gain the power to make meaningful decisions about how to live their lives.

Self-determination is an option for adults with DD and/or mental illness who are receiving services from all GHS network providers. Participation is voluntary and is available to individuals who request it and for whom an agreement on a plan of services and supports and an acceptable individual budget can be reached. Self-determination begins with person-centered planning, which is the process for planning and supporting persons served that builds upon their capacity to engage in activities that promote community life, and that honors their personal preferences, choices, and abilities. The process may involve friends, family, and professionals as desired by the individual. Related services currently available for this initiative include Independent Facilitation services (for direct assistance with the person-centered planning process) and Fiscal Intermediary services (for direct assistance with individual budgeting and payments for individual support staff). The Fiscal Intermediary provides oversight of the individual budget.
Individuals seeking self-determined arrangements work with the Unit Supervisor of Self-Determination and/or peer support specialists, along with their primary case manager or support coordinator, in order to:

- Identify the current actual costs of the individual's supports and services, complete the individual budget, and present the budget to the GHS Business Operations department.
- Complete the Self-Determination Agreement.
- Obtain assistance with employment.
- Complete the Purchase of Service Agreement.

Community Housing

Description

Community Housing provides a wide range of housing-related services to eligible consumers directly through the GHS network for the purpose of promoting and supporting individual independence and greater community integration. Community Housing staff, both professional and peer advocate staff, work directly with consumers to develop their independent living skills, self-confidence, and behaviors, so that they will be able to secure and maintain a home in their community of choice. Community housing provides short term and long term secondary supportive housing services.

The mission of Community Housing is to develop and provide a wide-range of housing alternatives and related support services to consumers of mental health services and their families. Many of these consumers are homeless or at risk of homelessness, or are living in situations that are both unstable and unsafe. Further, the mission of Community Housing is to assist consumers in their recovery as they move from homelessness, through transitional housing, and, ultimately, into permanent housing of their choice. The Community Housing Program is comprised of the Homeless Outreach Program, the Apartment Program, the Transitional Boarding House, Operation Lease-up and Shelter Plus Care. These programs are designed to assist individuals achieve success in, and satisfaction with, community living, or provide temporary shelter until a satisfactory living situation is attained. This is achieved by assessing the needs and desires of persons served in terms of locating and facilitating movement to the community housing option best suited to their situation. Supportive services are provided as needed to help ensure the success of the housing option each person chooses. Follow-up, outreach, and post-discharge services are completed at three and six-month intervals.

Community Housing staff have been trained in the SSI/SSDI Outreach, Access & Recovery Initiative (SOAR). Our SOAR-trained staff work with eligible individuals who are both homeless and have a disability to help them complete applications for benefits. The result is that more individuals receive benefits in less time and can be moved into safe and affordable housing more quickly.
An array of independent community living options is available for each individual depending on their needs and abilities. The program provides services for individuals who are capable of living successfully in independent living situations, and desire to do so. These individuals do not require dependent care or supervision. The program provides services to individual adults who meet these criteria, and also to children within a family system. In situations with children, one or several family members may meet program criteria to receive services. A variety of grant services and or Medicaid B-3 services for adults are often available based on individual criteria to facilitate the movement into a safe housing option.

There are variations across the array of programs within Community Housing, dependent on Medicaid and the particular program/grant requirements; these individual program admission requirements are available within the program. The following admission and discharge criteria are common to all Community Housing programs.

**Admission Criteria**

- At least 18 years of age.
- Has a diagnosis of SMI, developmental disability, or co-occurring mental illness and substance use disorder.
- In need of housing assistance, and meets HUD definition of homelessness.
- Willing to follow through with services, and has been assessed as appropriate for mental health services.
- Mental health issues are stable and the individual is capable of independent living.

**Discharge Criteria**

- The individual has secured stable, safe, and affordable housing and is, therefore, no longer in need of services.
- Individual no longer chooses to be active in Community Housing services.
- Individual has failed to follow lease obligations, including eviction.

**Transition Criteria/Process**

If an individual becomes hospitalized for medical or psychiatric reasons or enters crisis residential services, their housing can be maintained for approximately 90 days. After 90 days, they could return to the housing unit or be transitioned to another residential option such as a group home, depending on their condition and circumstances.

If a consumer is successfully maintaining their housing with grant assistance, he or she will continue to receive services through their case manager, and Community Housing will provide assistance with Section 8 vouchers and the SOAR process.

**Special Populations**
The Community Housing program specifically targets those individuals and families who are homeless or at risk of homelessness and have a diagnosis of mental illness, developmental disability, dual diagnosis, or co-occurring disorders. The Community Housing Program provides culturally competent services that address the needs of a variety of specialized population groups, such as persons with age-related barriers, physical/medical challenges, substance use issues, emotional/behavioral issues, and hearing impairments (including their families), as follows:

- The program will assist in obtaining assistive technology as needed to ensure that the physically disabled person can utilize the services offered by Community Housing.
- The program will help with the maintenance and periodic assessment of assistive technology and related equipment.
- The program will maintain a list of resources, including barrier-free housing, to assist the deaf or hard of hearing and the physically disabled.
- The program will help individuals acquire information about managing their physical disabilities.
- Program personnel have basic training in sign language for the deaf or hard of hearing population.
- Individuals with substance use diagnoses are linked through a case manager to appropriate treatment/services. They are reassessed on an ongoing basis regarding the effects substance use has had on their ability to manage housing issues.

Program Resources

The Community Housing program works in conjunction with Adult Case Management. The Housing program has one supervisor, two full-time case managers, and one staff member with an urban planning background who provides program consultation and grant management. Certified peer specialists are available via referral. To better address the needs and desires of individuals, appropriate linkage to various community resources is provided.

In addition to those Medicaid and General Funds that support all clinical programs, Community Housing receives funding through the SAMSHA PATH Grant, HUD Supportive Housing Program, HUD Emergency Shelter Grant, and United Way Emergency Shelter Grant. Grant funding ensures the ability of the program to deliver services to the homeless population.

Private interview rooms are available for individual assessment and counseling, and conference rooms are available for group presentations.

The Community Housing Program is located at 940 S. Grand Traverse, Flint, MI. Community Housing is open Monday through Friday from 8:00 a.m. to 5:00 p.m.

Service Modalities

GHS provides community housing services, supports, and resources to consumers of mental health services through the Apartment Program, Homeless Outreach, Transitional Boarding House, Operation Lease-Up, Shelter Plus Care, and the Homeownership Local Partnership Initiative. These
programs and services perform a critical role in the transitioning of consumers with disabilities from dependence and vulnerability to independent living with resources and supports.

Community Housing programs utilize the person-centered planning protocol to devise and implement a plan to provide opportunities for successful, permanent housing. Services include, but are not limited to: locating, viewing and choosing appropriate community living sites; periodic follow-up to maintain housing; rent/deposit assistance; moving assistance, limited household items and furniture; food; assistance with daily living skill development; and linking to other community services as needed to meet each individual's needs. Consumers must meet GHS eligibility requirements through the Access Center and associated grant criteria, and must actively comply with treatment options and housing regulations.

Upon referral and admission to any of the following Community Housing programs, an assessment of housing needs will be completed. This assessment helps the consumer and their case manager develop a housing goal and treatment plan that is incorporated into the IPOS. Community Housing treatment plans may also reflect certified peer specialist services.

Consumers involved in federally funded homeless assistance programs must have an individualized Homeless Intervention Plan as a part of their plan of service.

**Apartment Program**

The Apartment Program provides consumers of mental health services with the opportunity for independent living by empowering individuals with disabilities to live more independently in the community of their choice. This program seeks to enhance and support an individual consumer's independent living skills. Monthly apartment inspections are completed to ensure cleanliness and safety. A follow-up letter is generated within seven days of inspection, informing the person of areas in which he or she can improve. Quarterly reviews are done to track progress. Transportation services are provided on a limited, urgent need basis. Certified peer specialists are available to mentor and assist with life skills development.

**Homeless Outreach**

As a service provided by Community Housing, the Homeless Outreach program represents the first step in the continuum of care (the movement of consumers of mental health services, who are homeless or at immediate risk of homelessness) to enhanced independent living by providing emergency housing assistance and transitional housing with links to permanent housing, other community resources, and entitlements. An acute housing crisis is defined as: the individual is homeless, living on the street or in a shelter, in immediate danger of losing their housing without having a permanent residence, or being discharged from the hospital, jail, state hospital, or state correctional facility without a permanent residence.

The individual or family member must have a GHS case manager or primary therapist. An array of independent living options, based on person-centered planning objectives, is offered and includes
room & boards, single room occupancy, apartments, houses, mobile homes, and homeownership programs.

**Operation Lease-Up**  
Community Housing receives funding from the U.S. Department of Housing & Urban Development (HUD) for Operation Lease-Up. This program provides 36 units of scattered-site housing assistance for GHS consumers and their families, who are homeless and have a permanent disability, especially targeting those consumers who are chronically homeless and may have a co-occurring substance use disorder. This grant pays for one mental health therapist and one part-time certified peer specialist. In addition to providing housing assistance, this program provides hands-on life skill development integrated with primary mental health support services. As a condition of enrollment into the program, consumers are expected to sign a copy of the program’s rules and to comply fully with the residential lease agreements.

**Shelter Plus Care**  
This program is funded by the U.S. Department of HUD through the MDCH. Individuals referred to this program must be homeless and receiving community mental health services through a primary program. The intent of this program is to provide housing assistance equally matched by case management services. Criteria for admission to Shelter Plus Care is the same as Operation Lease-Up and the Transitional Boarding House. Certified peer specialist services are available to individuals in the program.

**Community Integration Center (CIC)**

**Description**  
This program provides skill building with an emphasis on community integration for individuals receiving services. The scope of these services is based on the identified needs and desires of the person served. Individuals are able to participate in a variety of community life experiences, e.g., leisure or recreational activities, religious activities, cultural activities, vocational pursuits, activities related to entertainment, communication activities, educational activities, development of work attitudes or living skills, and volunteering in the community. This program serves a varied age group, and skill building services are offered 5.5 hours per day, five days per week.

The CIC maintains a growing list of community integration and volunteer sites, such as the Habitat for Humanity re-sale shop, the YMCA, GCCARD, the City of Flint, local area churches, and senior centers.

**Admission Criteria**
- Must be 18 years of age and diagnosed as developmentally disabled, or dually diagnosed.
- May have health impairments requiring daily assistance.
• May need daily assistance with medication regimen and personal hygiene.
• Individual desires supportive day programming to enhance social, daily living, vocational, emotional, or community skills.
• Must be involved with case management/supports coordination services.
• Must be willing and able to work towards goals of community integration as defined through the person-centered planning process.
• Deemed not to be a threat to self or others.

Discharge Criteria
• Consumer no longer desires community support center services.
• Moves out of Genesee County.

Transition Criteria/Process
The Community Integration Center is committed to assisting persons served to move from one level of care to another and to obtain needed services that are not available within the program or organization. Transition to different or additional programs is completed with active participation of the consumers and their guardians. Transition planning may include friends, family, and other individuals and services as appropriate or permitted by the consumer. Throughout treatment and during the person-centered planning process, there are discussions regarding the needs and desires of the consumer, additional supports and services that may enhance recovery, and planning to a different level of care would be appropriate. As consumers in the Community Integration Center make progress in gaining skills, they may transfer to less restrictive vocational programs.

Special Populations
The Community Integration Center serves individuals with multiple disabilities and special needs through a person-centered planning process. Each person’s wants, needs, and desires are evaluated in order to serve them in the most effective and efficient manner. The Community Integration Center is barrier-free and designed to accommodate persons with a range of disabilities. These accommodations, in combination with the availability of various professional consultative augmentative communication devices, sign language interpreters, and sensitivity to cultural issues, form a solid foundation of support for persons with multiple disabilities. One part-time RN provides medication administration.

Program Resources
The Community Integration Center is located at 1057 E. Coldwater Road, Flint, MI. Hours of operation are Monday through Friday from 7:00 a.m. to 3:30 p.m. The community support programs work in conjunction with the supports coordinators and consultation personnel as necessary to ensure that the needs, wants, and desires of each individual are addressed. The staff-to-consumer ratio varies from 1:4 to 1:10, with 1:10 as a maximum. The site contains interview rooms so an individual may have privacy when speaking to his or her supports coordinator or other assigned personnel. Floor space and activity areas are sufficient to ensure the comfort of individuals while
they perform their chosen activities. The current program capacity is 150. Vans are available at the program for staff and consumer use for community integration activities.

All direct care staff are overseen by a full-time program supervisor. Additional staffing resources include the part-time RN, a medical clerk, and a program director who oversees The Community Integration Center.

Services Modalities
Services are based on the individual needs of each person served as identified in the IPOS and may include:

- Adult daily living skills
- Exercise/physical therapy
- Community integration
- Behavior modification
- Sensory integration
- Adaptive communication
- Leisure or recreational activities
- Cultural activities

The IPOS dictates the specific skill building services provided and activities offered on a daily basis. Individuals also have the opportunity to participate in a variety of special events such as the Annual Tailgate Party, receptions for Senior Companions, holiday events, and other activities. Staff also provide personal care services throughout the day in the areas of mealtime assistance, toileting, hygiene, and dressing.

Clubhouse

Description
The Clubhouse is a psychosocial program that provides services to adults with SMI. It is founded upon the principles of membership, empowerment, participation, and building on members’ strengths. Members are encouraged to take ownership of the program. Services are member-driven, and individual choice is highly respected. Participation is determined by the needs of the members, and members are active participants in all aspects of the program. Program settings are informal and nonhierarchical in order to break down barriers between personnel and members. The program focuses on a work-ordered day routine, an after-hours milieu of social opportunities, and vocational assistance for its members.

Admission Criteria
- At least 18 years of age.
- Diagnosed with SMI.
PROCEDURE MANUAL
Program/Service Structure Clinical Services Plan

SUBJECT
L. Tompkins Vice President of Clinical Operations
K. Baxter, Senior Clinical Director

- Has the potential and desire to be involved in all aspects of the program.
- Individual is not dangerous to self or others.
- New members attend a two-week orientation and will make a decision regarding maintaining membership by the end of the orientation.
- Actively involved in stabilizing primary psychiatric symptoms.

Discharge Criteria
- Member requests movement/closure from program due to active community integration.
- Non-participation in program for at least three months despite active efforts to develop a plan of service acceptable to the member.
- Moved to alumni status when competitively employed and needing minimal case management services.
- Moved out of county.
- Primary psychiatric symptoms not well controlled.
- Numerous clubhouse disciplinary actions.
- Serious clubhouse rule violations – weapons, drugs, physical harm to others or property.
- Death.

Transition Criteria/Process
Membership is voluntary, and consumers may choose to leave the clubhouse at any time. Rainbow Connection staff will assist members looking for additional or alternative community resources. Members leaving active status may become alumni. Alumni are welcome to stop by the clubhouse after the work-ordered day and are invited to attend special events at the clubhouse. Typical expectations include psychiatric stability, employed or volunteering on a regular basis in the community, stable housing, managing community resources independently, and being willing to maintain monthly contact with the clubhouse.

Special Populations
Deaf or hard of hearing individuals who use American Sign Language as their primary means of communication attend the program. One staff is proficient in American Sign Language and works primarily with this population. The PSR staff is able to sign to some degree, and members teach a weekly sign language class. A number of other accommodations are in place for deaf or hard of hearing individuals.

Crisis Management/After Hours
The GHS Crisis Line provides our consumers and the community with 24-hour crisis telephone support and, when needed, referral to mobile, face-to-face crisis intervention by the Crisis Intervention and Recovery Team (CIRT). The purpose of CIRT is to mitigate crisis, prevent hospitalization and link individuals to the safest services and supports available which includes coordination with existing GHS supports and services the following day. CIRT is available 24 hours a day, 7 days a week, serving GHS consumers and all residents of Genesee County in need of immediate assistance in defusing mental health, substance abuse, and/or family crises, and
accessing medically necessary services and supports. CIRT can also be accessed directly by Genesee County community providers, agencies, and safety net partners on behalf of consumers or others in distress to ensure timely after-hours crisis support. Persons will have access to services regardless of their living environment, physical condition, or disability. Interpreters or other communication assistance are provided as necessary, including TTY availability.

Program Resources
The program employs seven staff members ranging from certified peer support specialist to Masters-level staff. Ample space is available to provide services. Community resources such as the MSU Extension Service and the Genesee County Health Department are utilized throughout the year. The program works very closely with other GHS treatment providers as well as the private sector. The program also has the use of a van from the GHS van pool to transport members when needed.

The program is located at 705 S. Dort Hwy., Flint, MI, is barrier-free, and on the MTA bus line on a main north-south artery. The PSR clubhouse is open Monday through Friday from 8:00 a.m. to 4:30 p.m. Weekend and holiday hours are dependent on member choice and scheduled activities.

Service Modalities
The Clubhouse is open at least 60 hours per week in order to meet the needs of its members; evening and weekend hours are routinely provided. Program services are organized around the needs, goals, and preferences of members. The Clubhouse assists members served in securing arrangements to meet their basic needs, including:

- Case management
- Income maintenance
- Benefits and entitlements
- Food, clothing, and household goods
- Short-term shelter
- Housing subsidies
- Dental services
- Vision services
- Medical services
- The impact of employment on securing and accessing future benefits
- Transportation
- Substance use services

Each member’s plan is reviewed at least annually. Meetings between members and personnel are held regularly to discuss matters of mutual concern. The program assists members in securing arrangements to meet their basic needs. Curriculum-based programming and work in Units are available to members as desired. Outreach and follow-up procedures are in place and directed toward members who are referred, not attending, or isolated in the community. Outreach is also provided to members who have been admitted to more intensive levels of treatment. Procedures are
available to assist members in securing housing that is safe, decent, affordable, and accessible. For more detail, please see the program schedule and member handbook.

CHILDREN’S SERVICES AND SUPPORTS

Child and Family Supports—MI (SED) and DD

Description

The Child and Family Supports—MI (SED) and DD program is a case management/supports coordination-based multi-service program designed to meet the specialized needs of seriously emotionally disturbed and developmentally delayed children, and their families. This program provides services for families who require a higher level of care that is offered through outpatient therapy and/or case management, but do not need the level of services provided by Home Based services. The services are provided by Masters-level therapists, who are also Qualified Mental Retardation Professionals (QMRPs) and/or qualified Mental Health Professionals (QMHPs), and include in-home family therapy, family training/support, individual therapy, and case management or supports coordination to assess, plan, link, coordinate, and monitor activities and treatment. Family members and the child receive skill development services such as behavior management, life skills, conflict resolution, problem solving, anger management, decision-making, and crisis management. The emphasis of the program is to empower parents and caregivers to increase their skills so they can successfully manage children with special needs in their home. In addition, child psychiatrists, nurses, and other consultative behavioral health providers such as occupational therapists, psychologists, and dietitians are available to the children/adolescents and families served.

The program provides these services to families that may be impoverished, with the challenges that poverty may produce such as health disparities, single-parent families, children with no biological parent involved, few or no within-family resources, insularity from the community, low parental and child skills, etc. Even without the challenges of poverty, it is likely that the severity of the child’s disabilities exceeds the family’s ability to adequately support him or her without significant supports and services. As a result, case management or supports coordination needs are pronounced. Likewise, these challenges pull multi-service agencies into the picture, most prominently schools and/or special education programs, DHS, and Juvenile Court (see Other Child and Family Services Initiatives).

For children with DD, this program provides services via three unique initiatives, two of which are a significant part of the State of Michigan’s Medicaid Waiver to the Federal Centers for Medicare and Medicaid (Children’s Waiver, Habilitation Supports Waiver). They are:

Children’s Waiver

Children’s Waiver services are the most intensive services available for children with DD. Families apply for waiver services through a pre-screening process facilitated by the case manager. This
program serves children with DD who have severe physical and/or behavioral needs. Services include, but are not limited to, case management, psychological services, occupational therapy, assistive technology, durable medical equipment, home modifications, physical therapy, speech and language services, psychiatric services, health services, private-duty nursing, Behavioral Management Review Committee (BMRC), community living supports, and respite. This is a very specialized program, limited in its scope by prescribed slots allocated through MDCH. In the past, without this program many of these children would not have been able to be maintained at home by their parents.

**Habilitation Supports Waiver**

Habilitation Supports Waiver services, like the Children’s Waiver, are enrollment-based and focus eligibility on those persons with DD and associated conditions that threaten their ability to be maintained in the community. While mostly provided to adults with DD, some children with DD may be eligible, usually if they present less severe conditions than those eligible for the Children’s Waiver, or if they cannot access the Children’s Waiver due to the limited number of slots.

**Family Support Subsidy**

The Family Support Subsidy, funded by MDCH and administered by GHS, is an entitlement program for parents or guardians of children with severe cognitive impairments, severe multiple impairments, or autistic impairments. Currently, GHS has approximately 350 families receiving the monthly stipend of $222.11 per month. This stipend is used by the families to assist and maintain their child with DD in the family home. The staff assigned to the Family Support Subsidy program communicates with the families, the state-wide subsidy coordinator at MDCH, and the schools to ascertain and monitor eligibility.

**Admission Criteria**

The identified child must be seriously emotionally disturbed or developmentally disabled as reflected in a primary DSM-IV diagnosis.

- The family/community support system cannot be relied on to provide the essentials of care without mental health services and support.
- The family agrees to participate in services and supports provided in the home, school, and community.
- The home environment is physically safe for staff.
- For some children, meeting the unique eligibility criteria for Habilitation Supports Waiver or Children’s Waiver may be required.

**Discharge Criteria**

- The identified child is experiencing reduced symptoms, including improvement in behavior at home, school, or in the community.
The parent/caregiver is experiencing an increase in functioning based on a decrease in the caregiver score on the CAFAS.

- The family is experiencing an improvement in functioning based on accomplishing the family goals in the IPOS.
- The identified child and/or family that does not experience a reduction in symptoms as evidenced by an increased CAFAS score may be referred to Home Based services.
- The family no longer wants to receive services.

Transition Criteria/Process

Child and Family Supports—MI (SED)/DD is committed to assisting children and their families to move from one level of care to another and to obtain needed services that are not available within the program and/or organization. If needed, youth with SED can be transitioned to Home Based services, a higher level of care. Transition to different or additional programs is completed with active participation of the children, adolescents, and their parents/guardians. Transition planning may include friends, family, and other individuals and services as appropriate or permitted by families. Throughout treatment and during the family-centered planning process, there are discussions regarding the needs and desires of the youth and family, additional supports and services, and planning to determine if a different level of care would be appropriate.

Children and their families in Child and Family Supports MI (SED) may receive FPE or DBT. As they progress, they may transition to outpatient therapy and psychiatric services, and to other community-based services and supports.

Child and Family Supports—MI (SED) and DD Goals

1) The identified child will experience reduced symptoms, including improvement in behavior at home and at school as evidenced by a decrease in CAFAS score.
2) The family will experience restored and improved functioning and an increased ability to meet the needs of their child.
3) Inpatient care will be minimized (i.e., less than 15% will be readmitted within 30 days)
4) Masters-prepared staff will be trained to provide Trauma Focused – Cognitive Behavioral Therapy (TF-CBT) to promote the healing of the many children and adolescents who have experienced at least one, and possibly multiple incidents of trauma.

Special Populations

Children with Complex Disorders

These children are identified at initial assessment and/or during the course of receiving service. The program and its service array are designed to meet the needs of individuals with complex conditions. Person-centered planning and assessment assures that these unique conditions are identified and respected as truly individual, and treated as such in the service and supports planning process.
**Infant/Young Child**
Families with children age birth to six are served by Masters-level therapists who have experience working with young children. Infants and toddlers are served by Masters-level clinicians who receive specialized training in Infant Mental Health.

In addition to ongoing clinical supervision, a Masters-level Infant Mental Health specialist is available to consult with staff regarding the assessment and treatment of these families. Infants and toddlers can be served in Child and Family Supports MI (SED) and DD, or in Home Based services depending on the intensity of need.

**Deaf or Hard of Hearing**
Families with deaf or hard of hearing individuals have access to sign language interpreters, working in conjunction with the Child and Family clinical staff.

**Medical**
Children with medical problems are seen in the Child and Family Support MI (SED) and DD program, depending on their individual needs and primary diagnoses. Staff work with the family through their person/family-centered plan to identify which services may be necessary to help the family meet the medical needs of their children. Masters-level staff help families communicate with the primary care physician and other health resources in the community.

In those instances where foreign language assistance is required, GHS has at its disposal the use of Voices for Health, via telephone. Foreign language interpreter services are provided on a case-by-case basis.

**Crisis Management/After Hours**
The GHS Crisis Line provides our consumers and the community with 24-hour crisis telephone support and, when needed, referral to mobile, face-to-face crisis intervention by the Crisis Intervention and Recovery Team (CIRT). The purpose of CIRT is to mitigate crisis, prevent hospitalization and link individuals to the safest services and supports available which includes coordination with existing GHS supports and services the following day. CIRT is available 24 hours a day, 7 days a week, serving GHS consumers and all residents of Genesee County in need of immediate assistance in defusing mental health, substance abuse, and/or family crises and accessing medically necessary services and supports. CIRT can also be accessed directly by Genesee County community providers, agencies, and safety net partners on behalf of consumers or others in distress to ensure timely after-hours crisis support. Persons will have access to services regardless of their living environment, physical condition, or disability. Interpreters or other communication assistance are provided as necessary, including TTY availability.
Program Resources

Child and Family Supports (SED) MI and DD is located at Child and Family Services, 1102 Mackin, Flint, MI. Office hours are Mondays and Fridays from 8:00 a.m. to 5:00 p.m., and Tuesdays, Wednesdays, and Thursdays from 8:00 a.m. to 6:00 p.m. This program’s staffing resources include nine Masters-level clinical therapists and one Masters-level clinical supervisor. All clinicians are also Child Mental Health Professionals, a designation required as a part of our MDCH contract. A keystone of this requirement is that these clinicians receive 24 clock hours of training each year in the assessment and treatment of children. One full-time, board-eligible child psychiatrist and one part-time nurse serve this program through the Medication Clinic in the Mackin facility, along with secretarial resources that serve the entire facility. In addition, GHS’s professional and consultant staff (nurses, occupational therapists, physical therapists, dietitians, and psychologists) are utilized when necessary.

Service Modalities

- Case management/supports coordination services for children and their families are provided by Masters-level clinicians who assess, plan, link, coordinate, advocate, and monitor service needs and treatment.
- Services include access to psychiatric services and medication, individual therapy, family therapy, family training/support, community living supports, respite services, and crisis intervention.
- The case manager/supports coordinator links and coordinates services with other children’s agencies and community organizations, and helps the parent/guardian learn how to advocate for their child without being intimidated by, or inappropriate with, the professionals. Without this monitoring, children often do not make significant progress.
- Behavioral services to children and families are provided by Masters-level clinicians in consultation with Masters-level psychologists specialized in behavioral applications.
- Sensory Integration services are provided to children and families via referral from the case manager/supports coordinator with the service provided by an occupational therapist.
- Psychiatric services are provided by board-eligible child psychiatrists. Specific services include psychiatric evaluation and medication monitoring.
- Respite services are coordinated and provided to give caretakers a needed break from child care.
- CLS are coordinated and provided to assist children and families with community integration and skill-building activities.
- Masters-level case managers/supports coordinators are also able to provide individual and/or family therapy to reduce maladaptive behaviors, maximize behavioral self-control, and improve interpersonal and social functioning for both the child and the family members who interact with the child.
- In addition to the services above, Masters-level clinicians trained in Infant Mental Health can be utilized for consultation, as well as limited physical therapy and dietitian services.
Home Based Services

Description

Home Based services are provided in the home, school, and community in a supportive and interactive manner. This program provides intensive services for families who have not succeeded with less intensive interventions. The primary goal is to keep families together by preventing out-of-home placement while improving the family's functioning. The services demonstrate a multi-systemic approach to treatment with interventions that are family-centered and highly individualized. In order to have the most impact on the family system, the therapists work intensively with the adult caregivers, primarily in the home and community.

The identified children served range in age from birth to 17. Siblings who may benefit from their family's involvement range in age from infancy to 18. Many of the families have more than one member who has a diagnosed mental illness and a child with a serious emotional disturbance or functional impairment. Many of the children and their family members have experienced significant and/or multiple traumas, having been physically, emotionally, and/or sexually abused in the past. These traumas may have never been disclosed or adequately addressed. Family and other natural supports are minimal, and the families identify several major current psychosocial stressors.

Each family is linked with services that meet their needs and desires. Examples of organizational resources to which families are referred include: the Salvation Army, homeless shelters, domestic violence shelters and programs at the YWCA, Legal Aid, Love Inc., the Landlord-Tenant Association, free medical clinics, police departments, soup kitchens, substance use services, Goodwill, the Disability Network, DHS, Children’s Protective Services, Mott Children’s Health Center, the YMCA, Michigan Protection and Advocacy, Cause, and other GHS programs such as Wraparound services. Personnel work to keep each other informed of community resources.

Since success in school is so important for children, Home-Based staff are available to meet with teachers, attend IEPC meetings, and provide in-school support when a child’s school program is in danger of being disrupted.

Services also include moderate to intensive communication with family service agencies, Child Protective Services, courts and other community resources, and appropriate assistance with transportation, home repairs, and food/supplies.

Home Based services are designed on the premise that children or adolescents with emotional impairments are more likely to improve their functioning and behavior when the entire family is involved in the therapeutic process. Unless there are issues of physical or emotional safety that cannot be remedied, children have the best chance of success when living in their own homes; therefore, the program brings moderate to intensive interventions to the home, school, and community to improve the functioning of the entire family. Services are provided based on the individual child’s and family’s needs. Therapists use a family systems approach combined with
strength-based and person-centered interventions to work with family members collectively and individually. Additionally, staff are trained to practice in a trauma-informed manner and/or in trauma-specific interventions. Adult family members are encouraged to provide structure and a supportive environment for their children.

Specific goals are identified in sessions with family members through the use of a respectful family-centered planning philosophy. The program seeks to reduce symptoms in the identified child, restore and/or improve functioning of the entire family, and enhance the family's quality of life. Family members should experience reduced symptoms and restored function, and maintain their progress. Throughout the course of treatment, the child's behavior at home and school should improve, with family relationships becoming more fulfilling and positive.

Admission Criteria

- The identified child must be seriously emotionally disturbed as reflected in a primary DSM-IV diagnosis.
- The child must have an elevated subscale score (20 or greater) on at least two elements of the Child/Adolescent Section of the CAFAS, or an elevated subscale score (20 or greater) on one element of the CAFAS Child/Adolescent Section, combined with an elevated subscale score (20 or greater) on at least one CAFAS element involving Caregiver/Caregiving Resources, or a total impairment score of 80 or more on the CAFAS Child/Adolescent Section.
- The child is considered to be at risk of inpatient hospitalization and/or out-of-home placement.
- The family/community support systems cannot be relied on to provide the essentials of care without considerable support and intensive interventions.
- The family agrees to participate in Home Based services which are provided in the home, school, and community.
- The home environment is physically safe for staff.
- For infants and children through age six, there is substantial limitation of age-appropriate skills that is not transitory in nature and not solely due to developmental disability, physical illness, substance use, or a V-code DSM IV diagnosis.

Discharge Criteria

- The child is experiencing reduced symptoms through improvement in behavior at home, school, or in the community.
- The children in the home are not seriously emotionally disturbed as reflected in a primary DSM-IV diagnosis.
- The family/community support system is sufficiently stable to provide the essentials of care without Home Based services, and the children in the home are no longer at risk of out-of-home placement.
- The home is no longer physically safe for staff, even with adaptation of services, and the family is not willing to make the changes necessary to make the home physically safe.
• The family no longer wants to receive Home Based services.

Transition Criteria/Process

The Home Based program is committed to assisting children and their families to move from one level of care to another and to obtain needed services that are not available within the program or organization. Transition to different or additional programs is completed with active participation of the child, or adolescent, and their parents/ guardians. Transition planning may include friends, family, and other individuals and services as appropriate or permitted by families. Throughout treatment and during the family-centered planning process, there are discussions regarding the needs and desires of the youth and family, additional supports and services, and when moving to a different level of care would be appropriate.

Children and families in Home Based services may transition to Child and Family Supports - MI, to outpatient therapy and psychiatric services, and/or to other community-based services and supports.

Home Based Goals

1) The identified child will experience reduced symptoms -- including improvement in behavior at home and at school.
2) The family will experience restored and improved functioning and an increased ability to meet the needs of their children.
3) The identified child will return or remain at home with their family (i.e., 85% or more of children remaining in family home).
4) Readmission to inpatient care will be minimized (i.e., less than 15% will be readmitted within 30 days of hospital discharge).
5) Masters-level staff will be trained to provide Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) to promote the healing of the many children and adolescents who have experienced at least one, and possibly multiple incidents of trauma.

Special Populations

Infant/Young Child
Families with young children ages birth to six are served by Masters-level clinicians who have experience in working with young children. Infants and toddlers are served by Master's-level clinicians who receive specialized training in Infant Mental Health. The clinicians are endorsed or provisionally endorsed by the Michigan Association of Infant Mental Health as Infant Mental Health Level II (IMH-E II) or Level III (IMH-E III) Specialists. In addition to ongoing clinical supervision, a Masters-level Infant Mental Health specialist is available to consult with staff regarding the assessment and treatment of these families. Infants and toddlers can be served in Child and Family Supports -- DD or in Home Based services, depending on their individualized needs.

Developmental Disabilities (DD)
Home Based services clinicians are able to consult with Masters-level personnel who are Qualified intellectual Disability Professionals (QIDPs). This allows the program to work with families of children who are dually diagnosed with DD and serious emotional disturbances, and who require a more intense multi-systemic, family-centered approach that includes therapeutic services. Families with DD children who do not meet criteria for Home Based services but have some need for therapeutic intervention can be served by Masters-level therapists in Child and Family Supports – MI (SED) and DD.

Deaf or Hard of Hearing
Families with deaf or hard of hearing members have access to sign language interpreters working in conjunction with Child and Family clinical staff.

Medical
Children with medical problems can be seen in Home Based services. In the family-centered plan, staff work to identify which services may be necessary to help the family meet the medical needs of their children. Staff can help families communicate with the primary care physician and other health resources in the community. Referrals can be made for nursing evaluations and other medical services.

Crisis Management/After Hours
The first point of contact for families in crisis after hours is the on-call Home Based staff. Home Based therapists have flexible hours and are on call 24 hours a day, 7 days a week, to respond to families’ needs. They are available at all times by phone and/or in person to help coach and encourage the families to follow through with the established interventions and to respond to crisis situations. Families are given the Home Based on-call phone number for direct access to an on-call Home Based therapist. On-call duties are rotated on a weekly basis. After hours, a board-eligible child psychiatrist is available by phone to the Home Based supervisor and on-call staff for urgent psychiatric concerns.

Families also have access to the GHS Crisis Line that provides our consumers and the community with 24-hour crisis telephone support and, when needed, referral to mobile, face-to-face crisis intervention by the Crisis Intervention and Recovery Team (CIRT). The purpose of CIRT is to mitigate crisis, prevent hospitalization and link individuals to the safest services and supports available which includes coordination with existing GHS supports and services the following day. CIRT is available 24 hours a day, 7 days a week, serving GHS consumers and all residents of Genesee County in need of immediate assistance in defusing mental health, substance abuse, and/or family crises and accessing medically necessary services and supports. CIRT can also be accessed directly by Genesee County community providers, agencies, and safety net partners on behalf of consumers or others in distress to ensure timely after-hours crisis support. Persons will have access to services regardless of their living environment, physical condition, or disability. Interpreters or other communication assistance are provided as necessary, including TTY availability.
Families most often choose to call the Home Based on-call staff directly, but regardless of how crisis services are initiated, Home Based staff will follow up with the family to provide support and ongoing services. For deaf or hard of hearing children and their families, interpreters or other communication assistance are provided as necessary, including TTY availability.

Program Resources
Home Based services are located at Child and Family Services, 1102 Mackin, Flint, MI. Office hours are Mondays and Fridays from 8:00 a.m. to 5:00 p.m., and Tuesdays, Wednesdays, and Thursdays from 8:00 a.m. to 6:00 p.m. (actual program hours are 24/7 for Home Based). Clinicians have a set scheduled within the hours of operation, however, when needed, accommodations can be made to meet before or after the hours of operation.

This program’s staffing resources consist of eight Masters-level therapists, one Masters-level clinical coordinator and one master’s level clinical supervisor. All therapists are also Child Mental Health Professionals, a designation required as a part of the MDCH contract. A keystone of this requirement is that these clinicians receive 24 clock hours of training each year in the assessment and treatment of children. Home Based clinicians are supported through individual supervision, clinical case presentations, and training provided by the Masters-level supervisor in charge of the program.

One full-time, board-eligible child psychiatrist and one part-time nurse serve this program through the Medication Clinic in the Mackin facility, along with secretarial resources that serve the entire facility. In addition, GHS’s professional and consultant staff (nurses, occupational therapists, physical therapists, dietitians, and psychologists) are utilized when medically necessary.

Service Modalities
Home Based services are provided in the home, school, and/or community, and all members of the family may be involved in services. Services provided may include family, individual, couples, play, or group therapy, or behavioral plan development. Services are based on the specific needs of the child and family. Family members and the child receive skill development services such as behavioral management, life skills, conflict resolution, problem solving, anger management, decision making, and crisis management. These skills are provided directly to individuals in the school, home, or community, and often include accessing other community resources.

Home Based services are provided by Masters-level clinicians. Board-eligible child psychiatrists provide medications, and the family receives assistance in medication management and monitoring. Substance use patterns are assessed initially and over time, with appropriate interventions and referrals made. Staff with substance abuse credentials and experience are available to the other staff to discuss the possible substance use treatment needs of the children and their parents/guardians.

The Home Based program is committed to having an identified therapist work consistently with the family. Unless the family requests a change or staff leave the program, the same therapist and
support workers complete the episode of care with the family. If a family returns to Home Based services and requests a specific therapist, attempts are made to return that family to the previous therapist unless clinically contraindicated.

Home Based therapists rotate an on call phone which is available for the child or caregiver to use 24 hours a day, 7 days a week, to respond to families’ needs. During business hours families are encouraged to first contact the primary clinician or Home Based supervisor to resolve any difficulties that need immediate assistance and then if unavailable to contact the on-call worker. The on-call worker is available by phone and/or in person to help coach and encourage the families to follow through with the established interventions and to respond to crisis situations. After hours, a board-eligible child psychiatrist is available to the Home Based supervisor and on-call staff by phone for urgent psychiatric concerns.

Wraparound Services

Description

Wraparound services for children and adolescents consist of a highly individualized planning process performed by a Masters-level clinician who coordinates the planning and delivery of community services to increase the child's and family’s functioning. These services include mental health specialty services that are medically necessary for the child, services and supports from multiple agency partners, and the involvement of extended family and other natural supports. Identified children served range in age from birth to 18. Siblings who may benefit from their family's involvement range in age from infancy to 18.

The Wraparound plan is the result of a collaborative planning process that focuses on the unique strengths, values, and preferences of the child and family and is developed in partnership with other community agencies. Wraparound utilizes a Child and Family team, with its members having been determined by the family. The planning process works effectively with children who, due to safety and other risk factors, require services from multiple systems and informal supports. Program oversight is provided by a community team consisting of representatives from GHS, DHS, Family Court, the Intermediate School District, parents, and other community partners.

Wraparound services are provided in the home, school, and community in a supportive and interactive manner. Wraparound’s primary goal is to keep families together and prevent out-of-home placement. This is accomplished by creating a specially tailored team consisting of the parents, guardians, child, professionals, and natural supports, working together to come up with creative and effective strategies for helping the child and family. A Wraparound specialist supports the group process, with all members taking responsibility for individual parts of the Wraparound plan. Interventions are family-centered and highly individualized.
The program seeks to reduce symptoms in the identified child, restore and/or improve functioning of the entire family, and enhance the family’s quality of life. Family members should experience reduced symptoms and restored function, and maintain their progress. Throughout the course of treatment, the child’s behavior at home and school should improve, with family relationships becoming more fulfilling and positive.

**Admission Criteria**

The identified child must meet two or more of the following criteria:

- Seriously emotionally disturbed (SED) or Developmentally Disabled (DD) as reflected in a primary DSM-IV diagnosis.
- Involved in multiple systems (DHS, Family Court, school, GHS).
- At risk of, or currently in, out-of-home placement.
- Served through other mental health services with minimal success.
- Risk factors exceed the capacity for traditional community based options.
- Numerous providers are serving multiple children in a family and outcomes are not being met.

**Discharge Criteria**

- The child is experiencing reduced symptoms through improvement in behavior at home, school, or in the community.
- The family/community support system is now sufficiently stable to provide the essentials of care without Wraparound, and the children in the home are no longer at risk of out-of-home placement.
- The home is no longer physically safe for staff, even with adaptation of services, and the family is not willing to make the changes necessary to make the home physically safe.
- The family no longer wants to receive Wraparound services.

**Transition Criteria/Process**

The Wraparound program is committed to empowering the family to take a greater role in their treatment and make decisions about transitioning to other levels of care. Transition to different/additional programs is completed with active participation of the children, adolescents, and their parents/guardians. Transition planning includes friends, family, professionals, and other individuals on the Child and Family team. Throughout the process there are discussions regarding the needs and desires of the youth and family, additional supports and services, and when moving to a different level of care would be appropriate.

Children and families in Wraparound were likely receiving Home Based services or other clinical services from Child and Family Supports MI (SED and DD). Transition from Wraparound may include continuing these clinical services or possibly transfer to less intensive outpatient therapy or psychiatric services in the community.

**Wraparound Goals**
1) The identified child will experience reduced symptoms, including improvement in behavior at home and at school.
2) The family will experience restored and improved functioning and an increased ability to meet the needs of their children.
3) The identified child will return or remain at home with their family (i.e., 85% or more of children remaining in family home).
4) Readmission to inpatient care will be minimized (i.e., less than 15% will be readmitted within 30 days of hospital discharge).

Special Populations

**Infant Young Child**
Families with young children aged birth to six can be served in Wraparound if the admission criteria are met. The Wraparound Specialist would ensure that staff trained in Infant Mental Health (IMH) and early childhood were participants in the Child and Family team.

**Developmental Disabilities DD**
Families with children with DD and meet the admission criteria are eligible for Wraparound services. The Wraparound specialist will ensure that professionals who work with the developmentally disabled (mental health professionals who are designated as Qualified Intellectual Disability Professionals, or QIDPs) are part of the Child and Family team. Those who do not meet criteria for Wraparound services but who have some need for therapeutic intervention can be served by Masters-level therapists in Child and Family Supports – MI (SED) and DD.

**Deaf or Hard of Hearing**
Families with deaf or hard of hearing individuals have access to sign language interpreters working in conjunction with the Wraparound Specialist.

**Medical**
Children with medical problems can receive Wraparound services. The Wraparound plan would identify which services may be necessary to help the family meet the medical needs of their children. The Child and Family team with the family would determine who should best assist the family in communicating with the primary care physician and other health resources in the community. Referrals can be made for nursing evaluations and other medical services.

**Children and Adolescents in Foster Care**
The Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Pilot Program (SED-Waiver) provides fee for service funding for children and adolescents who are currently in foster care through DHS. These children are already residing in out-of-home care (either foster care
or residential placement) and require intensive services to succeed in the community. In order to qualify, these children must meet the criteria for admission to a state inpatient psychiatric hospital or have such significant needs that they would be at risk of hospitalization without waiver services. Each child must have a wraparound facilitator who is responsible to assist the child/family in identifying, planning and organizing the Child and Family Team, developing the IPOS, and coordinating services and supports. GHS also provides a clinical coordinator (housed at DHS) to assist in the referral of these children and serve as a consultant to the DHS staff regarding children with SED.

In those instances where foreign language assistance is required, GHS has at its disposal the use of Voices for Health, via telephone. Foreign language interpreter services are provided on a case-by-case basis.

Crisis Management/After Hours
All families involved with wraparound have a relapse plan developed in partnership with the family to identify natural supports in times of crisis.

The families have access to the GHS Crisis Line that provides our consumers and the community with 24-hour crisis telephone support and, when needed, referral to mobile face-to-face crisis intervention by the Crisis Intervention and Recovery Team (CIRT). The purpose of CIRT is to mitigate crisis, prevent hospitalization and link individuals to the safest services and supports available which includes coordination with existing GHS supports and services the following day. CIRT is available 24 hours a day, 7 days a week, serving GHS consumers and all residents of Genesee County in need of immediate assistance in defusing mental health, substance abuse, and/or family crises, and accessing medically necessary services and supports. CIRT can also be accessed directly by Genesee County community providers, agencies, and safety net partners on behalf of consumers or others in distress to ensure timely after-hours crisis support. Persons will have access to services regardless of their living environment, physical condition, or disability.

Interpreters or other communication assistance are provided as necessary, including TTY availability.

When crisis services are initiated, Wraparound staff will follow up with the family to provide support and ongoing services. For deaf children and their families, interpreters or other communication assistance are provided as necessary, including TTY availability.

Program Resources
Wraparound services are located at Child and Family Services, 1102 Mackin, Flint, MI. Office hours are Mondays and Fridays from 8:00 a.m. to 5:00 p.m., and Tuesdays, Wednesdays, and Thursdays from 8:00 a.m. to 6:00 p.m. (actual program hours are 24/7 for Wraparound). Since a majority of the

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work with families occurs off site, Wraparound specialists will accommodate needs of the family when scheduling.

Wraparound services are staffed with four Masters-level Wraparound specialists and one Masters-level Wraparound supervisor.

All therapists are also Child Mental Health Professionals, a designation required as a part of our MDCH contract. A keystone of this requirement is that these clinicians receive 24 clock hours of training each year in the assessment and treatment of children.

One full-time, board-eligible child psychiatrist and one part-time nurse serve this program through the Medication Clinic in the Mackin facility, and there are secretarial resources that serve the entire facility. In addition, GHS’s clinical consultation and nurse consultant staff are utilized when clinically necessary.

Service Modalities

Initially, Wraparound specialists work with the referring agency and meet with the families to help them identify members of their individualized Child and Family team. Team members include the child and family members, the Wraparound specialist, and also GHS therapists, Home Based staff, Family Court, DHS and school staff, neighbors, and other natural supports identified by the family.

Wraparound Child and Family team meetings initially occur once a week and may decrease to every two weeks and then monthly as the families’ situation improves. Decisions are discussed and plans are made in the team meetings. Individual members of the team take on certain tasks to accomplish between team meetings to support the child and the family.

Board-eligible child psychiatrists provide medications and the family receives assistance in medication management and monitoring through Home Based services, Child and Family Supports MI (SED) and DD, or by community psychiatrists. Substance use patterns can be assessed initially and over time by the professionals on the Child and Family team, with appropriate interventions and referrals made. Staff with substance abuse credentials and experience are available to the other staff to discuss the possible substance use treatment needs of the children and their parents/guardians.

Wraparound is committed to having one specialist work consistently with the family. Unless the family requests a change or staff leave the program, the same specialist completes the episode of care with the family. If a family returns to Wraparound and requests a specific specialist, attempts are made to return that family to the previous therapist unless clinically contraindicated.

_Multisystemic Therapy Services (MST)_
Description
Multisystemic Therapy (MST) is an evidence-based, intensive family and community treatment model that addresses the multiple determinates of serious antisocial behavior in juvenile offenders. The typical youth in MST services is involved in the Juvenile Justice system and has a variety of antisocial behaviors, multiple and/or serious criminal offenses, school truancy, and substance use and is at risk for out-of-home placement due to these behaviors. The primary purposes of MST are to empower parents with the skills and resources needed to independently address the difficulties that arise in raising these children and adolescents (most of whom can be identified as seriously emotionally disturbed), and to empower youth to cope with family, peer, school and neighborhood problems.

Admission Criteria
- The identified youth is a juvenile offender who is 12 to 17 years of age and has been referred by the Family Court.
- The youth presents with serious anti-social behaviors such as physical aggression in the home or community, committing criminal offense(s), school truancy, and/or substance use issues.
- The youth is assessed as high risk for criminal recidivism as measured by the Youth Assessment and Screening Instrument (YASI).
- The youth is considered to be at risk of, or is returning from, out-of-home placement.
- The youth may be seriously emotionally disturbed as reflected in a primary DSM-IV diagnosis.
- The family agrees to participate in MST provided in the home, school, and community.
- The home environment is physically safe for staff.

Discharge Criteria
- The child is experiencing reduced symptoms through improvement in behavior at home, school, or in the community based on MST measures, and a decrease in CAFAS scores.
- The family reports an improvement in functioning based on the MST Overarching Goals identified in the individual plan of service (IPOS).
- The family/community support system is now sufficiently skilled to maintain the youth in the home without MST services, and the youth is no longer at-risk of out-of-home placement.
- The family has completed a full course of MST time-limited treatment (two to five months).
- The home is no longer physically safe for staff, even with adaptation of services, and the family is not willing to make the changes necessary to make the home safe.
- The family no longer wants to receive MST services.

Transition Criteria/Process
MST is committed to providing comprehensive services that result in the youth and family requiring few, if any, formal services after MST has ended. Transition to different or additional services is completed with active participation of the youth and their parents/guardians. Transition planning may include friends, family, and other individuals and services as appropriate or permitted by the consumer.
MST youth and their families may be transitioned to community physicians to maintain medications. By the time MST has ended, they will have been linked to a variety of community supports. If additional GHS services are necessary, youth can be transferred to Child and Family Supports--(SED) MI and DD for case management/supports coordination and therapy, or to Home Based services.

Multi-Systemic Therapy Goals

1) The identified child will demonstrate a decrease in anti-social behaviors as evidenced by increased school attendance and performance, increased compliance at home, and no additional criminal offenses at discharge 6, 12, and 18 months post treatment (i.e., measured by MST outcome measures).
2) The identified child will experience reduced symptoms, including improvement in behavior at home and school.
3) The family will experience restored and improved functioning and an increased ability to meet the needs of their children.
4) The identified child will return or remain at home with their family (i.e., 85% or more of children remain in family home).

Special Populations

Due to the specific admission criteria for MST services, many children with unique or broader disabilities (e.g., DD, etc.) are excluded from program services. It is possible for youth with medical problems to receive MST; however, in the family-centered plan, staff work to identify which services may be necessary to help the family meet the medical needs of their children. Personnel can help families communicate with the primary care physician and secure other health resources in the community.

In those instances where foreign language assistance is required, GHS has at its disposal the use of Voices for Health, via telephone. Foreign language interpreter services are provided on a case-by-case basis.

Crisis Management/After Hours

The first point of contact for families in crisis after hours is the on-call MST staff. MST therapists have flexible hours and are on call 24 hours a day, 7 days a week to respond to families’ needs. MST therapists are available at all times by phone and/or in person to help coach and encourage families to follow through with the established interventions and to respond to crisis situations. Families are given the MST on-call phone number for direct access to the on-call MST therapist. On-call duties are rotated on a weekly basis.

Families also have access to the GHS Crisis Line that provides our consumers and the community with 24-hour crisis telephone support and, when needed, referral to mobile, face-to-face crisis intervention by the Crisis Intervention and Recovery Team (CIRT). The purpose of CIRT is to
mitigate crisis, prevent hospitalization and link individuals to the safest services and supports available which includes coordination with existing GHS supports and services the following day. CIRT is available 24 hours a day, 7 days a week, serving GHS consumers and all residents of Genesee County in need of immediate assistance in defusing mental health, substance abuse, and/or family crises, and accessing medically necessary services and supports. CIRT can also be accessed directly by Genesee County community providers, agencies, and safety net partners on behalf of consumers or others in distress to ensure timely after-hours crisis support. Persons will have access to services regardless of their living environment, physical condition, or disability. Interpreters or other communication assistance are provided as necessary, including TTY availability.

Families almost always chose to call MST directly, but regardless of how crisis services are initiated, MST staff will follow up with the family to provide support and ongoing services.

For deaf or hard of hearing children and their families, interpreters or other communication assistance are provided as necessary, including TTY availability.

Program Resources

MST staff are employees of GHS and have offices at Child and Family Services, 1102 Mackin, Flint, MI. Office hours are Monday through Thursday from 8:00 a.m. to 6:00 p.m., and Friday from 8:00 a.m. to 5:00 p.m. (actual program hours are 24/7 for MST). However, the MST team is primarily located at the building that houses the Genesee County Juvenile Probation Office, located at the McCree Building at 630 S. Saginaw, Flint, MI 48502.

The program’s staffing resources consist of three Masters-level MST therapists and one Masters-level MST supervisor.

All therapists are also Child Mental Health Professionals, a designation required as a part of our MDCH contract. A keystone of this requirement is that these clinicians receive 24 clock hours of training each year in the assessment and treatment of children. In accordance with the MST model, group supervision with the MST supervisor and the MST consultant is provided weekly. During weekly supervision, the efficacy of the previous week’s interventions are reviewed and modified to support ongoing progress.

In addition, one full-time, board-eligible child psychiatrist and one full-time nurse serve this program through the Medication Clinic in the Mackin facility, along with secretarial resources that serve the entire facility.

Service Modalities

MST delivers intensive home and community-based services, supported through weekly supervision and telephone consultation with an MST expert. Therapists carry a small caseload, and length of treatment averages two to five months. Within the MST model, therapists:

- Conduct comprehensive functional assessments of youth in the context of their families, peer
group, school, and neighborhood.

- Seek to understand the “fit” between the youth’s problems and the factors which contribute to them.
- Empower parents to address the needs of youth (i.e., structure, support) more effectively.
- system (family, peers, school, and indigenous support networks) to facilitate such change.
- Focus on helping parents build supportive social networks in their community.
- Promote behavioral change in the youth’s natural environment, using the strength of each

Emphasize long-term changes that families can maintain after their involvement in MST ends.

MST services are also community-based, with a strong working relationship with referral sources such as juvenile justice officers, Family Court personnel, deputy officers, social welfare workers, teachers, and guidance counselors. Considerable effort is made to obtain the perspectives of multiple systems that have the common goal of improving child, adolescent, and family treatment goals.

Specific goals are identified in sessions with family members through the use of a family-centered planning philosophy. Within the context of support and skill building, the MST therapist places developmentally appropriate demands on the adolescent and family for responsible behavior. In doing so, the program seeks to reduce antisocial behaviors in the identified child, restore and/or improve functioning of the entire family, and enhance the family’s quality of life. Family members should report increased skills to manage their children’s behavior and increased confidence in being able to sustain the progress made after MST is no longer working with the family.

MST therapists have flexible hours and are on call 24 hours a day, 7 days a week, to respond to families’ needs. MST therapists are available at all times by phone and/or in person to help coach and encourage families to follow through with the established interventions and to respond to crisis situations. Families are given the MST on-call phone number and back-up pager number for direct access to the on-call MST therapist. On-call duties are rotated on a weekly basis.

Services provided may include family therapy, individual therapy, couples therapy, play therapy, group therapy, substance use interventions, or behavioral plan development. A wide range of behavioral, cognitive behavioral and MST-specific interventions are used. Services are based on the specific needs of the child and family. Family members and the child receive skill development services such as behavioral management, life skills, conflict resolution, problem solving, anger management, decision-making, and crisis management. Substance use patterns are assessed initially and over time, with appropriate interventions made. Staff with substance use credentials and experience are available to the other staff to discuss the possible substance use treatment needs of the children and their parents/guardians.

Additionally, GHS provides MST-SA, an MST adaptation that utilizes contingency management (MC) protocols to treat adolescent substance use. Within the MST-SA model, the therapists teach
PROCEDURE MANUAL
Program/Service Structure Clinical Services Plan

SUBJECT
L. Tompkins Vice President of Clinical Operations
K. Baxter, Senior Clinical Director

caregivers and youth, the various components of contingency management (CM) treatment. These components include:

- Developing a functional analysis of the youth’s drug use
- Creating management plans for the youth and family members to use in response to the triggers elicited by the functional analysis
- Collecting a behavior plan that helps the family incentivize drug abstinence and punish drug use
- Teaching the youth drug refusal strategies
- Teaching the family to help the youth with each component of CM

All CM interventions are provided within the broader context of the MST model.

MST is committed to having an identified therapist work consistently with the family. Unless the family requests a change or personnel leave the program, the same therapist completes the episode of care with the family. If a family returns to the MST program and requests a specific therapist, attempts are made to return that family to the previous therapist unless clinically contraindicated.

Other Child and Family Initiatives

*Juvenile Justice Screening, Assessment, and Diversion*

GHS partners with the Family Court to provide a full-time Masters-level clinician to screen juveniles in the Family Court system where mental health issues may play a part in their offenses or rehabilitation. Juveniles are screened with the MAYSI-2, a self-report screening tool developed specifically for use with the Juvenile Justice population. The MAYSI-2 yields scores on seven areas of mental health and substance use problems. Juveniles exceeding a predefined cutoff on one or more MAYSI-2 scales receive a diagnostic interview by the GHS clinician, which results in a written evaluation. This written evaluation is provided to the probation officers with recommendations regarding the juvenile’s treatment needs and potential options for diversion out of the Juvenile Justice system, or to more appropriate services. On occasion, screening has revealed urgent issues such as active psychosis, and juveniles have been referred directly to crisis services in addition to longer-term recommendations. The clinician is also onsite to provide consultation to court staff.

*Genesee Valley Regional Center (GVRC)*

Responding to a need for mental health service in the GVRC, GHS assists the center in identifying and providing mental health and psychiatric services for youth incarcerated in the detention center. A Masters-level clinician provides services at the GVRC and assists in the care coordination of these youth to ensure that mental health needs are met while they are incarcerated, and that their families can obtain services for the youth after discharge. A GHS board-eligible child psychiatrist provides four hours of psychiatric consultations weekly at the detention center. Youth are also transported to the GHS Child Medication Clinic for appointments if necessary.

*Infant/Toddler Treatment Court (ITC)*
The ITC is a community-based project designed to provide Infant Mental Health services to maltreated infants and toddlers (and their families) who are temporary wards of the court by reason of abuse and neglect. Funds, staff, and resources have been provided by a variety of community partners, to further this endeavor, including staff provided by GHS Infant Mental health therapists who are endorsed as Level II or Level III clinicians by the Michigan Association of Infant Mental Health. The Masters-level clinicians trained in the Infant Mental Health model provide assessment and treatment to assist the primary caregiver in learning to provide a safe and nurturing environment for the children.

The primary goal of ITC is for the child to achieve permanence as quickly as possible. Intensive interventions are aimed at supporting a healthy attachment between the parent and young child, the parent obtaining and providing a safe home, and a reduction in maladaptive behavior on the part of the infant/toddler. When it is not possible for the parent to achieve this, the goal is for the young child to establish a permanent home without undue delay.

**Juvenile Mental Health Court**

Juvenile Mental Health Court is a project involving youth with serious emotional disturbances who are adjudicated in the 7th District Court. The Juvenile Justice Screening Assessment and Diversion clinician helps coordinate the program with the Family Court judge, probation officers, and GHS staff to provide a comprehensive treatment partnership and assist youth and their families to follow treatment recommendations. Youth who successfully complete this program “graduate” from the court process with appropriate mental health services in place.

**Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)**

Currently, the Masters-level staff at Child and Family Supports MI (SED) and DD, and Home Based services are being trained in TF-CBT. This evidenced-based model has proven itself to be valuable in treating posttraumatic stress and related emotional and behavioral problems in children and adolescents. Given that most of the children and adolescents who come to our programs have experienced at least one traumatic event (many have experienced multiple traumas), training staff in this model is a very important goal. Our therapists will provide services with model fidelity which includes providing psychoeducation and parenting skills, relaxation skills, affect expression and regulation skills, cognitive coping skills and processing, trauma narrative, and in vivo exposure (when needed).

**Genesee County Appropriate Trauma-informed Screening, Assessment & Treatment Project (GC-ASAP)**

The primary purpose of GC-ASAP is to establish a continuum of services that includes trauma-informed screenings, functional assessments and evidence-based treatments to improve the social and emotional well-being and developmental functioning of the children currently in foster care in Genesee County. Through collaboration with the Department of Human Services, Michigan Easter Seals, 7th Circuit Court Family Division, Mott Children’s Health Center, the Weiss Child Advocacy
Center, Court Appointed Special Advocates (CASA), and Western Michigan University’s Children’s Trauma Center (CTAC), we are working toward a system of change. This change will shift the current traditional child welfare service delivery to a trauma-informed system framework that matches children’s needs with trauma-informed interventions and case management practices, improving child outcomes of safety, permanency, and well-being. This will result in more successful adoptions and family reunification. GHS and the collaborating partners are committed to reconfiguring their systems which have resulted in creating new local and community policies to sustain the trauma-informed care.

**Family Supports Coordination**

**Description**
The purpose of Family Supports Coordination is to provide services to children who were exposed to lead during the Flint Water Crisis. The program aims to provide in-home assessment and case management services to mitigate lead exposure and assist with getting children and families connected with services.

**Service Modality**

*Initial Assessment and Development of Plan of Care*
- Clinician completes an in-home bio-psycho-social assessment and develops a Plan of Care with the family
- The clinician and family navigator will work together to provide resources and assist the family in mitigating lead exposure

*Follow Up Case Management*
- The clinician is allowed to bill for 5 30-minute face-to-face case management sessions a year; per beneficiary
- During these case management sessions, the clinician will review the goals and assist the family with addressing any barriers that are present

**Admission Criteria**
- Active with Flint Medicaid Waiver (Under 21 years of age or pregnant female)

**Program Resources**
- 1 Clinical Coordinator
- Grant-funded Family Navigators to assist with meeting goals

**Discharge Criteria**
- Client is connected to a higher level of care or other ongoing community-based treatment
- Client is no longer active in program
- Client no longer is active with the Flint Medicaid Waiver (21 years of age or older, past 60 days post-partum)
OUTPATIENT SERVICES-ADULTS AND CHILDREN
Behavioral Health Treatment Services/Applied Behavior Analysis

Description

The Genesee Health System Children’s Autism Center provides Applied Behavior Analysis (ABA) services to children 10 years of age and younger with Autism Spectrum Disorders (ASD). Behavioral Health Treatments such as ABA prevent the progression of ASD, prolong life, and promote the physical and mental health and efficiency of the child. ABA is based on the science of learning and behavior, is evidence based, and includes many different techniques including Discrete Trial Training, Natural Environmental Training, Verbal Behavior, and Pivotal Response Training, among others. Skill acquisition will often focus on those areas needed for school readiness and social skill development such as functional communication, independent self-care tasks, receptive language, expressive language, play behaviors, social skills, imitation, and/or any additional behaviors that will enable the child to more readily integrate with typically developing peers. Reduction of problem behavior is also an area of focus. Services are provided in both an individual one-to-one setting, as well as a small group setting. The ABA treatment plan is developed and closely supervised by a Masters prepared behavior analyst and delivered through a trained behavior technician.

Admission Criteria

The Michigan Department of Health and Human Services (MDHHS) determines eligibility for these services on an initial and annual basis. The target group for the ABA benefit includes Medicaid covered children under age 21, with a diagnosis of ASD. The GHS Children’s Autism Center provides the initial eligibility evaluation and annual re-evaluation. This data is submitted to MDHHS for eligibility determination where needs-based criteria are applied (i.e., substantial functional impairment in social interaction and restricted, repetitive, and stereotyped patterns of behavior, interests, and activities).

Discharge Criteria

- Greater than 21 years old;
  Medical necessity for the ABA service is no longer demonstrated based on annual re-evaluation and outcome measurement tools (Verbal Behavior Milestones Assessment and Placement Program or Assessment of Basic Language and Learning Skills – Revised);
- Attendance in the program falls below acceptable levels (defined as absence of 25% or more of the planned and scheduled ABA treatment hours), rendering the ABA service intensity ineffective and/or inappropriate.

Transition Criteria/Process

Transition planning occurs at the initiation of the ABA treatment by systematic incorporation of maintenance and generalization procedures in the treatment plan. Parent education is provided within the Center to develop parent skills in relation to ASD. Additionally, Center staff participate
in person-centered planning and school-based education planning. Transition planning intensifies during the last four to six months of treatment for children that entering school or planning to transfer to home-based services.

**Program Goals**

The goals of ABA treatment for Autism Spectrum Disorder focus on improving core deficits in communication, social interactions, and restricted behaviors. Changing these fundamental deficits may develop greater functional skills and independence, reduce intrusive, disruptive behaviors and/or stereotypic autistic behaviors and improve socially acceptable behaviors and communication skills. Interventions are directed toward developing functional communication, independent self-care tasks, receptive language, expressive language, play behaviors, social skills, imitation, and/or any additional behaviors that will enable the child to more readily integrate with typically developing peers.

**Crisis Management/After Hours**

The GHS Crisis Line provides our consumers and the community with 24-hour crisis telephone support and, when needed, referral to mobile, face-to-face crisis intervention by the Crisis Intervention and Recovery Team (CIRT). The purpose of CIRT is to mitigate crisis, prevent hospitalization, and linking individuals to the safest services and supports available which includes coordination with existing GHS supports and services the following day. CIRT is available 24 hours a day, 7 days a week, serving GHS consumers and all residents of Genesee County in need of immediate assistance in defusing mental health, substance abuse, and/or family crises and accessing medically necessary services and supports. CIRT can also be accessed directly by Genesee County community providers, agencies, and safety net partners on behalf of consumers or others in distress to ensure timely after-hours crisis support. Persons will have access to services regardless of their living environment, physical condition, or disability. Interpreters or other communication assistance are provided as necessary, including TTY availability.

**Program Resources**

The GHS Children’s Autism Center is located at 2700 Robert T. Longway Blvd, Suite C, Flint, MI 48503 and consists of multiple individual treatment rooms, large activity rooms, meeting rooms, and professional offices.

The Center’s staff is large and consists of the following: Doctoral level Psychologist as Clinic Director; Doctoral level Board Certified Behavior Analyst as Senior Manager – Behavioral Supports; Doctoral level Psychologist as Assistant Director of Evaluation Services; Master level Psychologist and Board Certified Behavior Analyst (BCBA) as Clinic Manager; one Clinic Supervisor (a BCBA); Office Manager, multiple ABA Technicians; contract and employed Masters and Doctoral level Psychologists for diagnostics; a Parent Support Partner; and clerical support staff.
Dialectical Behavior Therapy

Description
Dialectical behavior therapy (DBT), a psychosocial treatment initially designed to treat borderline personality disorder, is provided on an outpatient basis, either alone or in conjunction with other GHS services. It is also successfully used as a basis of treatment for other clinical syndromes, particularly those that involve impulsive and self-mutilating behaviors and substance use disorders.

DBT-based interventions are designed to ensure that new consumer-specific capabilities are generalized from the treatment environment to the consumer’s everyday life. The individual therapist is always considered to be the primary treatment provider in the DBT model and, along with the consumer, is responsible for organizing treatment to ensure that functional clinical supports are in place. In an outpatient setting, DBT is considered to be a 12-month treatment cycle.

Admission Criteria (any combination of five or more of the following):

- Adults or adolescents (ages 11-17) with SMI.
- Emotional dysregulation sufficient to result in socially maladaptive behaviors that substantially interfere with the individual’s ability to achieve a satisfying level of recovery.
- Para-suicidal behaviors including recurrent threat or risk of self-harm, gestures (cutting, self-mutilation, burning), or suicide.
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
- Identity disturbance or markedly and persistently unstable self-image or sense of self.
- Impulsivity in at least two life domains considered to be potentially self-damaging (e.g., spending beyond one’s resources, substance abuse, reckless driving, binge eating) exclusive of other self-harm behaviors.
- Affective instability due to a marked reactivity of mood (intense anxiety, dysphoria, irritability) lasting a few hours and only rarely more than a few days.
- Transient, stress-related paranoid ideation or dissociative symptoms.
- History of longstanding difficulty with engagement and unsuccessful treatment episodes in multiple programs, or admissions to the hospital emergency room, which often results in multiple inpatient psychiatric hospital admissions.

Discharge Criteria

- Completion of all four DBT Skill Building modules accompanied by regular (weekly) participation in DBT sessions.
- Sufficient mastery of skills to result in the reduction or cessation of self-harm behaviors.
- The person served and/or DBT Consultation Team members agree to cessation of services based on the “4 and Out Rule” consistent with DBT model fidelity.*
- Goals have been met to the satisfaction of the person served or their guardian.
- Individual/guardian/family requests and receives an alternative, medically necessary service to...
the exclusion of DBT.
- The DBT Consultation Team, despite repeated and ongoing effort, cannot locate the person served for over 35 calendar days.
- The consumer establishes a domicile outside Genesee County
- The “4 and Out Rule” is based on DBT best-practice protocols that provide for flexibility in service provision (accepting missed appointments) while at the same time reinforcing the importance of maintaining a commitment to DBT treatment as evidenced by participation in DBT services. The rule is summarized as missing four consecutive sessions of either DBT Skills Group or DBT individual therapy sessions. Exceptions may be made for circumstances beyond the consumer’s control. The decision to discharge using the “4 and Out Rule” is always made in consultation with members of the DBT Team in recognition of the need for a balanced approach that emphasizes acceptance of the consumer’s current maladaptive behavior and the need to achieve adaptive behavioral change.

Transition Criteria/Process

The DBT program is committed to assisting persons served to move fluidly between service levels to meet their identified needs. In DBT, every consumer has an individual DBT therapist who, with the consumer, assesses treatment needs, formulates treatment interventions, and initiates transition and discharge planning. Transition planning may include friends, significant others, or other individuals as desired or permitted by the consumer.

Throughout the course of DBT treatment, there are ongoing discussions regarding the needs and desires of the individual and consideration of options for the supports and services that will likely enhance recovery and support his or her increased functioning in a community of choice.

At the end of the treatment cycle, each individual is interviewed by the DBT individual therapist to determine his or her level of interest in continuing DBT. When interest is expressed, the individual therapist and the consumer develop specific goals and an accompanying treatment plan for continued DBT treatment. Possibilities include continuing to attend DBT Skills Training classes, attending DBT individual therapy without Skills Training Classes, or entering into prolonged exposure treatment (PET) with a DBT therapist. Information about the treatment plan is included in a transition planning document and distributed to the primary case manager for inclusion into the individual plan of service (IPOS).

When a consumer leaves DBT, they are able to continue receiving case management and psychiatric services, and as they progress in recovery could move to less intensive services at GHS or in the community.

Dialectical Behavior Therapy Goals

1) There will be a reduction in self-reported negative affect based on diary card entries made by
consumer and reviewed with the individual therapist.

2) There will be an increase in self-reported constructive coping behaviors based on DBT Diary Card entries.

DBT Special Populations

Adolescents and Older Latency Age Youth
The DBT Team is able to provide DBT services for youth with similar symptoms as the adult DBT population. These symptoms may not be as pronounced due to the ability to provide DBT intervention earlier in their lives. DBT therapists who work with adolescents and latency age youth are also trained in the assessment and treatment of adolescents and youth and are credentialed as child mental health professionals, a designation required as a part of the MDCH contract. Working with parents and family members is also a component of DBT for youth.

Adults with Developmental and/or Intellectual Disabilities
The DBT Team is also able to provide DBT services for adults with developmental and/or intellectual disabilities (DD/ID); i.e., mild mental retardation or slowed cognitive processing, who also have skills deficits in emotion regulation, distress tolerance, and interpersonal relationships. These persons receive weekly individual therapy with a DBT therapist, and weekly DBT skills training using a skills training manual adapted for special populations. (The adaptations were made with permission and support from the developer of DBT.) DBT therapists who work with these individuals are also trained in assessment and treatment of persons with mental retardation/cognitive processing delays and are credentialed as qualified mental retardation professionals.

In those instances where foreign language assistance is required, GHS has at its disposal the use of Voices for Health, via telephone. Foreign language interpreter services are provided on a case-by-case basis.

Crisis Management/After Hours
In outpatient DBT, the responsibility for assisting a consumer in crisis resides with the DBT individual therapist, or alternatively, a DBT team member who has the expressed duty to respond to requests for DBT Phone Coaching 24 hours a day, 7 days a week. The GHS DBT team provides a Masters-level clinician trained in DBT protocols, and a member of the DBT treatment team to respond to calls for assistance after hours and on weekends.

DBT Phone Coaching protocols structure the discourse to the point of paying attention and validating the caller's affect, mutual exploration that defines the parameters of the current problem, and identifying precipitating factors or triggers to emotional dysregulation, followed by a focus on problem solving. This pragmatic approach results in a time-limited conversation that is both practical and
functional and results in the client using the Mindfulness, Emotion Regulation, Distress Tolerance, or Interpersonal Effectiveness skills that have been practiced in individual and group sessions.

Prior to ending a DBT Phone Coaching call, the DBT therapist gains, to the greatest extent possible, consumer agreement to implement a plan of action that specifies what he or she and the therapist will do in the interim until the next contact. This plan contains the terms of an explicit, time-limited contract that includes requirements the caller must fulfill to lessen the effect of the current crisis.

The DBT Phone Coaching call will also assess factors associated with risk and safety (including suicidal ideation), the level of commitment demonstrated by the caller to implement the agreed-upon plan, the impulse control of the caller, and the natural supports immediately available to calm the crisis. If needed, DBT therapists assist clients to call 911 with medical or psychiatric emergencies.

DBT consumers also have access to the GHS Crisis Line which provides our consumers and the community with 24-hour crisis telephone support and, when needed, referral to mobile, face-to-face crisis intervention by the Crisis Intervention and Recovery Team (CIRT). The purpose of CIRT is to mitigate crisis, prevent hospitalization, and link individuals to the safest services and supports available, which includes coordination with existing GHS supports and services the following day. CIRT is available 24 hours a day, 7 days a week, serving GHS consumers and all residents of Genesee County in need of immediate assistance in defusing mental health, substance abuse, and/or family crises, and accessing medically necessary services and supports. CIRT can also be accessed directly by Genesee County community providers, agencies, and safety net partners on behalf of consumers or others in distress to ensure timely after-hours crisis support. Persons will have access to services regardless of their living environment, physical condition, or disability. Interpreters or other communication assistance are provided as necessary, including TTY availability.

Program Resources
The DBT team consists of three Masters-level DBT therapists engaged in DBT service provision, one peer support specialist, and a Masters-level DBT supervisor responsible for supervision, program development, and implementation. Hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m., with additional hours available based on medical necessity in addition to the Phone Coaching described above.

Service Modalities
In consideration of model fidelity requirements associated with this evidence-based practice, it should be noted that DBT's comprehensive treatment package orchestrates the delivery of five essential functions through five typical DBT treatment modes:

- A weekly 2.25-hour skills training group structured through the use of the DBT skills training manual to enhance DBT participant skills and capabilities. Skills training groups are two hours for adolescents, and 1.5 hours for persons with DD/ID.
- Weekly individual psychotherapy sessions (or twice weekly under some circumstances) with the
explicit goal of improving consumer motivation for treatment and behavioral change. The clinician providing this service will be considered the primary DBT therapist with authority to direct and coordinate other DBT team members in service delivery on behalf of the consumer.

- Structured telephone calls initiated by the consumer to a member of the DBT team for the purpose of reducing suicidal crisis behaviors and to further strengthen positive skills transfer to the consumer’s natural environment
- DBT individual therapists and DBT Skills Group facilitators meet in weekly consultation team meetings to enhance their therapeutic skills and to maintain or improve their motivation to provide therapeutic services to this difficult-to-serve population.
- DBT staff members may assist the DBT consumer in the effort to structure their environment to promote the successful achievement of consumer-defined treatment goals.

PROFESSIONAL AND CONSULTATIVE SERVICES

Medication Clinics

Description

The Medication Clinics (Adults and Children) provide a variety of services for adults, adolescents, and children to help meet their mental health needs. Services include medication administration, medication reviews, AIMS testing, psychiatric evaluations, and health screens. The majority of individuals utilizing the Adult Medication Clinic are also receiving services in other mental health, developmental disability, or substance use programs, either internally from the network provider panel, or from other community resources. The Children’s Medication Clinic provides services to seriously emotionally disturbed and developmentally disabled children and adolescents. They also provide psychiatric consultation services to the GVRC, which is the juvenile detention center. All services promote psychiatric stability so persons served can maintain their daily activities in the community.

On-site laboratory services are provided by Quest Diagnostics, which is centrally located in the 420 building in order to best serve the Medication Clinic and the Genesee Community Health Center. The lab is open Monday through Friday from 8:00 a.m. to 5:00 p.m. Closed from 12:00 to 1:00 p.m. for lunch. Lab work requested by the GHS physicians, primary care physicians, and other external psychiatrists can be completed at this site.

On-site pharmacy services are provided by Genoa Pharmacy. They provide injectable medications to the Medication Clinic and oral medications for ACT and others. They are open from 8:30 a.m. to 5:00 p.m. Monday through Friday.

Admission Criteria

- Medication management is necessary to maintain consumer’s level of functioning in conjunction with other forms of mental health supports or service.
- The consumer is receiving primary substance use services but needs medication management for mental illness due to a co-occurring disorder.
- A child or adolescent must be seriously emotionally disturbed and/or developmentally disabled
as reflected in a primary validated DSM-IV diagnosis.

Discharge Criteria

- The consumer’s mental health symptoms have been stabilized, and they will continue care with their primary care physician/managed care health plan.
- The consumer no longer needs psychotropic medication.
- The consumer no longer chooses to receive services.
- The consumer no longer meets criteria for primary services

Transition Criteria/Process

The Medication Clinics are committed to assisting persons served to move from one level of care to another and to obtain needed services that are not available within the program. Transition to a different aspect of the Medication Clinic is completed with active participation of consumers and their guardians. Consumers can transfer from case management and the traditional Medication Clinic to a private provider as they progress in their recovery. If an individual’s needs or symptoms increase and/or they are admitted to a psychiatric hospital, they can access case management services depending on their individual needs.

Special Populations

Given the inherent nature of persons with SMI, SED, DD, and substance use disorder, it is typically the case that individuals present with multiple disabilities, disorders, and conditions. Indeed, the entire service array is designed to meet the needs of consumers with complex conditions. Person-centered planning and assessment assures that these conditions are identified and respected as truly individual, and treated as such, in the service and supports planning process. For deaf or hard of hearing individuals, timely access to interpreter services is assured through the scheduling of an interpreter when each doctor’s appointment is scheduled.

The Medication Clinic provides the monitoring necessary to meet the special requirements for consumers taking Clozaril. These individuals are served by a dedicated physician and nurse to carefully monitor their blood levels and provide phone support ensuring that lab tests are completed and appointments are kept. They also provide ongoing education in symptom management.

Program Resources

The Medication Clinics, although diverse in its target population, has a sufficient number of personnel trained:

- Two full-time psychiatrists (one adult and one child)
- Four full time and two part time psychiatric nurse practitioners
- Four full time and two part time psychiatric nurse practitioners
The Adult Medication Clinic is housed on the 2nd floor of the GHS main campus at 420 W. Fifth Ave., Flint, MI, and is open Monday through Friday from 8:00 a.m. to 5:00 p.m. The Children’s Medication Clinic is housed at 806 Tuuri Place, Flint, MI, and is open Monday through Friday from 8:00 a.m. to 5:00 p.m.

Service Modalities
The Adult Medication Clinic provides services necessary for medical monitoring of a consumer’s symptoms and functional impairments. In addition to psychiatric evaluations, and medication reviews the Medication Clinic pays special attention to an individual’s physical health needs. When there are individuals with many and/or significant health issues, there is a collaborative approach between GHS and their primary care physician/Genesee Community Health Center to ensure that their needs are met. The following services are provided:

- Medication service (as an adjunct to services)
- Prescribing
- Administering
- Monitoring and education
- Vital signs, weight and body mass indices (BMI) and health screens
- Health assessment recommendations

The Children’s Medication Clinic psychiatric services are provided by qualified mental health processional which include psychiatric evaluation and medication monitoring and psychiatric consultation services to the GVRC. The following services are provided:

- Medication service
- Prescribing
- Monitoring and education
- Vital signs, height, weight and BMI
- Health screens
- Health assessment recommendations
- Family assistance in medication management

Clinical Consultation Services
Description
Professional and Consultative services provide specialized clinical support to developmentally disabled and mentally ill adults, children, and their families. These services are provided by psychologists, occupational therapists, a physical therapist, a speech and language pathologist, and registered dietitians.

Admission Criteria
A physician’s order is required for a consult to be completed for services from an occupational therapist, physical therapist, and a registered dietitian. A physician's order is not necessary for a
psychologist consult. This request must meet medical necessity which is demonstrated to be reasonable and necessary based on clinical information from the primary care physician or other health care professional. A consultative service is supported based upon results of a screening and/or assessment. Physician’s orders are required annually thereafter in order for services to continue.

Discharge Criteria
- Continued follow-up has occurred as indicated by the specific plan, and the consumer has attained the benefited outcome.
- Consultative Services staff has completed instruction to the caregivers in the implementation and maintenance of an ongoing plan.
- Individual no longer chooses to receive services.

Transition Criteria/Process
All consumers who receive clinical consultation services have a case manager responsible to monitor their progress. Many consumers have more than one consultant who works with the case manager as a team. When discharge criteria have been met, the consultant communicates their ongoing recommendations to the case manager and the treatment team. At any time, if the consumer requires additional consultative services, the case manager is able to make a new request.

Special Populations
The entire service array is designed to meet the needs of individuals with multiple and complex conditions. Person-centered planning and assessment assures that these unique conditions are identified and respected as truly individual, and treated as such, in the service and supports planning process.

Consultation services are provided by professionals with specialized training and experience. Consultation staff are experienced in providing services to persons with I/DD, mental illness, children with serious emotional disturbances and I/DD, and persons with substance use disorders. In addition, many of the staff are skilled in detecting and working with individuals with medical, neurological, and communicative disorders. Those disorders may be causal or concomitant to other primary conditions/disorders.

Neurodevelopmental Center of Excellence-Assessment Services
Description
The Genesee Health System’s Neurodevelopmental Center of Excellence (NCE) services children birth to 26 years of age, depending on the assessment service requested. There are three assessment tracks that are offered within NCE: Autism Spectrum Disorder (ASD); Fetal Alcohol Spectrum Disorder (FASD); Neuropsychological assessment resulting from exposure to lead contaminated water in Flint. Assessment
services are comprehensive in nature and provide extensive information about a child/young adults functioning in many areas. Recommendations provided from the outcome of the assessment can then help guide treatments and interventions that may be effective and appropriate, given the individual’s specific set of strengths and weaknesses.

**Autism Spectrum Disorder**

**Admission Criteria**
The Michigan Department of Health and Human Services (MDHHS) determines eligibility for these services on an initial and annual basis. The target group for the ABA benefit includes Medicaid covered children under age 21, with a diagnosis of ASD. The GHS NCE provides the initial eligibility evaluation and annual re-evaluation. This data is submitted to MDHHS for eligibility determination where needs-based criteria are applied (ie substantial functional impairment in reciprocal social and communication skills and interactions, as well as in restricted, repetitive, and stereotyped patterns of behavior, interests and activities.)

**Discharge Criteria**
Not Applicable

**Fetal Alcohol Spectrum Disorder**

**Admission Criteria**
Criteria for FASD assessment includes assessment of children below the age of 18 who had confirmed or suspected exposure of alcohol in utero. Anyone is able to refer and is limited to those with Medicaid.

**Discharge Criteria**
Not Applicable

**Neuropsychological Assessments**

**Admission Criteria**
Criteria for neuropsychological assessment includes assessment of children and young adults 3 to 26 years of age who resided in Flint beginning April 2014 to the present, have not graduated high school, and who currently reside in Genesee County. Anyone is able to refer and is limited to those with Medicaid.

**Discharge Criteria:**
Completion of the evaluation process

**Transition Criteria/Process**
Should the child be in need of services within the agency, if not already linked to services, the Family Navigator will assist the family in obtaining those resources as part of the neuropsychological evaluation track. For the Autism Spectrum Disorder assessment track, the child’s assigned case manager through their primary program can assist the family in following through with recommendations provided.

**Program Goals**
The goals of the assessments are to examine thinking, behavior, and social-emotional functioning of children and young adults. The assessments consist of standardized tests and procedures and may
measure the following: intelligence (IQ); learning; problem solving; planning and organization’ attention and memory’ processing speed; language’ academic skills; visual perception; control over hand movements and eye-hand coordination’ mood aggression and impulsive behavior’ social skills. Information obtained through direct testing in combination with information obtained during extensive interviews is integrated to formulate diagnostic impressions and recommendations, as well as provide the child/family with resources for which could assist the child/young adult be as successful as possible.

Crisis Management/After Hours
The GHS Crisis Line provides our consumers and the community with 24-hour crisis telephone support, and when needed, referral to mobile, face-to-face crisis intervention by the Crisis Intervention and Recovery Team (CIRT). The purpose of CIRT is to mitigate crisis, prevent hospitalization, and linking individuals to the safest services and supports available, which includes coordination with existing GHS supports and services the following day. CIRT is available 24 hours a day, 7 days a week, serving GHS consumers and all residents of Genesee County in need of immediate assistance in defusing mental health, substance abuse, and/or family crises and accessing medically necessary services and supports. CIRT can also be accessed directly by Genesee County community providers, agencies, and safety net partners on behalf of consumers or others in distress to ensure timely after-hours crisis support. Persons will have access to services regardless of their living environment, physical condition, or disability. Interpreters or other communication assistance are provided as necessary, including TTY availability.

Special Populations
Assessment services serve individuals within a broad range of ages, levels of functioning, family, and social environments. Assessment services are primarily provided within the clinic; however, a home-based intake interview option is available to families for the neuropsychological assessment track. For the Autism Spectrum Disorder track, while assessment occur primarily in the clinic, some exceptions can be made in certain circumstances to conduct some of the assessment in the community. In cases where an individual requires assistance with communication, assistance will be provided.

Program Resources
The GHS Neurodevelopmental Center of Excellence is located at 2700 Robert T. Longway Blvd, Suite G, Flint, MI 48503 and consists of multiple assessment rooms, meeting rooms, and professional offices. Office hours are Monday through Friday 8am-5pm.

The Center’s staff consists of the following: Doctoral level Psychologist as Clinic Director; Doctoral level Psychologist as Associate Director of Assessment Services; tow doctorate level Pediatric Neuropsychologists; multiple masters level Psychometrists; two masters level Clinical Coordinators; two Family Navigators; Office Manager; two clerical support staff. All staff are specially trained in the assessment of children, adolescents, and young adults.

Service Modalities
The service array includes the following: extensive clinical interviews, administration of comprehensive psychological and neuropsychological batteries, feedbacks, and supports/coordination by Family Navigators and case managers for follow through of recommendations made.
Referrals for the Autism Spectrum Disorder assessment services requires the family to go through the Access center and Intake before an assigned case manager can refer them directly for Autism Spectrum Disorder assessment services. Referrals for Fetal Alcohol Spectrum Disorder and neuropsychological assessments resulting from lead exposure can come from anywhere.