**LENAWEE-LIVINGSTON-MONROE-WASHTENAW**
**OVERSIGHT POLICY BOARD**

*VISION*

*"We envision that our communities have both an awareness of the impact of substance abuse and use, and the ability to embrace wellness, recovery and strive for a greater quality of life."*

# AGENDA
## December 5, 2019

## 705 N. Zeeb Road, Ann Arbor

## Second Floor Conference Room
## 9:30 a.m. – 11:30 a.m.

1. Introductions & Welcome Board Members– 5 minutes

2. Approval of Agenda **(Board Action)** – 2 minutes

3. Approval of October 24, 2019 OPB Minutes {Att. #1} **(Board Action)** – 5 minutes

4. Audience Participation – 3 minutes per person

5. Old Business –
   a. Finance Report {Att. #2} (Discussion) - 10 minutes
   b. Request for PA2 Funding for STR Project ASSERT Programming {Att. #3, 3a} **(Board Action)** – 15 minutes
   c. Organizational Chart Review {Att. #4} (Discussion) – 5 minutes
   d. RFP Chart Review {Att. # 5} (Discussion) – 5 minutes

6. New Business –
   a. Presentation of Opioid Media Campaign – Elizabeth Adeleye, Washtenaw County Health Department (Discussion) – 20 minutes
   b. Policy Updates – Welcoming, SUD Residential Treatment Services, Individual Treatment and Planning, SUD Recipient Rights, Women's Specialty {Att. #6, 6a-i} **Board Action)** – 15 minutes
   c. Request for Approval for Revised CCSEM Engagement Center Budget for FY 20 {Att. #7} **(Board Action)** – 10 minutes
   d. ProMedica Mini Grant Request {Att. #8} (Discussion) – 5 minutes

7. Report from Regional Board {Att. #9} (Discussion) – 10 minutes

8. SUD Director Updates (Discussion) – 10 minutes

**Next meeting: January 23, 2019**
**Location TBD**

**Parking Lot:**
**Appointments to OPB**
**Regional Board Representation**

# LENAWEE-LIVINGSTON-MONROE-WASHTENAW
# OVERSIGHT POLICY BOARD
# October 24, 2019 meeting
# 705 N. Zeeb Road
# Ann Arbor, MI 48103

Members Present: Mark Cochran, Charles Coleman, Kim Comerzan, William Green, Ricky Jefferson, Dianne McCormick, David Oblak, Dave O'Dell, Ralph Tillotson, Monique Uzelac, Tom Waldecker

Members Absent: Amy Fullerton

Guests:

Staff Present: Stephannie Weary, James Colaianne, Nicole Adelman, Dana Darrow, Alyssa Tumolo, Jackie Bradley

D. Oblak called the meeting to order at 9:30 a.m.

1. Introductions

2. Approval of the agenda

   **Motion by M. Cochran, supported by C. Coleman, to approve the agenda**
   **Motion carried**

3. Approval of the September 26, 2019 Oversight Policy Board minutes

   **Motion by W. Green, supported by D. McCormick, to approve the September 26, 2019 Oversight Policy Board minutes**
   **Motion carried**

4. Audience Participation
   - None

5. Old Business
   a. Finance Report
      - D. Darrow presented. Discussion followed.
      - Staff will bring the RFP schedule to the next OPB meeting.
      - OPB and J. Colaianne discussed staggering RFPs, rather than doing them all at the same time.
   b. Peers in MAT/MOUD Clinics Update
      - MAT (Medication Assistant Treatment) is moving toward being called MOUD (Medication for Opioid Use Disorder).
      - CMHPSM has received an application from Passion of Mind, which will go to Regional Board for approval of contract.
   c. SOR Recovery Housing Contract Update
      - Touchstone and Paula's House (both Monroe providers) have been approved for SOR funding. Their contracts will go to the Regional Board for approval.

6. New Business
   a. Officer Elections and Membership Status

**Motion by T. Waldecker, supported by C. Coleman, to approve the current slate of officers for FY 2020**
**Motion carried**

- There were no nominations from the floor.
- Officers for FY 2020:
  - Chair – D. Oblak
  - Vice-Chair – Amy Fullerton
  - Secretary – Mark Cochran

   b. Request for PA2 Funds for Marie's House of Serenity FY 2020
- Marie's House was not included in the group of PA2 funding that was submitted to OPB last month.

**Motion by D. McCormick, supported by W. Green, to approve funding for Marie's House of Serenity, a Recovery Housing program in Ypsilanti**
**Motion carried**

- OPB discussed the lack of recovery housing gap for non-emancipated youth with children.
- Dawn Farm does offer units for recovery for adults with children, but non-emancipated youth with children are not included.
- N. Adelman and J. Colaianne will gather information from other PIHPs to see how they are handling housing for non-emancipated youth with children.

   c. State Targeted Response (STR) Grant Ending
- STR, SOR and SOR Supplemental are the 3 current state opioid grants.
- STR is ending. It's on a May 1 – April 30 grant cycle.
- If there is a case of overspending for the STR grant or if there is interest in continuing these funded projects through the end of September to follow the fiscal year, PA2 may be requested to offset.
- Mid-year reports will be submitted within the next 2 weeks. Staff will bring data to either the December or January meeting.

7. Report from Regional Board
- C. Coleman reported that the Regional Board is pleased with their choice of J. Colaianne as CEO.
- The Regional Board also elected a new slate of officers.

8. SUD Director Updates
- The SUD audit went well. CMHPSM received a score of 13 out of 13.
- CMHPSM move update: we are still hoping for a Dec. 1 move in day.
- Alyssa Tumolo is the new Grants Coordinator working on STR, SOR, and Gambling.
- OPB requested a staff list with people's duties.
- CMHPSM recently hosted a statewide gambling training. 30 people attended.
- CMHPSM recently released an RFQ to determine if any providers were interested in implementing the evidence based program for gambling services.
- There is a media campaign in the works for opioid use.

**Upcoming OPB meetings**

- SUD staff would like to bring program updates to future OPB meetings. Some of the proposed topics include: Prevention, Naloxone use, Engagement Centers, Project Assert.
- OPB members would like:
  - To see emerging issues, such as marijuana and vaping issues
  - To hear from some of our core providers via agency presentations
  - To have a discussion with providers on the housing issues for non-emancipated minors with children
  - To hear from Touchstone
  - To hear what's going on in the other 3 counties
  - To possibly have a booklet of resources for the 4 counties
  - To hear more about the opioid media campaign
  - More/better oversight of RSS (recovery support specialists, i.e. peer supports)
  - To discuss OPB's responsibility re: peer support services, perhaps develop some standards.
- J. Bradley noted that Livingston has a peer group has developed a code of conduct.
- T Waldecker suggested having an ad hoc committee of professionals and peer supports to develop guidelines, requirements, etc.

9. Adjournment

**Motion by C Coleman, supported by W. Green, to adjourn the meeting**
**Motion carried**

Meeting adjourned at 10:35 a.m.

Community Mental Health Partnership Of Southeast Michigan
SUD SUMMARY OF REVENUE AND EXPENSE BY FUND
September 2019 FY19

| Summary Of Revenue & Expense | Funding Source | | | | | | | Total Funding Sources |
|---|---|---|---|---|---|---|---|---|
| | Medicaid | Healthy Michigan | SUD - Block Grant | SUD - SOR | SUD - STR | Gambling Prev | SUD-COBO/PA2 | |
| **Revenues** | | | | | | | | |
| Funding From MDCH | 2,400,132 | 4,352,789 | 7,487,017 | 477,137 | 701,516 | 97,126 | | $ 15,515,717 |
| PA2/COBO Tax Funding Current Year | - | - | - | - | - | - | 1,705,054 | $ 1,705,054 |
| PA2/COBO Reserve Utilization | - | - | - | - | - | - | 1,434,063 | $ 1,434,063 |
| Other | - | - | - | - | - | - | - | $ 1,020,491 |
| Total Revenues | $ 2,400,132 | $ 4,352,789 | $ 7,487,017 | $ 477,137 | $ 701,516 | $ 97,126 | $ 3,139,117 | $ 19,675,325 |
| **Expenses** | | | | | | | | |
| Funding for County SUD Programs | | | | | | | | |
| CMHPSM | | | | 477,137 | 665,575 | 92,150 | | 1,234,862 |
| Lenawee | 393,981 | 928,359 | 410,799 | | | | 263,958 | 1,997,097 |
| Livingston | 277,745 | 660,866 | 372,785 | | | | 443,508 | 1,754,904 |
| Monroe | 358,388 | 648,565 | 692,814 | | | | 309,153 | 2,008,921 |
| Washtenaw | 925,668 | 2,370,618 | 1,514,877 | | | | 1,406,969 | 6,218,132 |
| Total SUD Expenses | $ 1,955,783 | $ 4,608,408 | $ 2,991,275 | $ 477,137 | $ 665,575 | $ 92,150 | $ 2,423,587 | $ 13,213,915 |
| Administrative Cost Allocation | 120,120 | 283,019 | 237,755 | | 35,941 | 4,976 | - | $ 681,812 |
| Total Expenses | $ 2,075,904 | $ 4,891,427 | $ 3,229,030 | $ 477,137 | $ 701,516 | $ 97,126 | $ 2,423,587 | $ 13,895,727 |
| Revenues Over/(Under) Expenses | $ 324,229 | $ (538,638) | $ 4,257,987 | $ - | $ - | $ - | $ 715,529 | $ 5,779,598 |

| Current fiscal year utilization of PA2 | Revenues | Expenditures | Revenues Over/(Under) Expenses |
|---|---|---|---|
| PA2 by County | | | |
| Lenawee | 251,637 | 263,958 | (12,321) |
| Livingston | 757,886 | 443,508 | 314,378 |
| Monroe | 554,689 | 309,153 | 245,536 |
| Washtenaw | 1,574,905 | 1,406,969 | 167,936 |
| Totals | $ 3,139,117 | $ 2,423,587 | $ 715,529 |

| Unallocated PA2 | FY 19 Beginning Balance | FY19 Projected Utilization | FY20 Projected Utilization | FY20 Projected Ending Balance |
|---|---|---|---|---|
| Lenawee | 924,325 | (222,723) | (222,723) | 478,878 |
| Livingston | 3,039,734 | (613,133) | (613,133) | 1,813,468 |
| Monroe | 522,226 | (164,037) | (164,037) | 194,152 |
| Washtenaw | 2,730,440 | (598,506) | (598,506) | 1,533,429 |
| Total | $ 7,216,725 | $ (1,598,399) | $ (1,598,399) | $ 4,019,927 |

**CMHPSM SUD OVERSIGHT POLICY BOARD**

**ACTION REQUEST**

**Board Meeting Date:** December 5, 2019

**Action Requested**: Approve PA2 Funding for STR Project ASSERT to extend programming for the remainder of FY20.

**Background:** Project ASSERT is an evidence-based program that has been implemented through agencies partnering with CMPHSP utilizing STR funding. It is currently in place at ProMedica in Monroe through Catholic Charities of Southeast MI; University of Michigan Psychiatric Emergency Services and St. Joseph Mercy Hospital Ann Arbor through Home of New Vision; and soon to start at St. Joseph Mercy Hospital Brighton through Livingston County Community Mental Health. STR funding ends in April 2020, causing these programs sustainability challenges to the end of FY20. This program has been very well received by participating hospitals, and agencies report engaging with a large number of individuals needing substance use services. Based on expenditures and annualized funding to date, the programs are expected to require the following funding for the remainder of the fiscal year: Catholic Charities of SE MI $14,416.25; Home of New Vision $44,158.75; Livingston CMH $22,075.

**Connection to PIHP/MDHHS Contract, Regional Strategic Plan or Shared Governance Model:**

Improving access to SUD services for individuals utilizing Emergency Departments.

**Recommendation**:

Approval of PA2 funding to continue Project ASSERT through the end of FY20 for the total amount of $80,650.


Lenawee
Livingston
Monroe
Washtenaw

# SUBSTANCE USE DISORDER PREVENTION & TREATMENT SERVICES

Project Assert Overview

The goal of Project ASSERT is to enhance services for persons with SUD who are admitted into the respective emergency departments, utilizing peers to make connections to community resources including SUD treatment services, and to reduce readmission rates. Trained peers use SBIRT techniques of negotiated interviews and non-judgmental conversations, and determine available treatment or resources necessary, making it easier for the patient to make positive choices upon discharge. Utilizing recovery peers enables the person to connect to a someone who has had similar experiences. Follow up in the community is an important component of supporting relationships to recovery in a non-traditional way.

Program Objectives

- Emergency room staff and peers will receive training in Project ASSERT Model and SBIRT techniques
- Recovery peers will meet with identified patients in the emergency department
- Recovery peers will assist the ED staff in securing next step resources for patients
- Recovery peers will conduct outreach follow up with patient after discharge

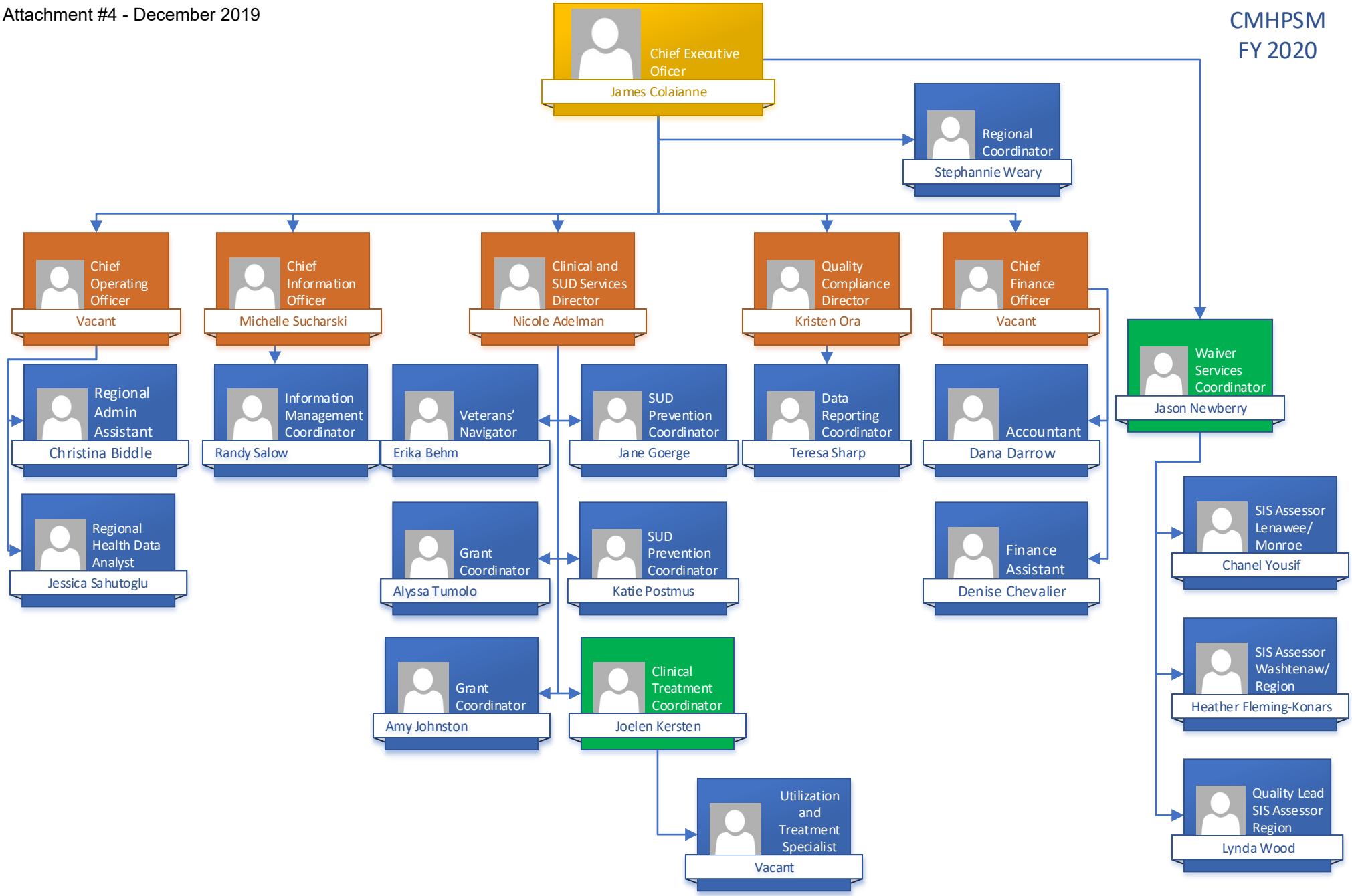
Providers Involved in the Initiative

- Catholic Charities of Southeast Michigan, Monroe County
- Home of New Vision, Washtenaw County
- Livingston County CMH, Livingston County

Individuals Screened (May 1-October 31, 2019)

A total of 260 individuals screened positive for substance use during the mid-year reporting period of May 1 through October 31, 2019. This number does not include St. Joseph Mercy Ann Arbor, as the data was not yet available. This also does not reflect the total number of individuals who were screened.

CMHPSM
FY 2020






Updated 10/24/19 sw

COMMUNITY MENTAL HEALTH PARTNERSHIP of Southeast Michigan

**Procurement Long Term Planning Chart**

Planning | Issue | Review | Award | Procurement Contract Term

| | FY20 Q1 | | | FY20 Q2 | | | FY20 Q3 | | | FY20 Q4 | | | FY21 Q1 | | | FY21 Q2 | | | FY21 Q3 | | | FY21 Q4 | | | FY22 Q1 | | | FY22 Q2 | | | FY22 Q3 | | | FY22 Q4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | O | N | D | J | F | M | A | M | J | J | A | S | O | N | D | J | F | M | A | M | J | J | A | S | O | N | D | J | F | M | A | M | J | J | A | S |
| **PREVENTION RFP#2020A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CONTRACT TERM | | | | | | | | | | | | | CY1 | | | | | | | | | | | | CY2 | | | | | | | | | | | |
| **PREVENTION RFP #2023A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CONTRACT TERM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CORE PROVIDER RFP#2021A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CONTRACT TERM | | | | | | | | | | | | | | | | | | | | | | | | | CY1 | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PA2 SPECIAL INITIATIVES RFP #2020B** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CONTRACT TERM | | | | | | | | | | | | | CY1 | | | | | | | | | | | | CY2 | | | | | | | | | | | |
| **PA2 SPECIAL INITIATIVES RFP #2022A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CONTRACT TERM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **STACKED DECK RFQ#2020A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CONTRACT TERM | | | | CY1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| | FY23 Q1 | | | FY23 Q2 | | | FY23 Q3 | | | FY23 Q4 | | | FY24 Q1 | | | FY24 Q2 | | | FY24 Q3 | | | FY24 Q4 | | | FY25 Q1 | | | FY25 Q2 | | | FY25 Q3 | | | FY25 Q4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | O | N | D | J | F | M | A | M | J | J | A | S | O | N | D | J | F | M | A | M | J | J | A | S | O | N | D | J | F | M | A | M | J | J | A | S |
| **PREVENTION RFP#2020A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CONTRACT TERM | CY3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PREVENTION RFP #2023A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CONTRACT TERM | | | | | | | | | | | | | CY1 | | | | | | | | | | | | CY2 | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CORE PROVIDER RFP#2021A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CONTRACT TERM | CY2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PA2 SPECIAL INITIATIVES RFP #2020B** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CONTRACT TERM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PA2 SPECIAL INITIATIVES RFP #2022A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CONTRACT TERM | CY1 | | | | | | | | | | | | CY2 | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **STACKED DECK RFQ#2020A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CONTRACT TERM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| **Community Mental Health Partnership of Southeast Michigan/PIHP** | ***Policy and Procedure*** **Recipient Rights for Substance Use Disorder Recipients** |
|---|---|
| **Department: Substance Use Disorders** **Author: M. Scalera, S. Ray** | **Local Policy Number (if used)** |
| **Regional Operations Committee Approval Date 8/22/2016** | **Implementation Date 10/1/2016** |

## I. PURPOSE

This policy establishes that a Recipient Rights Advisor shall be designated to oversee recipient rights activities for individuals seeking substance abuse/use services through the Community Mental Health Partnership to ensure compliance with R325.1391 to R325.1399 of the Administrative Rules for Substance Abuse Service Programs in Michigan and the following policies and procedures. It shall also be the responsibility of the Rights Advisor to annually review these policies and procedures and consider necessary revisions. Documentation of this annual review and the majority approval of the governing body shall become a part of the administrative record.

## II. REVISION HISTORY

| DATE | REVISION NUMBER | MODIFICATION |
|---|---|---|
| 11/21/2006 | 1.0 | Original document |
| 08/01/2016 | 2.0 | Adopted by CMHPSM |
| 9/18/19 | 3.0 | Inclusion of Administrative Rules for Substance Use Disorders Service Program Requirements adopted December 17, 2018 |
| | | |

## III. APPLICATION

This policy applies to all staff, students, volunteers, and contractual organizations receiving any funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) who provide Substance Use Disorder (SUD) services.

## IV. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Regional Rights Consultant: Individual designated by the CMHPSM to conduct recipient rights activities according to procedures outlined by the administrative rules and Michigan Department of Health and Human Services for the Regional Entity.

Recipient – An individual who receives services from a licensed substance abuse program in the State of Michigan.

Recipient Abuse – An intentional act by a staff member which inflicts physical injury upon a recipient or which results in sexual contact with a recipient or a communication made by a staff member to a recipient, the purpose of which is to curse, vilify, intimidate or degrade a recipient or to threaten a recipient with a physical injury.

Recipient Neglect – A recipient suffers injury, temporarily or permanently, because the staff or other person responsible for the recipient's health or welfare has been found negligent.

Sexual Contact – The intentional touching by a staff member of the recipient's intimate parts or the intentional touching of clothing covering the immediate area of the recipient's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or gratification.

## V. POLICY

**A.** A recipient as defined in the 2018 Administrative Rules for Substance Abuse Services Programs in Michigan shall not be denied appropriate service on the basis of race, color, national origin, religion, sex, age, mental or physical handicap, marital status, sexual orientation, sexual identity or political beliefs.

**B.** The admission of a recipient to the program, or the provisions of prevention services, shall not result in the recipient being deprived of any rights, privileges, or benefits which are guaranteed to individuals by state or federal law or by the state or federal constitution.

**C.** A recipient may present grievances or suggested changes in program policies and services to the program staff, to governmental officials, or to another person within or outside the program. In this process, the program shall not in any way restrain the recipient.

**D.** A recipient shall participate in the development of his or her treatment plan.

**E.** A client has the right to refuse treatment and to be informed of the consequences of that refusal. When a refusal of treatment prevents the program from providing services according to ethical and professional standards, the relationship with the

recipient may be terminated, with the Program Director's written approval and upon reasonable notice. The reason for termination will be recorded in the recipient's record.

**F.** Upon admission, each recipient is provided with program rules, which are also posted in public places in the program. These rules inform new recipients of the infractions which can lead to discharge. The rules also describe the mechanism for appealing a discharge decision and which staff have authority to discharge. The recipient shall sign a form that documents that a written coy of the program rules has been received and questions about it answered. This form shall be maintained in the recipient's record.

**G.** A recipient shall have the benefits, side effects and risks associated with the use of any medication fully explained in language which is understood by the recipient. Recipients receiving medication shall sign an informed consent form.

**H.** A recipient has the right to review, copy, or receive a summary of his or her program records, unless in the judgment of the Executive Director, such actions will be detrimental to the recipient or to others for either of the following reasons:

a. Granting the request for disclosure will cause substantial harm to the relationship between the recipient and the program or to the program's capacity to provide services in general.
b. Granting the request for disclosure will cause substantial harm to the recipient.

If the Program Director determines that such action will be detrimental, the recipient is allowed to review non-detrimental portions of the record or a summary of the record. If a recipient is denied the right to review all or part of his or her record, the reason for the denial shall be stated to the recipient. An explanation of what portions of the record are detrimental and for what reasons shall be stated in the client record and shall be signed by the Program Director.

**I.** A program staff member shall not physically or mentally abuse or neglect or sexually abuse a recipient as the terms "abuse" and "neglect" are defined in the Substance Abuse Quality Assurance and Licensing Section of the Administrative Rules.

**J.** A recipient has the right to review the written fee schedule. Any revisions of fees will be approved by the governing authority and posted at least two weeks in advance.

**K.** A recipient is entitled to receive an explanation of his or her bill upon request, regardless of the source of payment.

**L.** Should the program engage in any experimental or research procedure, any or all recipients will be advised as to the procedures to be used and have the right to refuse participation in the experiment or research without jeopardizing their continuing services. State and federal rules and regulations concerning research involving human subjects will be reviewed and followed.

**M.** A recipient has the right to give prior informed consent, consistent with federal confidentiality regulations, for the use and future disposition of products of special

observation and audiovisual techniques, such as one-way vision mirrors, tape recorders, television, movies or photographs.

**N.** Fingerprints may be taken and used in connection with treatment or research or to determine the name of a recipient only if expressed written consent has been obtained from the recipient. Fingerprints shall be kept as a separate part of the recipient's record and shall be destroyed or returned to the recipient when the fingerprints are no longer essential to treatment or research.

**O.** These policies and procedures shall be provided to each member of the program staff. Each staff member shall review and sign a form, which indicates that he or she understands, and shall abide by this program's recipient rights policy and procedures. A copy of the signed form will be maintained in the staff member's personnel file; a second copy will be retained by the staff member.

**P.** The Program Director shall designate one staff member to function as the program rights advisor. The rights advisor shall:

a. Attend all Substance Abuse Quality Assurance & Licensing training pertaining to recipient rights
b. Receive and investigate all recipient rights complaints independent of interference or reprisal from program administration
c. Communicate directly with the CMHPSM Regional Rights Consultant when necessary.

**Q.** Rights of recipients shall be displayed in a public place on a poster to be provided by the Michigan Department of Health and Human Services (MDHHS). The poster will indicate the designated rights advisor's name and phone number, as well as the contact information for the Regional Rights Consultant.

**R.** As part of the intake or admission process, each recipient will receive a brochure which summarizes recipient rights.

**S.** Staff from the program shall explain each right listed on the brochure to the recipient. The recipient will then be given the brochure. The recipient is asked to sign a rights acknowledgement form upon receipt of the brochure by the program. Program staff shall indicate that the recipient was given information on recipient rights and any questions regarding those rights were explained by indicating on the Recipient Rights checkbox in the medical record. Refusal to acknowledge rights information will be noted in the medical record.

**T.** If the recipient is incapacitated, he or she shall be presented with the brochure, explanation of rights, and opportunity to document understanding of the rights as soon as feasible, but not more than 72 hours after admission.

**U.** The procedure to be followed when the Rights Advisor receives a formal complaint is described in detail in the January 1982 Recipient Rights Procedure Manual. It is this program's policy that the Program Rights Advisor follows the procedures outlined in that manual.

a. In addition to procedures above, the CMHPSM will require the provider rights advisor to submit a copy of *any* rights complaint upon receipt.
b. The provider shall follow up as indicated and submit a copy of the investigation and resolution response to the CMHPSM upon completion.

## VI. EXHIBITS

A. Staff Acknowledgement Form
B. Recipient Rights Complaint Log

## VII. REFERENCES

A. Administrative Rules for Substance Use Disorders Service Program Requirements December 17, 2018
B. Michigan Model Recipient Rights Policy & Procedure Manual, May 2013
C. Substance Abuse Recipient Rights, “Know Your Rights” Pamphlet
D. Community Mental Health Partnership of Southeast Michigan (CMHPSM) Confidentiality & Access to Consumer l Records Policy (8-20-18)
E. Community Mental Health Partnership of Southeast Michigan (CMHPSM) Consumer Appeals Policy (6/4/2018).\

| | |
|---|---|
| **Community Mental Health Partnership of Southeast Michigan/PIHP** | ***Policy and Procedure*** **Recipient Rights for Substance Use Disorder Recipients** |
| **Department: Substance Use Disorders**<br>**Author: M. Scalera, S. Ray** | **Local Policy Number (if used)** |
| **Regional Operations Committee Approval Date 8/22/2016** | **Implementation Date 10/1/2016** |

Formatted: Header distance from edge: 0.3"

## I. PURPOSE

This policy establishes that a Recipient Rights Advisor shall be designated to oversee recipient rights activities for individuals seeking substance abuse/use services through the Community Mental Health Partnership to ensure compliance with R325.1391 to R325.1399 of the Administrative Rules for Substance Abuse Service Programs in Michigan and the following policies and procedures. It shall also be the responsibility of the Rights Advisor to annually review these policies and procedures and consider necessary revisions. Documentation of this annual review and the majority approval of the governing body shall become a part of the administrative record.

Deleted: 14301

Deleted: 14306

## II. REVISION HISTORY

| DATE | REVISION NUMBER | MODIFICATION |
|---|---|---|
| 11/21/2006 | 1.0 | Original document |
| 08/01/2016 | 2.0 | Adopted by CMHPSM |
| 9/18/19 | 3.0 | Inclusion of Administrative Rules for Substance Use Disorders Service Program Requirements adopted December 17, 2018 |
| | | |

## III. APPLICATION

This policy applies to all staff, students, volunteers, and contractual organizations receiving any funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) who provide Substance Use Disorder (SUD) services.

## IV. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Regional Rights Consultant: Individual designated by the CMHPSM to conduct recipient rights activities according to procedures outlined by the administrative rules and Michigan Department of Health and Human Services for the Regional Entity.

Recipient – An individual who receives services from a licensed substance abuse program in the State of Michigan.

Recipient Abuse – An intentional act by a staff member which inflicts physical injury upon a recipient or which results in sexual contact with a recipient or a communication made by a staff member to a recipient, the purpose of which is to curse, vilify, intimidate or degrade a recipient or to threaten a recipient with a physical injury.

Recipient Neglect – A recipient suffers injury, temporarily or permanently, because the staff or other person responsible for the recipient's health or welfare has been found negligent.

Sexual Contact – The intentional touching by a staff member of the recipient's intimate parts or the intentional touching of clothing covering the immediate area of the recipient's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or gratification.

## V. POLICY

**A.** A recipient as defined in the 2018 Administrative Rules for Substance Abuse Services Programs in Michigan shall not be denied appropriate service on the basis of race, color, national origin, religion, sex, age, mental or physical handicap, marital status, sexual orientation, sexual identity or political beliefs.

Deleted: 1981

Deleted: preference

**B.** The admission of a recipient to the program, or the provisions of prevention services, shall not result in the recipient being deprived of any rights, privileges, or benefits which are guaranteed to individuals by state or federal law or by the state or federal constitution.

**C.** A recipient may present grievances or suggested changes in program policies and services to the program staff, to governmental officials, or to another person within or outside the program. In this process, the program shall not in any way restrain the recipient.

**D.** A recipient shall participate in the development of his or her treatment plan.

Formatted: List Paragraph, No bullets or numbering

**E.** A client has the right to refuse treatment and to be informed of the consequences of that refusal. When a refusal of treatment prevents the program from providing services according to ethical and professional standards, the relationship with the recipient may be terminated, with the Program Director's written approval and upon reasonable notice. The reason for termination will be recorded in the recipient's record.

Formatted: List Paragraph, No bullets or numbering

**F.** Upon admission, each recipient is provided with program rules, which are also posted in public places in the program. These rules inform new recipients of the infractions which can lead to discharge. The rules also describe the mechanism for appealing a discharge decision and which staff have authority to discharge. The recipient shall sign a form that documents that a written coy of the program rules has been received and questions about it answered. This form shall be maintained in the recipient's record.

Formatted: List Paragraph, No bullets or numbering

**G.** A recipient shall have the benefits, side effects and risks associated with the use of any medication fully explained in language which is understood by the recipient. Recipients receiving medication shall sign an informed consent form.

Formatted: List Paragraph, No bullets or numbering

**H.** A recipient has the right to review, copy, or receive a summary of his or her program records, unless in the judgment of the Executive Director, such actions will be detrimental to the recipient or to others for either of the following reasons:

a. Granting the request for disclosure will cause substantial harm to the relationship between the recipient and the program or to the program's capacity to provide services in general.
b. Granting the request for disclosure will cause substantial harm to the recipient.

If the Program Director determines that such action will be detrimental, the recipient is allowed to review non-detrimental portions of the record or a summary of the record. If a recipient is denied the right to review all or part of his or her record, the reason for the denial shall be stated to the recipient. An explanation of what portions of the record are detrimental and for what reasons shall be stated in the client record and shall be signed by the Program Director.

**I.** A program staff member shall not physically or mentally abuse or neglect or sexually abuse a recipient as the terms "abuse" and "neglect" are defined in the Substance Abuse Quality Assurance and Licensing Section of the Administrative Rules.

**J.** A recipient has the right to review the written fee schedule. Any revisions of fees will be approved by the governing authority and posted at least two weeks in advance.

**K.** A recipient is entitled to receive an explanation of his or her bill upon request, regardless of the source of payment.

**L.** Should the program engage in any experimental or research procedure, any or all recipients will be advised as to the procedures to be used, and have the right to refuse participation in the experiment or research without jeopardizing their continuing services. State and federal rules and regulations concerning research involving human subjects will be reviewed and followed.

**M.** A recipient has the right to give prior informed consent, consistent with federal confidentiality regulations, for the use and future disposition of products of special observation and audiovisual techniques, such as one-way vision mirrors, tape recorders, television, movies or photographs.

**N.** Fingerprints may be taken and used in connection with treatment or research or to determine the name of a recipient only if expressed written consent has been obtained from the recipient. Fingerprints shall be kept as a separate part of the recipient's record and shall be destroyed or returned to the recipient when the fingerprints are no longer essential to treatment or research.

**O.** These policies and procedures shall be provided to each member of the program staff. Each staff member shall review and sign a form, which indicates that he or she understands, and shall abide by this program's recipient rights policy and procedures. A copy of the signed form will be maintained in the staff member's personnel file; a second copy will be retained by the staff member.

**P.** The Program Director shall designate one staff member to function as the program rights advisor. The rights advisor shall:

a. Attend all Substance Abuse Quality Assurance & Licensing training pertaining to recipient rights
b. Receive and investigate all recipient rights complaints independent of interference or reprisal from program administration
c. Communicate directly with the CMHPSM Regional Rights Consultant when necessary.

**Q.** Rights of recipients shall be displayed in a public place on a poster to be provided by the Michigan Department of Health and Human Services (MDHHS). The poster will indicate the designated rights advisor's name and phone number, as well as the contact information for the Regional Rights Consultant.

**R.** As part of the intake or admission process, each recipient will receive a brochure which summarizes recipient rights.

**S.** Staff from the program shall explain each right listed on the brochure to the recipient. The recipient will then be given the brochure. The recipient is asked to sign a rights acknowledgement form upon receipt of the brochure by the program. Program staff shall indicate that the recipient was given information on recipient rights and any questions regarding those rights were explained by indicating on the Recipient Rights checkbox in the medical record. Refusal to acknowledge rights information will be noted in the medical record.

**T.** If the recipient is incapacitated, he or she shall be presented with the brochure, explanation of rights, and opportunity to document understanding of the rights as soon as feasible, but not more than 72 hours after admission.

**U.** The procedure to be followed when the Rights Advisor receives a formal complaint is described in detail in the January 1982 Recipient Rights Procedure Manual. It is

this program's policy that the Program Rights Advisor follows the procedures outlined in that manual.

**a. In addition to procedures above, the CMHPSM will require the provider rights advisor to submit a copy of *any* rights complaint upon receipt. The provider shall follow up as indicated and submit a copy of the investigation and resolution response to the CMHPSM upon completion.**

## VI. EXHIBITS

**A.** Staff Acknowledgement Form
**B.** Recipient Rights Complaint Log

## VII. REFERENCES

A. Administrative Rules for Substance Use Disorders Service Program Requirements December 17, 2018
B. Michigan Model Recipient Rights Policy & Procedure Manual, May 2013
C. Substance Abuse Recipient Rights, "Know Your Rights" Pamphlet
D. Community Mental Health Partnership of Southeast Michigan (CMHPSM) Confidentiality & Access to Consumer l Records Policy (8-20-18)
E. Community Mental Health Partnership of Southeast Michigan (CMHPSM) Consumer Appeals Policy (6/4/2018).

Deleted: Abu
Deleted: Services Programs
Deleted: In Michigan, Section 6231 (1) of Michigan Public Act 368 of 1978…
Deleted: February 2010
Deleted: 11-25-2014

| **Community Mental Health Partnership of Southeast Michigan/PIHP** | ***Policy*** **Individual Treatment and Planning Process Policy** |
|---|---|
| **Department: Substance Use Disorder Services** **Author: Marci Scalera** | **Local Policy Number (if used)** |
| **Regional Operations Committee Approval Date 9/14/2016** | **Implementation Date 10/1/2016** |

## I. PURPOSE

The purpose of this policy is to establish the requirements for individualized treatment and recovery planning. Consistent with the Recovery Oriented System of Care, treatment and recovery plans must be a product of the client's active involvement and informed agreement. Direct client involvement in establishing the goals and expectations for treatment is required to ensure appropriate level of care determination, identify true and realistic needs and increase the client's motivation to participate in treatment. By participating in the development of their recovery plan, clients can identify resources they already are familiar with in their community and begin to learn about additional available services. Treatment and recovery planning requires an understanding that each client is unique and each plan must be developed based upon the individual needs, goals, desires and strengths of each client.

The planning process can be limited by the information that is gathered in the assessment or by actual treatment planning forms. These planning forms should be reviewed on at least an annual basis to ensure the information being gathered, or the manner in which it is recorded, continues to support the individualized treatment and recovery planning process.

## II. REVISION HISTORY

| DATE | REV. NO. | MODIFICATION |
|---|---|---|
| March, 2012 | 1 | |
| August 26, 2016 | 2 | Language updates |
| November 2019 | 3 | Language updates |
| | | |

## III. APPLICATION

This policy applies to all staff, students, volunteers, and contractual organizations receiving any funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

## IV. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

## V. POLICY

All consumers of treatment and recovery services shall have an individualized, person centered treatment and recovery plan developed within the defined timelines and reviewed throughout the treatment process.

## VI. STANDARDS

Treatment and recovery planning begins at the time the client enters treatment – either directly or based on a referral from an access system, and ends when the client completes formal treatment services. Planning should be a dynamic process that evolves beyond the first or second session when required documentation has been completed. Throughout the treatment process, as the client's needs change, the plan must be revised to meet the new needs of the client.

Recovery Planning is undertaken as a component of the treatment plan and should progress as the client moves through the treatment process. It is important that the recovery plan be a viable and workable plan for the client and that upon discharge he/she is able to continue along his/her recovery path with guidance from his/her plan. It is not acceptable that the recovery plan be developed the day before a client's planned discharge from treatment services.

The treatment and recovery plans are not limited to just the client and the counselor. The client can request any family members, friends or significant others to be involved in the process. Once each plan is completed, the client, counselor and other involved individuals must sign the form indicating understanding of the plan and the expectations.

Establishing Goals and Objectives

The initial step in developing an individualized treatment and recovery plan involves the completion of a biopsychosocial assessment. This is a comprehensive assessment that includes current and historical information about the client. From this assessment, the needs and strengths of the client are identified and it is this information that assists the counselor and the client in establishing the goals and objectives that will be focused on in treatment. The identified strengths can be used to help meet treatment goals. After strengths are identified, the counselor assists the client in using these strengths to accomplish the identified goals and objectives. Identifying strengths of the client can provide motivation to participate in treatment and may take the focus off any negative situations that surround the client getting involved in treatment-- such as legal problems, work problems, relationship problems, etc.

Writing the Plan

Once the goals and objectives are jointly decided on, they are recorded in the planning document utilized by the provider. Goals must be stated in the client's words. Each goal that is written down should be directly tied to a need that was identified in the assessment. Once a goal has been identified, then the objectives – the steps that need to be taken to achieve the goal – are recorded. The objective must be developed with the client but do not have to be recorded in the client's exact words. The objectives need to be written in a manner in which they can be measured for progress toward completion along with a

targeted completion date. The completion dates must be realistic to the client or the chances of compliance with treatment are greatly reduced.

Establishing Treatment Interventions

The next component of the plan is to determine the intervention(s) that will be used to assist the client in being able to accomplish the objective. What act or actions will the client take to achieve a goal and what action will the counselor take to assist the client in achieving the goal. Again, these actions must be mutually agreed upon to provide the best chance of success for the client.

Framework for Treatment

The individualized treatment and recovery plan provides the framework by which the services should be provided. Any individual or group sessions that the client participates in must address or be related to the goals and objectives in the plan. When progress notes are written, they reflect what goal(s)/objective(s) were addressed during a treatment session. The progress notes, recorded by the clinician, should document any adjustments/changes to the treatment and recovery plan. Once a change is decided on, it should then be added to the plan in the format described above and initialed by the client or with documentation of client approval.

Treatment Plan Progress Reviews

Plans must be reviewed and this review must be documented in the client record. The frequency of the reviews can be based on the time frame in treatment (60, 90 120 days) or on the number of treatment episodes that have taken place since admission or since the last review (8,10,12 episodes). The reviews must include input from all clinicians/treatment/recovery providers involved in the care of the client as well as any other individuals the client involved in their plan. This review should reflect on the progress the client has made toward achieving each goal and/or objective, the need to keep specific goals/objectives or discontinue them, and the need to add any additional goals/objectives due to new needs of the client. As with the initial plan, the client, clinician and other relevant individuals should sign this review. If individual signatures are unable to be obtained, documentation explaining why must be provided.

The plan and plan reviews not only serve as tools to provide care to the client, they help in the administrative function of service authorizations. All decisions concerning, but not limited to, length of stay, transfer, discharge, continuing care and authorizations by the PIHP must be based on individualized determinations of need and on progress toward treatment and recovery goals and objectives. Such decisions must not be based on arbitrary criteria such as pre-determined time or payment limits.

Policy Monitoring and Review

The PIHP will monitor compliance with individualized treatment and recovery planning and these reviews will be made available to the MDHHS, Michigan Department of Health and Human Services, and Office of Recovery Oriented Systems of Care (OROSC) during site visits. OROSC will also review for individualized treatment and recovery planning during the provider site visits. Reviews of plans will occur in the following manner:

- A review of the biopsychosocial assessment to determine where and how the needs were identified
- A review of the plan to check for:
    1. Matching goals to need – Needs from the assessment are reflected in the goals on the plan

2. Goals are in the client's words and are unique to the client. No standard or routine goals that are used by all clients
3. Measurable objectives – the ability to determine if and when an objective will be completed
4. Target dates for completion – the dates identified for completion of the goals and objectives are unique to the client and not just routine dates put in for completion of the plan
5. Intervention strategies – the specific types of strategies that will be used in treatment- group therapy, individual therapy, cognitive behavioral therapy, didactic groups, etc.
6. Signatures – client, counselor and other involved individuals
7. Recovery planning activities are taking place during the treatment episode

- A review of progress notes to ensure documentation relates to goals and objectives

- An audit of the treatment and recovery plan progress review to check for:
    1. Progress note information matching what is in the review
    2. Rationale for continuation/discontinuation of goals/objectives
    3. New goals and objectives developed with client input
    4. Client participation/feedback present in the review
    5. Signatures, i.e., client, counselor, and involved individuals, or documentation as to why no signature.

## VII. EXHIBITS

None

## VIII. REFERENCES

| Reference: | Check if Applies | Standard Numbers: |
|---|---|---|
| 42 CFR Parts 400 et al. (Balanced Budget Act) | X | |
| 45 CFR Parts 160 & 164 (HIPAA) | X | |
| 42 CFR Part 2 (Substance Abuse) | X | |
| Michigan Mental Health Code Act 258 of 1974 | X | |
| Michigan Department of Community Health (MDHHS) Medicaid Contract | X | |
| MDHHS Substance Abuse Contract | X | |
| Michigan Medicaid Provider Manual | X | |
| | | |

**ADDITIONAL REFERENCES:**

Mee-Lee, D., Shulman, G.D., Fishman, M., Gastfriend, D.R., & Griffith, J.J. (Eds.) (2001). ASAM *Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R).* **Chevy Chase, MD: American Society of Addiction Medicine, Inc.**

Miller, Scott, Mee-Lee, David, Plum, Bill and Hubble, Mark. (2005). *Making Treatment Count: Client-Directed, Outcome Informed Clinical Work with Problems Drinkers.* **John**

**Wiley & Sons, Inc., Hoboken, N.J.**

Mee-Lee,,David, Shulman, G.D., Fishman, M., Gastfriend, D.R, et.al. (2013). *Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions:* **Chevy Chase, MD: American Society of Addiction Medicine, Inc.**

National Institute on Drug Abuse (2000). *Principles of Drug Addiction Treatment.* Washington D.C.: NIDA

Scott, D. Miller, Barry L. Duncan. (2000). *Paradigm Lost: From Model-Driven to Client-Directed, Outcome Informed Clinical Work.* **Institute for the Study of Therapeutic Change, Chicago, Illinois.**

| **Community Mental Health Partnership of Southeast Michigan/PIHP** | ***Policy*** **Individual Treatment and Planning Process Policy** |
|---|---|
| **Department: Substance Use Disorder Services** **Author: Marci Scalera** | **Local Policy Number (if used)** |
| **Regional Operations Committee Approval Date 9/14/2016** | **Implementation Date 10/1/2016** |

Formatted: Header distance from edge: 0.3"

## I. PURPOSE

The purpose of this policy is to establish the requirements for individualized treatment and recovery planning. Consistent with the Recovery Oriented System of Care, treatment and recovery plans must be a product of the client's active involvement and informed agreement. Direct client involvement in establishing the goals and expectations for treatment is required to ensure appropriate level of care determination, identify true and realistic needs and increase the client's motivation to participate in treatment. By participating in the development of their recovery plan, clients can identify resources they already are familiar with in their community and begin to learn about additional available services. Treatment and recovery planning requires an understanding that each client is unique and each plan must be developed based upon the individual needs, goals, desires and strengths of each client.

Deleted: a
Deleted: r
Deleted: o
Deleted: s
Deleted: c

The planning process can be limited by the information that is gathered in the assessment or by actual treatment planning forms. These planning forms should be reviewed on at least an annual basis to ensure the information being gathered, or the manner in which it is recorded, continues to support the individualized treatment and recovery planning process.

Deleted: that
Deleted: that is
Deleted: ¶

## II. REVISION HISTORY

| DATE | REV. NO. | MODIFICATION |
|---|---|---|
| March, 2012 | 1 | |
| August 26, 2016 | 2 | Language updates |
| November 2019 | 3 | Language updates |
| | | |

## III. APPLICATION

This policy applies to all staff, students, volunteers, and contractual organizations receiving any funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

## IV. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

## V. POLICY

All consumers of treatment and recovery services shall have an individualized, person centered treatment and recovery plan developed within the defined timelines and reviewed throughout the treatment process.

## VI. STANDARDS

Treatment and recovery planning begins at the time the client enters treatment – either directly or based on a referral from an access system, and ends when the client completes formal treatment services. Planning should be a dynamic process that evolves beyond the first or second session when required documentation has been completed. Throughout the treatment process, as the client's needs change, the plan must be revised to meet the new needs of the client.

Recovery Planning is undertaken as a component of the treatment plan and should progress as the client moves through the treatment process. It is important that the recovery plan be a viable and workable plan for the client and that upon discharge he/she is able to continue along his/her recovery path with guidance from his/her plan. It is not acceptable that the recovery plan be developed the day before a client's planned discharge from treatment services.

The treatment and recovery plans are not limited to just the client and the counselor. The client can request any family members, friends or significant others to be involved in the process. Once each plan is completed, the client, counselor and other involved individuals must sign the form indicating understanding of the plan and the expectations.

Establishing Goals and Objectives

The initial step in developing an individualized treatment and recovery plan involves the completion of a biopsychosocial assessment. This is a comprehensive assessment that includes current and historical information about the client. From this assessment, the needs and strengths of the client are identified and it is this information that assists the counselor and the client in establishing the goals and objectives that will be focused on in treatment. The identified strengths can be used to help meet treatment goals. After strengths are identified, the counselor assists the client in using these strengths to accomplish the identified goals and objectives. Identifying strengths of the client can provide motivation to participate in treatment and may take the focus off any negative situations that surround the client getting involved in treatment-- such as legal problems, work problems, relationship problems, etc.

Writing the Plan

Once the goals and objectives are jointly decided on, they are recorded in the planning document utilized by the provider. Goals must be stated in the client's words. Each goal that is written down should be directly tied to a need that was identified in the assessment. Once a goal has been identified, then the objectives – the steps that need to be taken to achieve the goal – are recorded. The objective must be developed with the client but do not have to be recorded in the client's exact words. The objectives need to be written in a manner in which they can be measured for progress toward completion along with a

targeted completion date. The completion dates must be realistic to the client or the chances of compliance with treatment are greatly reduced.

Establishing Treatment Interventions

The next component of the plan is to determine the intervention(s) that will be used to assist the client in being able to accomplish the objective. What act or actions will the client take to achieve a goal and what action will the counselor take to assist the client in achieving the goal. Again, these actions must be mutually agreed upon to provide the best chance of success for the client.

Framework for Treatment

The individualized treatment and recovery plan provides the framework by which the services should be provided. Any individual or group sessions that the client participates in must address or be related to the goals and objectives in the plan. When progress notes are written, they reflect what goal(s)/objective(s) were addressed during a treatment session. The progress notes, recorded by the clinician, should document any adjustments/changes to the treatment and recovery plan. Once a change is decided on, it should then be added to the plan in the format described above and initialed by the client or with documentation of client approval.

Deleted: Once a change is decided on, it should then be added to the plan in the format described above.

Treatment Plan Progress Reviews

Plans must be reviewed and this review must be documented in the client record. The frequency of the reviews can be based on the time frame in treatment (60, 90 120 days) or on the number of treatment episodes that have taken place since admission or since the last review (8,10,12 episodes). The reviews must include input from all clinicians/treatment/recovery providers involved in the care of the client as well as any other individuals the client involved in their plan. This review should reflect on the progress the client has made toward achieving each goal and/or objective, the need to keep specific goals/objectives or discontinue them, and the need to add any additional goals/objectives due to new needs of the client. As with the initial plan, the client, clinician and other relevant individuals should sign this review. If individual signatures are unable to be obtained, documentation explaining why must be provided.

The plan and plan reviews not only serve as tools to provide care to the client, they help in the administrative function of service authorizations. All decisions concerning, but not limited to, length of stay, transfer, discharge, continuing care and authorizations by the PIHP must be based on individualized determinations of need and on progress toward treatment and recovery goals and objectives. Such decisions must not be based on arbitrary criteria such as pre-determined time or payment limits.

Policy Monitoring and Review

The PIHP will monitor compliance with individualized treatment and recovery planning and these reviews will be made available to the MDHHS, Michigan Department of Health and Human Services, and Office of Recovery Oriented Systems of Care (OROSC) during site visits. OROSC will also review for individualized treatment and recovery planning during the provider site visits. Reviews of plans will occur in the following manner:

- A review of the biopsychosocial assessment to determine where and how the needs were identified
- A review of the plan to check for:
    1. Matching goals to need – Needs from the assessment are reflected in the goals on the plan

Formatted: List Paragraph, Indent: Left: 1.06", Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 1.25" + Indent at: 1.5"

2. Goals are in the client's words and are unique to the client. No standard or routine goals that are used by all clients
3. Measurable objectives – the ability to determine if and when an objective will be completed
4. Target dates for completion – the dates identified for completion of the goals and objectives are unique to the client and not just routine dates put in for completion of the plan
5. Intervention strategies – the specific types of strategies that will be used in treatment- group therapy, individual therapy, cognitive behavioral therapy, didactic groups, etc.
6. Signatures – client, counselor and other involved individuals
7. Recovery planning activities are taking place during the treatment episode

- A review of progress notes to ensure documentation relates to goals and objectives

- An audit of the treatment and recovery plan progress review to check for:
  1. Progress note information matching what is in the review
  2. Rationale for continuation/discontinuation of goals/objectives
  3. New goals and objectives developed with client input
  4. Client participation/feedback present in the review

Signatures, i.e., client, counselor, and involved individuals, or documentation as to why no signature.

Deleted: e

Formatted: Indent: Left: 0.75", No bullets or numbering

Deleted: A review

Formatted: Bulleted + Level: 2 + Aligned at: 1" + Indent at: 1.25"

Deleted: Signatures¶

## VII. EXHIBITS

None

## VIII. REFERENCES

| Reference: | Check if Applies | Standard Numbers: |
|---|---|---|
| 42 CFR Parts 400 et al. (Balanced Budget Act) | X | |
| 45 CFR Parts 160 & 164 (HIPAA) | X | |
| 42 CFR Part 2 (Substance Abuse) | X | |
| Michigan Mental Health Code Act 258 of 1974 | X | |
| Michigan Department of Community Health (MDHHS) Medicaid Contract | X | |
| MDHHS Substance Abuse Contract | X | |
| Michigan Medicaid Provider Manual | X | |
| | | |

**ADDITIONAL REFERENCES:**

Mee-Lee, D., Shulman, G.D., Fishman, M., Gastfriend, D.R., & Griffith, J.J. (Eds.) (2001). ASAM *Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R).* **Chevy Chase, MD: American Society of Addiction Medicine, Inc.**

Miller, Scott, Mee-Lee, David, Plum, Bill and Hubble, Mark. (2005). *Making Treatment Count: Client-Directed, Outcome Informed Clinical Work with Problems Drinkers.* **John Wiley & Sons, Inc., Hoboken, N.J.**

Mee-Lee,,David, Shulman, G.D., Fishman, M., Gastfriend, D.R, et.al. (2013). *Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions:* **Chevy Chase, MD: American Society of Addiction Medicine, Inc.**

National Institute on Drug Abuse (2000). *Principles of Drug Addiction Treatment.* Washington D.C.: NIDA

Scott, D. Miller, Barry L. Duncan. (2000). *Paradigm Lost: From Model-Driven to Client-Directed, Outcome Informed Clinical Work.* **Institute for the Study of Therapeutic Change, Chicago, Illinois.**

| **Community Mental Health Partnership of Southeast Michigan/PIHP** | ***Policy***<br><br>**Residential Treatment Services Policy** |
|---|---|
| **Department: Substance Use Disorder Treatment Services**<br>**Author: Marci Scalera** | **Local Policy Number (if used)** |
| **Regional Operations Committee Approval Date**<br>**9/14/2016** | **Implementation Date**<br>**10/1/2016** |

## I. PURPOSE

To establish the philosophy and requirements for residential treatment services to be consistent with the Recovery Oriented System of Care (ROSC) that are based on the American Society of Addiction Medicine (ASAM) Level of Care (LOC) criteria that supports individualized services that maintain cultural, age and gender appropriateness.

## II. REVISION HISTORY

| DATE | REV. NO. | MODIFICATION |
|---|---|---|
| 3/2012 | | Original policy |
| 8/17/2016 | 2 | Update Language |
| 11/2019 | 3 | Update Language |
| | | |

## III. APPLICATION

This policy applies to all staff, students, volunteers, and contractual organizations receiving any funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) for Substance Use Disorder services.

## IV. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM) – the Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP) – a program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Regional Entity – the entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Core Provider – a local provider of substance abuse services utilizing the ROSC model that provides for and/or coordinates all levels of care for clients with substance use disorders.

Core Services - are defined as Treatment Basics, Therapeutic Interventions, and Interactive Education/Counseling. See the chart in the "Covered Services" section for further information.

Counseling – an interpersonal helping relationship that begins with the client exploring the way they think, how they feel and what they do, for the purpose of enhancing their life. The counselor helps the client to set the goals that pave the way for positive change to occur.

Crisis Intervention – a service for the purpose of addressing problems/issues that may arise during treatment and could result in the client requiring a higher level of care if intervention is not provided.

Detoxification/Withdrawal Management – monitoring for the purpose of preventing/alleviating medical complications related to no longer using or decreasing the use of a substance.

Face-to-Face- this interaction not only includes in-person contact, it may also include real-time video and audio linkage between a client and provider, as long as this service is provided within the established confidentiality standards for substance use disorder services.

Facilitates Transportation – assist the client, or potential client, or referral source in arranging transportation to and from treatment.

Family Counseling – face-to-face intervention with the client and the significant other and/or traditional or non-traditional family members for the purpose of goal setting and achievement, as well as skill building. Note: in these situations, the identified client need not be present for the intervention.

Family Psychotherapy – face-to-face, insight-oriented interventions with the client and the significant other and/or traditional or non-traditional family members. Note: in these situations, the identified client need not be present for the intervention.

Group Counseling – face-to-face intervention for the purpose of goal setting and achievement, as well as skill building.

Group Psychotherapy – face-to-face, insight-oriented interventions with three or more clients.

Individual Assessment – a face-to-face service for the purpose of identifying functional and treatment needs, and to formulate the basis for the Individualized Treatment Plan to be implemented by the provider.

Individual Counseling – face-to-face intervention for the purpose of goal setting and achievement, and skill building.

Individual Psychotherapy- face-to-face, insight-oriented interventions with the client.

Individual Treatment Planning- direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current level of care, to ensure true and realistic needs are being addressed and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each client and be specific to the diagnostic impression and assessment.

Interactive Education – services that are designed or intended to teach information about addiction and/or recovery skills, often referred to as didactic education.

Interactive Education Groups – activities that center on teaching skills to clients necessary to support recovery, including "didactic" education.

Medical Necessity – treatment which is reasonable, necessary and appropriate based on individualized treatment planning and evidence-based clinical standards.

Peer Support – individuals who have shared experiences of addiction and recovery and offer support and guidance to one another.

Professional Staff – as identified in the Staff Qualifications for SUD Treatment Services portion of the PIHP/MDHHS Contract include Substance Abuse Treatment Specialists, Substance Abuse Treatment Practitioner, Specially Focused Staff and Treatment Supervisor.

Psychotherapy – an advanced clinical practice that includes the assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other bio- psychosocial problems and may include the involvement of the intrapsychic, intrapersonal, or psychosocial dynamics of individuals.

Recovery – a process of change through which an individual achieves abstinence and improved health, wellness and quality of life. The experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life.

Recovery Planning – process that highlight's and organize a person's goals, strengths and capacities and to determine what barriers need to be removed or problems resolved to help people achieve their goals. This should include an asset and strength based assessment of the client.

Recovery Support and Preparation – services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery.

Referral/Linking/Coordination of Services – office-based service activity performed by a primary clinician or other assigned staff to address needs

identified through the assessment, and/or of ensuring follow through with access to outside services, and/or to establish the client with another substance use disorder provider.

Substance Use Disorder – a term inclusive of substance abuse and dependence that also encompasses problematic use of substances.

Toxicology Screening – screening used for the purpose of tracking ongoing use of substances when this has been established as a part of the treatment plan or an identified part of the treatment program. (This may include onsite testing such as portable breathalyzers or non- laboratory urinalysis)

## V. POLICY

CMHPSM will provide oversight and on-site monitoring to residential providers to ensure the philosophy, standards and requirements of client specific residential series are being appropriately implemented and provided. The core providers will refer to external residential providers when necessary based on capacity or clinical need and coordinate care with external provider.

## VI. STANDARDS

The residential levels of care from ASAM are established based on the needs of the client. As part of the purpose of this document, the short- and long-term descriptors will no longer be used to describe residential services. The frequency and duration of residential treatment services are expected to be guided by the ASAM levels of care, and are described as follows:

### ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services

These services are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual in the worlds of work, education, and family life. Treatment services are similar to low-intensity outpatient services focused on improving the individual's functioning and coping skills in Dimension 5 and 6.

The functional deficits found in this population may include problems in applying recovery skills to their everyday lives, lack of personal responsibility, or lack of connection to employment, education, or family life. This setting allows clients the opportunity to develop and practice skills while reintegrating into the community.

This type of programming can be beneficial to individuals who do not acknowledge a substance use problem, and services would be focused on engagement and continuing treatment. Treatment at this level is sometimes necessary to due to deficits in the individual's recovery environment and length of stay in clinically managed Level 3.1 programs is generally longer than that of the more intensive levels of residential care. This allows the individual to practice and master the application of recovery skills.

*Support Systems*

Necessary support systems include telephone or in-person consultation with a physician and emergency services, available 24 hours a day, and 7 days a week. There also must be direct affiliations with other levels of care, or close coordination through referral to more and less intensive levels of care and other services. Programs should have the

ability to arrange for needed procedures as appropriate to the severity and urgency of the individual's condition. These programs should also have the ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications. They should also have direct affiliations with other levels of care or close coordination through referral to more and less intensive levels of care and other services such as literacy training and adult education.

*Staff Requirements*
Level 3.1 programs are staffed by allied health professional staff such as counselor aides or group living workers who are available onsite 24-hours a day or as required by licensing regulations. Clinical staff must be knowledgeable about the biological and psychosocial dimensions of substance use disorders and their treatment. They must also be able to identify the signs and symptoms of acute psychiatric conditions including psychiatric decompensation. Staff at this level are not involved in direct service provision, however, addiction physicians should review admission decisions to confirm clinical necessity of services

*Co-occurring Enhanced Programs*
These should be staffed by credentialed mental health professionals that have the ability to treat co-occurring disorders with the capacity to involve addiction-trained psychiatrists. These professionals should also have sufficient cross-training in addiction and mental health to understand the signs and symptoms of mental disorders, be able to understand and explain to the individual the purposes of different psychotropic medications and how they interact with substance use.

**ASAM Level 3.3 – Clinically Managed Medium-Intensity Residential Services**
These programs provide a structured recovery environment in combination with medium intensity clinical services to support recovery. Services may be provided in a deliberately repetitive fashion to address the special needs of individuals who are often elderly, cognitively impaired, or developmentally delayed. Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning.

The deficits for clients at this level are primarily cognitive, either temporary or permanent. The clients in this LOC have needs that are more intensive and therefore, to benefit effectively from services, they must be provided at a slower pace and over a longer period of time. The client's level of impairment is more severe at this level, requiring services be provided differently in order for maximum benefit to be received.

*Support Systems*
Necessary support systems within this level include telephone or in-person consultations with a physician, or a physician assistant or nurse practitioner in states where they are licensed as physician extenders and may perform the duties designated here for a physician; and emergency services, available 24 hours a day, 7 days a week. They should have direct affiliations with other easily accessible levels of care or close coordination through referral to more and less intensive levels of care and other services. They need medical, psychiatric, psychological, laboratory and toxicology services available through consultation and referral as appropriate to the severity and urgency of the individual's condition.

*Staff Requirements*

Level 3.3 programs are staffed by physician extenders, and appropriately credentialed mental health professionals as well as allied health professional staff. These staff should be on-site 24hours a day or as required by licensing regulations. In addition, one or more clinicians with competence in the treatment of substance use disorders should be onsite 24-hours a day. These staff should also be knowledgeable about the biological and psychosocial dimensions of substance abuse and mental health disorders as well as their treatments. They should also be able to identify signs and symptoms of acute psychiatric conditions including psychiatric decompensation. Staff should also have specialized training in behavior management techniques.

*Co-occurring Enhanced Programs*
This type of program needs to be staffed by credentialed psychiatrists and mental health professionals. They should be able to assess and treat people with co-occurring mental disorders and they need to have specialized training in behavior management techniques. Most, if not all, treatment professionals should have sufficient cross-training to understand signs and symptoms of mental disorders and be able to understand and explain to the individual the purpose of psychotropic medication and its interactions with substance use.

**ASAM Level 3.5 – Clinically Managed High-Intensity Residential Services**
These programs are designed to treat clients who have significant social and psychological problems. Treatment is directed toward diminishing client deficits through targeted interventions. Effective treatment approaches are primarily habilitative in focus; addressing the client's educational and vocational deficits, as well as his or her socially dysfunctional behavior. Clients at this level may have extensive treatment or criminal justice histories, limited work and educational experiences, and antisocial value systems.

The length of treatment depends on an individual's progress. However, as impairment is considered to be significant at this level, services should be of a duration that will adequately address the many habilitation needs of this population. Very often, the level of impairment will limit the services that can actually be provided to the client resulting in the primary focus of treatment at this level being focused on habilitation and development, or re-development, of life skills. Due to the increased need for habilitation in this client population, the program will have to provide the right mix of services to promote life skill mastery for each individual.

*Support Systems*
Programs in this level of care should have telephone or in-person consultation with a physician, or a physician assistant or nurse practitioner in state where they are licensed as physician extenders and may perform the duties designated here for a physician; emergency services, available 24 hours a day, 7 days a week. They must also have direct affiliations with other levels or close coordination through referral to more and less intensive levels of care and other services. They must also have arranged medical, psychiatric, psychological, laboratory, and toxicology services as appropriate to the severity and urgency of the individual's condition.

*Staff Requirements*
Level 3.5 programs staffed by licensed or credentialed clinical staff such as addiction counselors and other professional staff who work with the allied health staff in

interdisciplinary approach. Professional staff should be onsite 24-hours a day or per licensing regulations. One or more clinicians with competence in treatment of substance use disorders must be available onsite or on-call 24-hours per day. These staff should also be knowledgeable about the biological and psychosocial dimensions of substance abuse and mental health disorders as well as their treatments. Clinicians should be able to identify the signs and symptoms of acute psychiatric conditions and have specialized training in behavior management techniques.

*Co-occurring Enhanced Programs*
This type of program should offer psychiatric services, medication evaluation and laboratory services. These services should be available by telephone within 8 hours and on-site or closely coordinated off-site staff within 24 hours, as appropriate by severity and urgency of the individual's mental health condition. These programs should be staffed by credentialed mental health professionals, including addiction psychiatrists who are able to assess and treat the cooccurring mental health disorder and have specialized training in behavior management. They should also have cross-training to understand the signs and symptoms of co-occurring mental disorders and be able to explain to the individual, the purpose of psychotropic drugs and how they interact with substance use.

**ASAM Level 3.7 – Medically Monitored High-Intensity Inpatient Services**
These programs offer a structured regime of professional 24-hour directed evaluation, observation, medical monitoring and addiction treatment in an inpatient setting. These programs operate in permanent facilities with inpatient beds and function under a set of defined policies, procedures and clinical protocols. These programs are for patients with subacute biomedical and emotional, behavioral or severe cognitive problems that require individual treatment but do not require the full resources of an acute care general hospital or medically managed individual program.

These services are designed to meet needs of patients who have functional limitations in Dimensions 1, 2, and 3. The care provided in these programs is delivered by an interdisciplinary staff of appropriately credentialed staff, including addiction credentialed physicians. The main focus of treatment is specific to substance related disorders. The skills of this team and their availability can accommodate withdrawal management and/or intensive inpatient treatment of addiction, and/or integrated treatment of co-occurring subacute biomedical, and/or emotional, behavioral or cognitive conditions.

*Support Systems*
This level of care requires physician monitoring, nursing care, and observations are made available. The following staffing is required for this level of care: a physician must be available to assess the individual in person within 24 hours of admission and thereafter as medically necessary; a registered nurse to conduct alcohol and other drug-focused nursing assessment at time of admission; an appropriately credentialed nurse is responsible for monitoring the individual's progress and for medication administration. There must be additional medical specialty consultation, psychological, laboratory and toxicology services available on-site through consultation or referral. There also must be coordination of necessary services or other levels of care are available through direct affiliation or a referral process. Psychiatric services should be available on-site through consultation or referral when presenting an issue that could be attended to at a later time. These services should be available within 8 hours by telephone or 24 hours in person.

*Staff Requirements*
These programs are staffed by an interdisciplinary staff (including physicians, nurses, addiction counselors, and behavioral health specialists) who are able to assess and treat the individual and obtain and interpret information regarding the individuals psychiatric and substance use or addictive disorders. Staff should be knowledgeable about the biological and psychosocial dimensions of addictions and other behavioral health disorders. The staff should have training in behavior management techniques and evidence-based practices. The staff should be able to provide a planned regimen of 24-hour professionally directed evaluation, care and treatment services. A licensed physician should oversee the treatment process and assure quality of care. Physicians perform physical examinations for all admitted to this level of care. These staff should have specific training in addiction medicine or addiction psychiatry and experience with adolescent medicine. Individuals should receive pharmacotherapy integrated with psychosocial therapies.

*Co-occurring Enhanced Programs*
Programs at this level should offer appropriate psychiatric services, medication evaluation and laboratory services. A psychiatrist should assess the individual within four hours of admission by telephone and within 24 hours following admission in person, if not sooner, as appropriate by individual's behavioral health condition. A registered nurse or licensed mental health clinician should conduct a behavioral health-focused assessment at the time of admission. If not done by a registered nurse, a separate nursing assessment must be done. The nurse is responsible for monitoring the individual's progress and administering or monitoring the individual's self-administration of psychotropic medications. These must also be staffed by addiction psychiatrists and credentialed behavioral health professionals who can assess and treat co-occurring psychiatric disorders and who have specialized training in behavior management. These programs are ideally staffed by a certified addiction specialist physician, or a physician certified as an addiction psychiatrist. Some, if not all, treatment professionals should have sufficient cross-training to understand signs and symptoms of psychiatric disorders and be able to explain to the individual the purpose of psychotropic medication and how they interact with substance use. The intensity and care should meet the individual's needs.

ASAM LOC describe the need for treatment from the perspective of the level of impairment of the client; with the higher the level of impairment requiring the longer duration, slower more repetitive services. The identification of these needs is intended to assist with service selection and authorization for care. The placement of the client is based on the ASAM LOC determination. Due to the unique and complex nature of each client, it is recognized that not every client will "fit" cleanly into one level over another by just looking at the level of impairment. There may be situations where a case could be made for a client to receive services in each of these levels and each would be appropriate. In these situations, documentation should be made as to the rationale for the decision. In addition, variations in treatment that do not follow these guidelines should also be documented in the client record.

The cost of the service should not be the driving force behind the decision; the decision should be made based on what is most likely to help the client be successful in treatment and achieve recovery.

The ASAM Assessment Dimensions must be used to assist in the determination of the LOC needed by a client:

| Level of Care | Level 3.1 | Level 3.3 | Level 3.5 | Level 3.7 |
|---|---|---|---|---|
| **Dimension 1** Withdrawal Potential | No withdrawal risk, or minimal/stable withdrawal; Concurrently receiving Level 1-WM or Level 2-WM | Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level 3.2-WM | At minimal risk of severe withdrawal at Levels 3.3 or 3.5. If withdrawal is present, it meets Level 3.2-WM criteria | Approach "unbundled" withdrawal management for adults. |
| **Dimension 2** Medical conditions & complications | None or very stable, or receiving concurrent medical monitoring | None or stable or receiving concurrent medical monitoring | None or stable or receiving concurrent medical monitoring | Individual in significant risk of serious damage to physical health or concomitant biomedical conditions |

| | | | | |
|---|---|---|---|---|
| **Dimension 3** Emotional, behavioral, or cognitive conditions and complications | None or minimal; not distracting to recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required | Mild to moderate severity; needs structure to focus on recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required. Treatment should be designed to respond to any cognitive deficits | Demonstrates a repeated inability to control impulses, or a personality disorder that requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A dual diagnosis enhanced setting is required for the seriously mentally ill client | Individual must be admitted into cooccurring capable or co-occurring enhanced program, depending on level of function or degree of impairment |
| **Dimension 4** Readiness to change | Open to recovery but needs a structured environment to maintain therapeutic gains | Has little awareness and needs interventions available only at Level 3.3 to engage and stay in treatment; or there is high severity in this dimension but not in others. The client needs a Level 1 motivational enhancement program (Early Intervention) | Has marked difficulty engaging in treatment, with dangerous consequences; or there is high severity in this dimension but not in others; The client needs a Level 1 motivational enhancement program (Early Intervention) | Does not accept or relate the addictive disorder to severity of existing problems; need intensive motivating strategies; need 24hour monitoring to assure follow through with treatment plan |

| | | | | |
|---|---|---|---|---|
| **Dimension 5** Relapse, continued use or continued problem potential | Understands relapse but needs structure to maintain therapeutic gains | Has little awareness and needs intervention only available at Level 3.3 to prevent continued use, with imminent dangerous consequences because of cognitive deficits or comparable dysfunction | Has no recognition of skills needed to prevent continued use, with imminently dangerous consequences | Experiencing acute psychiatric/substance use disorder marked by intensification of symptoms of the substance-related disorder despite participation in a less intensive level of treatment; OR b) There is a high likelihood that the patient will continue to use or relapse to use without close outpatient monitoring and structured therapeutic services. |
| **Dimension 6** Recovery/living environment | Environment is dangerous, but recovery achievable if Level 3.1. 24-hour structure is available | Environment is dangerous and client needs 24-hour structure to cope | Environment is dangerous and client lacks skills to cope outside of a highly structured 24-hour setting | Environment is dangerous and patient lacks skills to cope outside of highly structured 24-hour setting |

**Admission Criteria**

Admission to residential treatment is limited to the following criteria:

- Medical necessity.
- Diagnosis: The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression of a substance use disorder (also known as provisional diagnosis). The diagnosis will be confirmed by the provider's assessment process.
- Individualized determination of need.
- ASAM Criteria is used to determine substance use disorder treatment placement/admission and/or continued stay needs, and are based on a LOC determination using the six assessment dimensions of the ASAM Criteria below:
    i. Withdrawal potential.
    ii. Medical conditions and complications.
    iii. Emotional, behavioral, or cognitive conditions and complications.
    iv. Readiness to change – as determined by the Stages of Change Model.
    v. Relapse, continued use or continued problem potential.
    vi. Recovery/living environment.

Treatment must be individualized based on a biopsychosocial assessment, diagnosis, and client characteristics that include, but are not limited to, age, gender, culture, and development.

Authorization decisions on length of stay (including continued stay), change in LOC, and discharge must be based on the ASAM Criteria. As a client's needs change, the frequency, and/or duration, of services may be increased or decreased as medically necessary. Client participation in referral, continuing care, and recovery planning must occur prior to a move to another LOC for continued treatment.

**Service Requirements**
The following chart details the required amount of services that have been established for residential treatment in the three levels of care. Documentation of all core services, and the response to them by the client, must be found in the client's chart. In situations where the required services cannot be provided to a client in the appropriate frequency or quantity, a justification must also be documented in the client record.

| Level of Care | Minimum Weekly Core Services | Minimum Weekly Life Skills/Self Care |
|---|---|---|
| ASAM 3.1 Clients with lower impairment or lower complexity of needs | At least 5 hours of clinical services per week | At least 5 hours per week |
| ASAM 3.3 Clients with moderate to high impairment or moderate to high complexity of needs | Not less than 13 hours per week | Not less than 13 hours per week |
| ASAM 3.5 Clients with a significant level of impairment or very complex needs | Not less than 20 hours per week | Not less than 20 hours per week |
| ASAM 3.7 Clients with significant level of impairment or very complex needs | Not less than 20 hours per week | Not less than 20 hours per week |

**Covered Services:**
The following services must be available in a residential setting regardless of the LOC and based on individual client need:

| Type | Residential Services Description |
|---|---|
| **Basic Care** | Room, board, supervision, monitoring self administration of medications, toxicology screening, facilitates transportation to and from treatment, treatment environment: structured, safe, and recovery oriented. |
| **Treatment Basics**<br><br>**<u>Core Service</u>** | Assessment; Episode of Care Plan (addressing treatment, recovery, discharge and transition across episode); coordination and referral; medical evaluation and attempt to link to services; connection to next provider and medical services, preparation for 'next step.' |

| | |
|---|---|
| **Therapeutic Interventions**<br><br>**<u>Core Service</u>** | Individual, group and family psychotherapy services; appropriate for the individual's needs; and crisis intervention. Services provided by an appropriately licensed, credentialed and supervised professional working within their scope of |
| **Interactive Education /Counseling**<br><br>**<u>Core Service</u>** | Interaction and teaching with client(s) and staff that process skills and information adapted to the individual client needs. This includes alternative therapies, individual, group and family counseling, anger management, coping skills, recovery skills, relapse triggers, and crisis intervention.<br>Ex: disease of addiction, mental health & substance use disorder. |
| **Life Skills/Self-Care (building recovery capital)** | Social activities that promote healthy community integration/reintegration, development of community supports, parenting, employment, job readiness, how to use public transportation, hygiene, nutrition, laundry, education. |
| **Milieu/Environment (building recovery capital)** | Peer support; recreation/exercise; leisure activities; family visits; coordination with treatment, support groups; maintaining a drug/alcohol free campus. |
| **Medical Services**<br>**<u>Core Service</u>** | Physician monitoring, nursing care, and observation available. Medical specialty consultation, psychological, laboratory and toxicology services available. Psychiatric services available on-site. |

**Treatment Planning & Recovery Planning:**
Clients entering any level of residential care will have recovery and functional needs that will continue to require intervention once residential services are no longer appropriate. Therefore, residential care should be viewed as a part of an episode of care within a continuum of services that will contribute toward recovery for the client. Residential care should not be presented to clients as being a complete episode of care. To facilitate the client moving along the treatment continuum, it is expected that the provider, as part of treatment planning, begins to prepare the client for the next stage of the recovery process as soon after admission as possible. This will help to facilitate a smooth transition to the next LOC, as appropriate, and make sure that the client is aware that services will continue once the residential stay is over.

To make the transition to the next LOC, the residential care provider may assist the client in choosing an appropriate service based on needs and location scheduling appointments, arranging for a meeting with the new service provider, arranging transportation, and ensuring all required paperwork is completed and forwarded to the new service provider in a timely manner. These activities are provided, as examples of activities that could take place if it were determined there would be a benefit to the client. There could potentially be many other activities or arrangements that may be needed, or the client may require very little assistance. To the best of their ability, it is expected that the residential provider arrange for any needed assistance to ensure a seamless transfer to the next LOC.

**Continuing Stay Criteria:**
Re-authorization or continued treatment should be based on ASAM PPC continued service criteria, medical necessity, and when there is a reasonable expectation of benefit from continued care.

Continuing stay can be denied in situations where the client has decided not to participate in his/her treatment. This is evidenced by continued non-compliance with treatment activities, other behavior that is deemed to violate the rules and regulations of the program providing the services, or a demonstrated lack of benefit from treatment received, after documented attempts to meet the needs of the client, by adjusting the services, were made. Progress notes must support lack of benefit, and that other appropriate services have been offered, before a client can be terminated from a treatment episode.

The ASAM Assessment Dimensions must be used to assist in the determination of the level of care needed by a client.

## VII. EXHIBITS

None

## VIII. REFERENCES

| Reference: | Check if applies: | Standard Numbers: |
|---|---|---|
| 42 CFR Parts 400 et al. (Balanced Budget Act) | X | |
| 45 CFR Parts 160 & 164 (HIPAA) | X | |
| 42 CFR Part 2 (Substance Abuse) | X | |
| Michigan Mental Health Code Act 258 of 1974 | X | |
| The Joint Commission - Behavioral Health Standards | | |
| Michigan Department of Health and Human Services (MDHHS) Medicaid Contract | X | |
| MDHHS Substance Abuse Contract | X | |
| Michigan Medicaid Provider Manual | X | |
| HITECH Act of 2009 | X | |
| MDHHS Office of Recovery Systems of Care | X | |

Mee-Lee D, Shulman GD, Fishman M, Gastfriend DR, and Griffth JH, eds. (2001). *ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition-Revised (ASAM PPC-2R).*

Chevy Chase, MD: American Society of Addiction Medicine, Inc.

3rd Edition: *The ASAM CRITERIA: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* (2015); Chevy Chase, MD: American Society of Addiction Medicine, Inc.

Michigan Department of Health and Human Services, Office of Recovery Oriented Systems of Care. Michigan's ROSC Glossary of Terms. Retrieved from http://www.michigan.gov/documents/mdch/ROSC_Glossary_of_Terms_350345_7.pdf.

Michigan Department of Licensing and Regulatory Affairs, Michigan Administrative Code. (n.d.). [Administrative Rules for] Substance Use Disorder Service Programs. Promulgated pursuant to Michigan Public Act 368 of 1978, Section 6231(1), as amended. Retrieved from http://www7.dleg.state.mi.us/orr/Files/AdminCode/103_65_AdminCode.pdf

Michigan Department of Licensing and Regulatory Affairs, Michigan Administrative Code. (n.d.). [Administrative Rules for] Social Work General Rules. Promulgated pursuant to Michigan Public Act 368 of 1978, Sections 16145(3) and 18501, as amended. Retrieved from http://www7.dleg.state.mi.us/orr/Files/AdminCode/104_85_AdminCode.pdf

*Treatment Policy #6, Individualized Treatment Planning,* (2006) Michigan Department of Community Health, Office of Drug Control Policy, http://www.michigan.gov/mdch/O,1607,7-132-2941_4871_4877-133156--,00.html.

*Treatment Policy* #7, *Access Management System,* (2006) Michigan Department of Community Health, Office of Drug Control Policy, http://www.michigan.gov/mdch/O,1607,7-132-2941_4871_4877-133156--,00.htrnf.

*Treatment Technical Advisory* #7, *Peer Recovery/Recovery Support Services,* (2008) Michigan Department of Community Health, Office of Drug Control Policy, http://www.michigan.gov/mdch/O,1607,7-132-2941_4871_4877-133156--,00.html.

*Treatment Technical Advisory #10: Residential Treatment Continuum of Services.* Michigan Department of Community Health, Bureau of Substance Abuse and Adduction Services. TA_10_-_Residential_TX_Continuum_of_Services_-_FINAL_33456_7.docx.

| **Community Mental Health Partnership of Southeast Michigan/PIHP** | ***Policy***<br><br>**Residential Treatment Services Policy** |
|---|---|
| **Department: Substance Use Disorder Treatment Services**<br>**Author: Marci Scalera** | **Local Policy Number (if used)** |
| **Regional Operations Committee Approval Date**<br>**9/14/2016** | **Implementation Date**<br>**10/1/2016** |

Formatted: Header distance from edge: 0.3"

## I. PURPOSE

To establish the philosophy and requirements for residential treatment services to be consistent with the Recovery Oriented System of Care (ROSC) that are based on the American Society of Addiction Medicine (ASAM) Level of Care (LOC) criteria that supports individualized services that maintain cultural, age and gender appropriateness.

Deleted: a

## II. REVISION HISTORY

| DATE | REV. NO. | MODIFICATION |
|---|---|---|
| 3/2012 | | Original policy |
| 8/17/2016 | 2 | Update Language |
| 11/2019 | 3 | Update Language |
| | | |

## III. APPLICATION

This policy applies to all staff, students, volunteers, and contractual organizations receiving any funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) for Substance Use Disorder services.

## IV. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM) – the Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP) – a program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Regional Entity – the entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Core Provider – a local provider of substance abuse services utilizing the ROSC model that provides for and/or coordinates all levels of care for clients with substance use disorders.

Core Services - are defined as Treatment Basics, Therapeutic Interventions, and Interactive Education/Counseling. See the chart in the "Covered Services" section for further information.

Counseling – an interpersonal helping relationship that begins with the client exploring the way they think, how they feel and what they do, for the purpose of enhancing their life. The counselor helps the client to set the goals that pave the way for positive change to occur.

Crisis Intervention – a service for the purpose of addressing problems/issues that may arise during treatment and could result in the client requiring a higher level of care if intervention is not provided.

Detoxification/Withdrawal Management – monitoring for the purpose of preventing/alleviating medical complications related to no longer using or decreasing the use of a substance.

Face-to-Face- this interaction not only includes in-person contact, it may also include real-time video and audio linkage between a client and provider, as long as this service is provided within the established confidentiality standards for substance use disorder services.

Facilitates Transportation – assist the client, or potential client, or referral source in arranging transportation to and from treatment.

Family Counseling – face-to-face intervention with the client and the significant other and/or traditional or non-traditional family members for the purpose of goal setting and achievement, as well as skill building. Note: in these situations, the identified client need not be present for the intervention.

Family Psychotherapy – face-to-face, insight-oriented interventions with the client and the significant other and/or traditional or non-traditional family members. Note: in these situations, the identified client need not be present for the intervention.

Group Counseling – face-to-face intervention for the purpose of goal setting and achievement, as well as skill building.

Group Psychotherapy – face-to-face, insight-oriented interventions with three or more clients.

Individual Assessment – a face-to-face service for the purpose of identifying functional and treatment needs, and to formulate the basis for the Individualized Treatment Plan to be implemented by the provider.

Individual Counseling – face-to-face intervention for the purpose of goal setting and achievement, and skill building.

Individual Psychotherapy- face-to-face, insight-oriented interventions with the client.

Individual Treatment Planning- direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current level of care, to ensure true and realistic needs are being addressed and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each client and be specific to the diagnostic impression and assessment.

Interactive Education – services that are designed or intended to teach information about addiction and/or recovery skills, often referred to as didactic education.

Interactive Education Groups – activities that center on teaching skills to clients necessary to support recovery, including "didactic" education.

Medical Necessity – treatment which is reasonable, necessary and appropriate based on individualized treatment planning and evidence-based clinical standards.

Peer Support – individuals who have shared experiences of addiction and recovery, and offer support and guidance to one another.

Professional Staff – as identified in the Staff Qualifications for SUD Treatment Services portion of the PIHP/MDHHS Contract include Substance Abuse Treatment Specialists, Substance Abuse Treatment Practitioner, Specially Focused Staff and Treatment Supervisor.

Psychotherapy – an advanced clinical practice that includes the assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other bio- psychosocial problems and may include the involvement of the intrapsychic, intrapersonal, or psychosocial dynamics of individuals.

Recovery – a process of change through which an individual achieves abstinence and improved health, wellness and quality of life. The experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life.

Recovery Planning – process that highlight's and organize a person's goals, strengths and capacities and to determine what barriers need to be removed or problems resolved to help people achieve their goals. This should include an asset and strength based assessment of the client.

Recovery Support and Preparation – services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery.

Referral/Linking/Coordination of Services – office-based service activity performed by a primary clinician or other assigned staff to address needs identified through the assessment, and/or of ensuring follow through with access to outside services, and/or to establish the client with another substance use disorder provider.

Substance Use Disorder – a term inclusive of substance abuse and dependence that also encompasses problematic use of substances.

Toxicology Screening – screening used for the purpose of tracking ongoing use of substances when this has been established as a part of the treatment plan or an identified part of the treatment program. (This may include onsite testing such as portable breathalyzers or non- laboratory urinalysis)

## V. POLICY

CMHPSM will provide oversight and on-site monitoring to residential providers to ensure the philosophy, standards and requirements of client specific residential series are being appropriately implemented and provided. The core providers will refer to external residential providers when necessary based on capacity or clinical need and coordinate care with external provider.

Deleted: The

Deleted: CA

## VI. STANDARDS

The residential levels of care from ASAM are established based on the needs of the client. As part of the purpose of this document, the short- and long-term descriptors will no longer be used to describe residential services. The frequency and duration of residential treatment services are expected to be guided by the ASAM levels of care, and are described as follows:

ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services
These services are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual in the worlds of work, education, and family life. Treatment services are similar to low-intensity outpatient services focused on improving the individual's functioning and coping skills in Dimension 5 and 6.

The functional deficits found in this population may include problems in applying recovery skills to their everyday lives, lack of personal responsibility, or lack of connection to employment, education, or family life. This setting allows clients the opportunity to develop and practice skills while reintegrating into the community.

This type of programming can be beneficial to individuals who do not acknowledge a substance use problem, and services would be focused on engagement and continuing treatment. Treatment at this level is sometimes necessary to due to deficits in the individual's recovery environment and length of stay in clinically managed Level 3.1 programs is generally longer than that of the more intensive levels of residential care. This allows the individual to practice and master the application of recovery skills.

Support Systems
Necessary support systems include telephone or in-person consultation with a physician and emergency services, available 24 hours a day, and 7 days a week. There also must be direct affiliations with other levels of care, or close coordination through referral to more and less intensive levels of care and other services. Programs should have the ability to arrange for needed procedures as appropriate to the severity and urgency of the individual's condition. These programs should also have the ability to arrange for

Deleted: **ASAM Level III.1- ¶**
**Clinically Managed Low-Intensity Residential Services¶**
These services are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual in the worlds of work, education and family life. Treatment services are similar to low-intensity outpatient services focused on improving the individual's functioning and coping skills in Dimension 5 and 6.¶
¶
The functional deficits found in this population may include problems in applying recovery skills to their everyday lives, lack of personal responsibility or lack of connection to employment, education or family life. This setting allows clients the opportunity to develop and practice skills while reintegrating into the community.

pharmacotherapy for psychiatric or anti-addiction medications. They should also have direct affiliations with other levels of care or close coordination through referral to more and less intensive levels of care and other services such as literacy training and adult education.

Staff Requirements
Level 3.1 programs are staffed by allied health professional staff such as counselor aides or group living workers who are available onsite 24-hours a day or as required by licensing regulations. Clinical staff must be knowledgeable about the biological and psychosocial dimensions of substance use disorders and their treatment. They must also be able to identify the signs and symptoms of acute psychiatric conditions including psychiatric decompensation. Staff at this level are not involved in direct service provision, however, addiction physicians should review admission decisions to confirm clinical necessity of services

Co-occurring Enhanced Programs
These should be staffed by credentialed mental health professionals that have the ability to treat co-occurring disorders with the capacity to involve addiction-trained psychiatrists. These professionals should also have sufficient cross-training in addiction and mental health to understand the signs and symptoms of mental disorders, be able to understand and explain to the individual the purposes of different psychotropic medications and how they interact with substance use.

ASAM Level 3.3 – Clinically Managed Medium-Intensity Residential Services
These programs provide a structured recovery environment in combination with medium intensity clinical services to support recovery. Services may be provided in a deliberately repetitive fashion to address the special needs of individuals who are often elderly, cognitively impaired, or developmentally delayed. Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning.

The deficits for clients at this level are primarily cognitive, either temporary or permanent. The clients in this LOC have needs that are more intensive and therefore, to benefit effectively from services, they must be provided at a slower pace and over a longer period of time. The client's level of impairment is more severe at this level, requiring services be provided differently in order for maximum benefit to be received.

Support Systems
Necessary support systems within this level include telephone or in-person consultations with a physician, or a physician assistant or nurse practitioner in states where they are licensed as physician extenders and may perform the duties designated here for a physician; and emergency services, available 24 hours a day, 7 days a week. They should have direct affiliations with other easily accessible levels of care or close coordination through referral to more and less intensive levels of care and other services. They need medical, psychiatric, psychological, laboratory and toxicology services available through consultation and referral as appropriate to the severity and urgency of the individual's condition.

Staff Requirements
Level 3.3 programs are staffed by physician extenders, and appropriately credentialed mental health professionals as well as allied health professional staff. These staff should be on-site 24hours a day or as required by licensing regulations. In addition, one or more clinicians with competence in the treatment of substance use disorders should be onsite 24-hours a day. These staff should also be knowledgeable about the biological and psychosocial dimensions of substance abuse and mental health disorders as well as their treatments. They should also be able to identify signs and symptoms of acute psychiatric conditions including psychiatric decompensation. Staff should also have specialized training in behavior management techniques.

Co-occurring Enhanced Programs
This type of program needs to be staffed by credentialed psychiatrists and mental health professionals. They should be able to assess and treat people with co-occurring mental disorders and they need to have specialized training in behavior management techniques. Most, if not all, treatment professionals should have sufficient cross-training

to understand signs and symptoms of mental disorders and be able to understand and explain to the individual the purpose of psychotropic medication and its interactions with substance use.

ASAM Level 3.5 – Clinically Managed High-Intensity Residential Services
These programs are designed to treat clients who have significant social and psychological problems. Treatment is directed toward diminishing client deficits through targeted interventions. Effective treatment approaches are primarily habilitative in focus; addressing the client's educational and vocational deficits, as well as his or her socially dysfunctional behavior. Clients at this level may have extensive treatment or criminal justice histories, limited work and educational experiences, and antisocial value systems.

The length of treatment depends on an individual's progress. However, as impairment is considered to be significant at this level, services should be of a duration that will adequately address the many habilitation needs of this population. Very often, the level of impairment will limit the services that can actually be provided to the client resulting in the primary focus of treatment at this level being focused on habilitation and development, or re-development, of life skills. Due to the increased need for habilitation in this client population, the program will have to provide the right mix of services to promote life skill mastery for each individual.

Support Systems
Programs in this level of care should have telephone or in-person consultation with a physician, or a physician assistant or nurse practitioner in state where they are licensed as physician extenders and may perform the duties designated here for a physician; emergency services, available 24 hours a day, 7 days a week. They must also have direct affiliations with other levels or close coordination through referral to more and less intensive levels of care and other services. They must also have arranged medical, psychiatric, psychological, laboratory, and toxicology services as appropriate to the severity and urgency of the individual's condition.

Staff Requirements
Level 3.5 programs staffed by licensed or credentialed clinical staff such as addiction counselors and other professional staff who work with the allied health staff in interdisciplinary approach. Professional staff should be onsite 24-hours a day or per licensing regulations. One or more clinicians with competence in treatment of substance use disorders must be available onsite or on-call 24-hours per day. These staff should also be knowledgeable about the biological and psychosocial dimensions of substance abuse and mental health disorders as well as their treatments. Clinicians should be able to identify the signs and symptoms of acute psychiatric conditions, and have specialized training in behavior management techniques.

Co-occurring Enhanced Programs
This type of program should offer psychiatric services, medication evaluation and laboratory services. These services should be available by telephone within 8 hours and on-site or closely coordinated off-site staff within 24 hours, as appropriate by severity and urgency of the individual's mental health condition. These programs should

Deleted: **ASAM Level III.3- ¶**
**Clinically Managed Medium-Intensity Residential Services**¶
These programs provide a structured recovery environment in combination with medium- intensity clinical services to support recovery. Services may be provided in a deliberately repetitive fashion to address the special needs of individuals who are often elderly, cognitively impaired or developmentally delayed. Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning.¶
¶
The deficits for clients at this level are primarily cognitive, either temporary or permanent. The clients in this LOC have more intensive needs and therefore, to effectively benefit from services, they must be provided at a slower pace and over a longer period of time. The client's level of impairment is more severe at this level, requiring services be provided differently in order for any benefit to be received.¶

Deleted: ¶
¶
**ASAM Level III.5- ¶**
**Clinically Managed High-Intensity Residential Services**¶
These programs are designed to treat clients who have significant social and psychological problems. Treatment is directed toward diminishing client deficits through targeted interventions. Effective treatment approaches are primarily habilitative in focus addressing the client's educational and vocational deficits, as well as his or her socially dysfunctional behavior. Clients at this level may have extensive treatment or criminal justice histories, limited work and educational experiences, and antisocial value systems.¶
¶
The services offered to clients in this modality tend to be of the longest duration among the four levels of care. As impairment is considered to be significant at this level, services must be provided over a longer time frame in order for any benefit to be received. Very often, the level of impairment will limit the services that can actually be provided to the client resulting in the primary focus of treatment at this level being centered on habilitation and development, or re-development of life skills.

be staffed by credentialed mental health professionals, including addiction psychiatrists who are able to assess and treat the cooccurring mental health disorder and have specialized training in behavior management. They should also have cross-training to understand the signs and symptoms of co-occurring mental disorders and be able to explain to the individual, the purpose of psychotropic drugs and how they interact with substance use.

ASAM Level 3.7 – Medically Monitored High-Intensity Inpatient Services
These programs offer a structured regime of professional 24-hour directed evaluation, observation, medical monitoring and addiction treatment in an inpatient setting. These programs operate in permanent facilities with inpatient beds and function under a set of defined policies, procedures and clinical protocols. These programs are for patients with subacute biomedical and emotional, behavioral or severe cognitive problems that require individual treatment but do not require the full resources of an acute care general hospital or medically managed individual program.

These services are designed to meet needs of patients who have functional limitations in Dimensions 1, 2, and 3. The care provided in these programs is delivered by an interdisciplinary staff of appropriately credentialed staff, including addiction credentialed physicians. The main focus of treatment is specific to substance related disorders. The skills of this team and their availability can accommodate withdrawal management and/or intensive inpatient treatment of addiction, and/or integrated treatment of co-occurring subacute biomedical, and/or emotional, behavioral or cognitive conditions.

Support Systems
This level of care requires physician monitoring, nursing care, and observations are made available. The following staffing is required for this level of care: a physician must be available to assess the individual in person within 24 hours of admission and thereafter as medically necessary; a registered nurse to conduct alcohol and other drug-focused nursing assessment at time of admission; an appropriately credentialed nurse is responsible for monitoring the individual's progress and for medication administration. There must be additional medical specialty consultation, psychological, laboratory and toxicology services available on-site through consultation or referral. There also must be coordination of necessary services or other levels of care are available through direct affiliation or a referral process. Psychiatric services should be available on-site through consultation or referral when presenting an issue that could be attended to at a later time. These services should be available within 8 hours by telephone or 24 hours in person.

Staff Requirements
These programs are staffed by an interdisciplinary staff (including physicians, nurses, addiction counselors, and behavioral health specialists) who are able to assess and treat the individual and obtain and interpret information regarding the individuals psychiatric and substance use or addictive disorders. Staff should be knowledgeable about the biological and psychosocial dimensions of addictions and other behavioral health disorders. The staff should have training in behavior management techniques and

evidence-based practices. The staff should be able to provide a planned regimen of 24-hour professionally directed evaluation, care and treatment services. A licensed physician should oversee the treatment process and assure quality of care. Physicians perform physical examinations for all admitted to this level of care. These staff should have specific training in addiction medicine or addiction psychiatry and experience with adolescent medicine. Individuals should receive pharmacotherapy integrated with psychosocial therapies.

Co-occurring Enhanced Programs
Programs at this level should offer appropriate psychiatric services, medication evaluation and laboratory services. A psychiatrist should assess the individual within four hours of admission by telephone and within 24 hours following admission in person, if not sooner, as appropriate by individual's behavioral health condition. A registered nurse or licensed mental health clinician should conduct a behavioral health-focused assessment at the time of admission. If not done by a registered nurse, a separate nursing assessment must be done. The nurse is responsible for monitoring the individual's progress and administering or monitoring the individual's self-administration of psychotropic medications. These must also be staffed by addiction psychiatrists and credentialed behavioral health professionals who can assess and treat co-occurring psychiatric disorders and who have specialized training in behavior management. These programs are ideally staffed by a certified addiction specialist physician, or a physician certified as an addiction psychiatrist. Some, if not all, treatment professionals should have sufficient cross-training to understand signs and symptoms of psychiatric disorders and be able to explain to the individual the purpose of psychotropic medication and how they interact with substance use. The intensity and care should meet the individual's needs.

ASAM LOC describe the need for treatment from the perspective of the level of impairment of the client; with the higher the level of impairment requiring the longer duration, slower more repetitive services. The identification of these needs is intended to assist with service selection and authorization for care. The placement of the client is based on the ASAM LOC determination. Due to the unique and complex nature of each client, it is recognized that not every client will "fit" cleanly into one level over another by just looking at the level of impairment. There may be situations where a case could be made for a client to receive services in each of these levels and each would be appropriate. In these situations, documentation should be made as to the rationale for the decision. In addition, variations in treatment that do not follow these guidelines should also be documented in the client record.

The cost of the service should not be the driving force behind the decision; the decision should be made based on what is most likely to help the client be successful in treatment and achieve recovery.

Deleted: **ASAM Level III.7- ¶**
**Medically Monitored Intensive Inpatient Treatment¶**
These programs provide 24-hour medical monitoring, evaluation, observation and addiction treatment in an inpatient setting. "They are appropriate for patients whose sub-acute biomedical and emotional, behavioral or cognitive problems are so severe that they require inpatient treatment, but who do not need the full resources of an acute care general hospital or a medically managed inpatient treatment," (Mee-Lee, Shulman, Fishman, Gastfriend & Griffith, 2001). Treatment is provided by an interdisciplinary staff of appropriately credentialed treatment professionals, and is specific to substance use disorders. The treatment team can also accommodate clients with detoxification, medical, emotional, behavioral and cognitive conditions. Clients at this level will have functional deficits in Dimensions 1, 2 and/or 3.¶
**<object>¶**
The length of service will vary, based on the severity of a client's illness and their response to treatment. In addition, clients with a high severity of illness in Dimension 1, 2 or 3 require more intensive support services, as well as staff monitoring the program.¶
¶
ASAM levels of care describe the need for treatment from the perspective of the level of impairment of the client; with the higher level of impairment requiring the longer duration, slower more repetitive services. The identification of these needs is intended to assist with service selection and authorization for care. The placement of the client is based on the ASAM LOC determination. Due to the unique and complex nature of each client, it is recognized that not every client will "fit" cleanly into one level over another by just looking at the level of impairment. There may be situations where a case could be made for a client to receive services in each of these levels and each would be appropriate. In these situations, documentation should be made as to the rationale for the decision. The cost of the service should not be the driving force behind the decision; the decision should be made based on what is most likely to help the client be successful in treatment.¶

The ASAM Assessment Dimensions must be used to assist in the determination of the LOC needed by a client:

| Level of Care | Level 3.1 | Level 3.3 | Level 3.5 | |
|---|---|---|---|---|
| **Dimension 1** Withdrawal Potential | No withdrawal risk, or minimal/stable withdrawal; Concurrently receiving Level 1-WM or Level 2-WM | Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level 3.2-WM | At minimal risk of severe withdrawal at Levels 3.3 or 3.5. If withdrawal is present, it meets Level 3.2-WM criteria | Ap… with… for… |
| **Dimension 2** Medical conditions & complications | None or very stable, or receiving concurrent medical monitoring | None or stable or receiving concurrent medical monitoring | None or stable or receiving concurrent medical monitoring | Ind… risk… phy… cor… conditions |
| **Dimension 3** Emotional, behavioral, or cognitive conditions and complications | None or minimal; not distracting to recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required | Mild to moderate severity; needs structure to focus on recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required. Treatment should be designed to respond to any cognitive deficits | Demonstrates a repeated inability to control impulses, or a personality disorder that requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A dual diagnosis enhanced setting is required for the seriously mentally ill client | Individual must be admitted into cooccurring capable or co-occurring enhanced program, depending on level of function or degree of impairment |
| **Dimension 4** Readiness to change | Open to recovery but needs a structured environment to maintain therapeutic gains | Has little awareness and needs interventions available only at Level 3.3 to engage and stay in treatment; or there is high severity in this dimension but not in others. The client needs a Level 1 motivational enhancement program (Early Intervention) | Has marked difficulty engaging in treatment, with dangerous consequences; or there is high severity in this dimension but not in others; The client needs a Level 1 motivational enhancement program (Early Intervention) | Does not accept or relate the addictive disorder to severity of existing pro… motivating strategies; need 24hour monitoring to assure follow through with treatment plan |

Deleted: III.5
Deleted: III.1
Deleted: III.3
Deleted: III.3
Deleted: III.5.
Deleted: III.2- D
Deleted: I
Deleted: III.2-D
Deleted: D
Deleted: II
Deleted: D
Deleted:
Deleted:
Deleted: III.3
Deleted: I
Deleted: I

| | | | | |
|---|---|---|---|---|
| **Dimension 5** Relapse, continued use or continued problem potential | Understands relapse but needs structure to maintain therapeutic gains | Has little awareness and needs intervention only available at Level 3.3 to prevent continued use, with imminent dangerous consequences because of cognitive deficits or comparable dysfunction | Has no recognition of skills needed to prevent continued use, with imminently dangerous consequences | Experiencing acute psychiatric/substance use disorder marked by inte Deleted: III.3 of the substance-related disorder despite participation in a less intensive level of treatment; OR b) There is a high likelihood that the patient will continue to use or relapse to use without close outpatient monitoring and structured therapeutic services. |
| **Dimension 6** Recovery/living environment | Environment is dangerous, but recovery achievable if Level 3.1. 24-hour structure is available | Environment is dangerous and client needs 24-hour structure to cope | Environment is dangerous and client lacks skills to cope outside of a highly structured 24-hour setting | Environment is dangerous and patient lacks skills to cope outside of highly str Deleted: III |

Admission Criteria
Admission to residential treatment is limited to the following criteria:
• Medical necessity.
• Diagnosis: The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression of a substance use disorder (also known as provisional diagnosis). The diagnosis will be confirmed by the provider's assessment process.
• Individualized determination of need.
• ASAM Criteria is used to determine substance use disorder treatment placement/admission and/or continued stay needs, and are based on a LOC determination using the six assessment dimensions of the ASAM Criteria below:
1) Withdrawal potential.
2) Medical conditions and complications.
3) Emotional, behavioral, or cognitive conditions and complications.
4) Readiness to change – as determined by the Stages of Change Model.
5) Relapse, continued use or continued problem potential.
6) Recovery/living environment.

Treatment must be individualized based on a biopsychosocial assessment, diagnosis, and client characteristics that include, but are not limited to, age, gender, culture, and development.

Authorization decisions on length of stay (including continued stay), change in LOC, and discharge must be based on the ASAM Criteria. As a client's needs change, the frequency, and/or duration, of services may be increased or decreased as medically necessary. Client participation in referral, continuing care, and recovery planning must occur prior to a move to another LOC for continued treatment.

Service Requirements

The following chart details the required amount of services that have been established for residential treatment in the three levels of care. Documentation of all core services, and the response to them by the client, must be found in the client's chart. In situations where the required services cannot be provided to a client in the appropriate frequency or quantity, a justification must also be documented in the client record.

| Level of Care | Minimum Weekly Core Services | Minimum Weekly Life Skills/Self Care |
|---|---|---|
| ASAM 3.1 Clients with lower impairment or lower complexity of needs | At least 5 hours of clinical services per week | At least 5 hours per week |
| ASAM 3.3 Clients with moderate to high impairment or moderate to high complexity of needs | Not less than 13 hours per week | Not less than 13 hours per week |
| ASAM 3.5 Clients with a significant level of impairment or very complex needs | Not less than 20 hours per week | Not less than 20 hours per week |
| ASAM 3.7 Clients with significant level of impairment or very complex needs | Not less than 20 hours per week | Not less than 20 hours per week |

Covered Services:
The following services must be available in a residential setting regardless of the LOC and based on individual client need:

| Type | Residential Services Description |
|---|---|
| **Basic Care** | Room, board, supervision, monitoring self administration of medications, toxicology screening, facilitates transportation to and from treatment, treatment environment: structured, safe, and recovery oriented. |

Deleted: Admission Criteria¶
Admission to residential treatment is limited to the following criteria:¶
¶
<#>Diagnosis: The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression of a substance use disorder (also known as provisional diagnosis)- the diagnostic impression must include all five axes:¶
<#>Axis I Clinical Disorders¶
<#>Axis II Personality Disorders, Mental Impairment¶
<#>Axis III General Medical Conditions¶
<#>Axis IV Psychosocial and Environmental Problems¶
<#>Global Assessment of Functioning¶
¶
<#>Medical Necessity¶
¶
<#>Use of ASAM Patient Placement Criteria (PPC) to determine substance use disorder treatment placement/admission and/or continued stay needs, and are based on a LOC determination using the six assessment dimensions of the current ASAM PPC below:¶
¶
<#>Withdrawal potential.¶
<#>Medical conditions and complications.¶
<#>Emotional, behavioral or cognitive conditions and complications.¶
<#>Readiness to change- as determined by the Stages-of-change Model.¶
<#>Relapse, continued use or continued problem potential.¶
<#>Recovery/living environment.¶
¶
<#>Individualized determination of need¶
¶
**<object>**¶
Treatment must be individualized based on a biopsychosocial assessment, diagnostic impression and client characteristics that include, but are not limited to age, gender, culture, and development. Authorization decisions on length of stay (including continued stay), change in level of care, and discharge, must be based on the ASAM PPC. As a client's needs change, the frequency and/or duration of services may be increased or decreased as medically necessary. Client participation in referral and continuing care planning must occur prior to a move to another level of care for continued treatment.¶
¶
Service Requirements:¶
The following chart details the required amount of services that have been established for residential treatment in the four levels of care. Alternative forms of therapy such as art, music, etc., should be reflected in the client's treatment plan and follow the documentation requirements. Documentation of all required services, and the response to them by the client, must be found in the client's chart. In situations where the required services cannot be provided to a client in the appropriate frequency or quantity, a justification must also be documented in the client record.¶
¶

Deleted: ¶
¶
¶

Formatted Table

| | |
|---|---|
| **Treatment Basics**<br><br>**Core Service** | Assessment; Episode of Care Plan (addressing treatment, recovery, discharge and transition across episode); coordination and referral; medical evaluation and attempt to link to services; connection to next provider and medical services, preparation for 'next step.' |
| **Therapeutic Interventions**<br><br>**Core Service** | Individual, group and family psychotherapy services; appropriate for the individual's needs; and crisis intervention. Services provided by an appropriately licensed, credentialed and supervised professional working within their scope of |
| **Interactive Education /Counseling**<br><br>**Core Service** | Interaction and teaching with client(s) and staff that process skills and information adapted to the individual client needs. This includes alternative therapies, individual, group and family counseling, anger management, coping skills, recovery skills, relapse triggers, and crisis intervention. |
| **Life Skills/Self-Care (building recovery capital)** | Social activities that promote healthy community integration/reintegration, development of community supports, parenting, employment, job readiness, how to use public transportation, hygiene, nutrition, laundry, education. |
| **Milieu/Environment (building recovery capital)** | Peer support; recreation/exercise; leisure activities; family visits; coordination with treatment, support groups; maintaining a drug/alcohol free campus. |
| **Medical Services**<br><br>**Core Service** | Physician monitoring, nursing care, and observation available. Medical specialty consultation, psychological, laboratory and toxicology services available. Psychiatric services available on-site. |

Formatted: Underline

Deleted: ¶

Formatted: Space Before: 0 pt, Line spacing: single

Formatted: Centered

Deleted: ¶
¶
¶
¶
¶
¶
¶

Treatment Planning & Recovery Planning:

Clients entering any level of residential care will have recovery and functional needs that will continue to require intervention once residential services are no longer appropriate. Therefore, residential care should be viewed as a part of an episode of care within a continuum of services that will contribute toward recovery for the client. Residential care should not be presented to clients as being a complete episode of care. To facilitate the client moving along the treatment continuum, it is expected that the provider, as part of treatment planning, begins to prepare the client for the next stage of the recovery process as soon after admission as possible. This will help to facilitate a smooth transition to the next LOC, as appropriate, and make sure that the client is aware that services will continue once the residential stay is over.

To make the transition to the next LOC, the residential care provider may assist the client in choosing an appropriate service based on needs and location scheduling appointments, arranging for a meeting with the new service provider, arranging

transportation, and ensuring all required paperwork is completed and forwarded to the new service provider in a timely manner. These activities are provided, as examples of activities that could take place if it were determined there would be a benefit to the client. There could potentially be many other activities or arrangements that may be needed, or the client may require very little assistance. To the best of their ability, it is expected that the residential provider arrange for any needed assistance to ensure a seamless transfer to the next LOC.

Continuing Stay Criteria:
Re-authorization or continued treatment should be based on ASAM PPC continued service criteria, medical necessity, and when there is a reasonable expectation of benefit from continued care.

Continuing stay can be denied in situations where the client has decided not to participate in his/her treatment. This is evidenced by continued non-compliance with treatment activities, other behavior that is deemed to violate the rules and regulations of the program providing the services, or a demonstrated lack of benefit from treatment received, after documented attempts to meet the needs of the client, by adjusting the services, were made. Progress notes must support lack of benefit, and that other appropriate services have been offered, before a client can be terminated from a treatment episode.

The ASAM Assessment Dimensions must be used to assist in the determination of the level of care needed by a client:

| | | | |
|---|---|---|---|
| | | | |
| | | | |

Deleted: Clients entering any level of residential care will have recovery and functional needs that will continue to require intervention once residential services are no longer appropriate. Therefore, residential care should be viewed as a part of an episode of care within a continuum of services that will contribute toward recovery for the client. Residential care should not be presented to clients as being a complete episode of care. ¶
¶
To facilitate the client moving along the treatment **<object>**continuum, it is expected that the provider, as part of treatment planning, begin the process of preparing the client for the next stage of the recovery process as soon after admission as possible. This will help to facilitate a smooth transition to the next service, as appropriate, and make sure that the client is aware that services will continue once the residential stay is over.¶
¶
To make the transition to the next level of care, the residential care provider may assist the client in: choosing an appropriate service based on needs and location, scheduling appointments, arranging for a meeting with the new service provider, arranging transportation, and ensuring all required paperwork is completed and forwarded to the new service provider in a timely manner. These activities are provided as examples of activities that could take place if it were determined that doing so would benefit the client. There could potentially be many other activities or arrangements that may be needed or the client may require very little assistance. To the best of their ability, it is expected that the residential provider provide any needed assistance to ensure a seamless transfer to the next level of care.¶

Deleted: **Level III.5**

Deleted: **Level of Care**

Deleted: **Level III.1**

Deleted: **Level III.3**

Deleted: ¶
Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level III.2-D
At minimal risk of severe withdrawal at Levels III.3 or III.5. If withdrawal is present, it meets Level III.2- D criteria

Deleted: At minimal risk of severe withdrawal at Levels III.3 withdrawal is present, it meets Level III.2- D criteria

Deleted: No withdrawal risk, or minimal/stable withdrawal; Concurrently receiving Level I-D or Level II-D
¶
Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level III.2-D ... [1]

Deleted: ¶
**Dimension 1**¶
Withdrawal¶
Potential

Deleted: ¶
None or very stable, or receiving concurrent medical monitoring
¶ ... [2]

Deleted: ¶
None or stable or receiving concurrent medical monitoring

Deleted: ¶
None or stable or receiving concurrent medical monitoring

Deleted: **Dimension 2**¶
Medical conditions & complications

| | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Deleted: ¶
None or minimal; not distracting to recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis- enhanced program is required
Mild to moderate severity; needs structure to focus on recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required. Treatment should be designed to respond to any cognitive deficits
Demonstrates a repeated inability to control impulses, or a personality disorder that requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills.¶
A dual diagnosis enhanced¶
setting is required for the seriously mentally ill client

Deleted: Mild to moderate severity; needs structure to focus recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required. Treatment should be designed to respond to any cognitive deficits
Demonstrates a repeated inability to control impulses, or a personality disorder that requires structure to shape be ... [4]

Deleted: ¶
¶
¶ ... [3]

Deleted: Demonstrates a repeated inability to control personality disorder that requires structure to shape be ... [5]

Deleted: ¶
¶
¶ ... [6]

Deleted: ¶
¶
¶ ... [7]

Deleted: ¶
¶ ... [9]

Deleted: Has little awareness and needs interventions at Level III.3 to engage and stay in treatment; or there is high severity in this dimension but not in others. The client ... [8]

Deleted: ¶
¶
¶ ... [10]

Deleted: ¶
¶
¶ ... [12]

Deleted: Has little awareness and needs intervention only Level III.3 to prevent continued use, with imminent ... [11]

Deleted: ¶
**Dimension 5**¶
Relapse, continued use or continued problem potential

Deleted: ¶
Environment is dangerous and client needs 24-hour structure to cope ... [15]

Deleted: ¶
Environment is dangerous¶
and client lacks skills to cope outside of a highly struc ... [16]

Deleted: Environment is dangerous, but recovery achievable if Level III.¶
24-hour structure is¶ ... [14]

Deleted: ¶
**Dimension 6**¶
Recovery/living¶ ... [13]

## VII. EXHIBITS

None

## VIII. REFERENCES

| Reference: | Check if applies: | Standard Numbers: |
|---|---|---|
| 42 CFR Parts 400 et al. (Balanced Budget Act) | X | |
| 45 CFR Parts 160 & 164 (HIPAA) | X | |
| 42 CFR Part 2 (Substance Abuse) | X | |
| Michigan Mental Health Code Act 258 of 1974 | X | |
| The Joint Commission - Behavioral Health Standards | | |
| Michigan Department of Health and Human Services (MDHHS) Medicaid Contract | X | |
| MDHHS Substance Abuse Contract | X | |
| Michigan Medicaid Provider Manual | X | |
| HITECH Act of 2009 | X | |
| MDHHS Office of Recovery Systems of Care | X | |

Mee-Lee D, Shulman GD, Fishman M, Gastfriend DR, and Griffth JH, eds. (2001). *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R).* Chevy Chase, MD: American Society of Addiction Medicine, Inc.

3rd Edition: *The ASAM CRITERIA: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* (2015); Chevy Chase, MD: American Society of Addiction Medicine, Inc.

Michigan Department of Health and Human Services, Office of Recovery Oriented Systems of Care. Michigan's ROSC Glossary of Terms. Retrieved from http://www.michigan.gov/documents/mdch/ROSC_Glossary_of_Terms_350345_7.pdf.

Michigan Department of Licensing and Regulatory Affairs, Michigan Administrative Code. (n.d.). [Administrative Rules for] Substance Use Disorder Service Programs. Promulgated pursuant to Michigan Public Act 368 of 1978, Section 6231(1), as amended. Retrieved from http://www7.dleg.state.mi.us/orr/Files/AdminCode/103_65_AdminCode.pdf

Michigan Department of Licensing and Regulatory Affairs, Michigan Administrative Code. (n.d.). [Administrative Rules for] Social Work General Rules. Promulgated pursuant to Michigan Public Act 368 of 1978, Sections 16145(3) and 18501, as amended. Retrieved from http://www7.dleg.state.mi.us/orr/Files/AdminCode/104_85_AdminCode.pdf

*Treatment Policy #6, Individualized Treatment Planning,* (2006) Michigan Department of Community Health, Office of Drug Control Policy, http://www.michigan.gov/mdch/O,1607,7-132-2941_4871_4877-133156--,00.html.

*Treatment Policy* #7, *Access Management System,* (2006) Michigan Department of Community Health, Office of Drug Control Policy, http://www.michigan.gov/mdch/O,1607,7-132-2941_4871_4877-133156--,00.htrnf.

*Treatment Technical Advisory* #7, *Peer Recovery/Recovery Support Services,* (2008) Michigan Department of Community Health, Office of Drug Control Policy, http://www.michigan.gov/mdch/O,1607,7-132-2941_4871_4877-133156--,00.html.

*Treatment Technical Advisory #10: Residential Treatment Continuum of Services.* Michigan Department of Community Health, Bureau of Substance Abuse and Adduction Services.
TA_10_-_Residential_TX_Continuum_of_Services_-_FINAL_33456_7.docx.

Deleted: State of Michigan, State Office of Administrative Hearings and Rules, Michigan Administrative Code, Substance Abuse Service Programs, http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Single&Admin Num=3251410 I &Dpt=CH&RngHigh¶

| | | |
|---|---|---|
| Page 13: [1] Deleted | Amy Johnston | 11/4/2019 11:29:00 AM |
| Page 13: [2] Deleted | Amy Johnston | 11/4/2019 11:29:00 AM |
| Page 14: [3] Deleted | Amy Johnston | 11/4/2019 11:29:00 AM |
| Page 14: [4] Deleted | Amy Johnston | 11/4/2019 11:29:00 AM |
| Page 14: [5] Deleted | Amy Johnston | 11/4/2019 11:29:00 AM |
| Page 14: [6] Deleted | Amy Johnston | 11/4/2019 11:29:00 AM |
| Page 14: [7] Deleted | Amy Johnston | 11/4/2019 11:29:00 AM |
| Page 14: [8] Deleted | Amy Johnston | 11/4/2019 11:29:00 AM |
| Page 14: [9] Deleted | Amy Johnston | 11/4/2019 11:29:00 AM |
| Page 14: [10] Deleted | Amy Johnston | 11/4/2019 11:29:00 AM |
| Page 14: [11] Deleted | Amy Johnston | 11/4/2019 11:29:00 AM |
| Page 14: [12] Deleted | Amy Johnston | 11/4/2019 11:29:00 AM |
| Page 14: [13] Deleted | Amy Johnston | 11/4/2019 11:29:00 AM |
| Page 14: [14] Deleted | Amy Johnston | 11/4/2019 11:29:00 AM |
| Page 14: [15] Deleted | Amy Johnston | 11/4/2019 11:29:00 AM |
| Page 14: [16] Deleted | Amy Johnston | 11/4/2019 11:29:00 AM |

| **Community Mental Health Partnership of Southeast Michigan PIHP** | ***Policy*** **Women's Specialty Treatment Services** |
|---|---|
| **Department: Substance Use Disorders** **Author: M. Scalera/A. Marshall** | **Local Policy Number (if used)** |
| **Regional Operations Committee Approval Date 9/14/2016** | **Implementation Date 10/1/16** |

## I. PURPOSE

The purpose of this policy is to describe the philosophy and requirements for women's treatment services (designated as both women's programs and gender competent programs) and to describe the contracting of specialized services for women and their children. Women's specific funding is restricted to assuring access for chemically dependent pregnant women, post-partum women and single men who are in treatment while raising their children. Services offered include the provision of transportation, childcare and medical care assistance, as well as needed treatment service and coordination.

## II. REVISION HISTORY

| DATE | REV. NO. | MODIFICATION |
|---|---|---|
| 1/2016 | 1 | Revised language |
| 9/2016 | 2 | Language updates |
| 11/2019 | 3 | Language updates and addition of Enhanced Women's Services criteria |
| | | |

## III. APPLICATION

This policy applies to all staff, students, volunteers, and contracted organizations receiving any funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM), who would either provide designated women's specialty treatment services *or* refer individuals who meet criteria for Women's Specialty Treatment services.

## IV. DEFINITIONS

Care Management/Care Coordination: an administrative function performed at the PIHP or through the access system, via the core provider

Case Management: a SUD program that coordinates, plans, provides, evaluates and monitors services or recovery from a variety of resources on behalf of and in collaboration with a client who has a substance use disorder. A SUD Women's case management program offers these services through designated staff working in collaboration with the SUD treatment team and as guided by the individualized treatment planning process.

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental

health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Community Based: the provision of services outside of an office setting. Typically these services are provided in a client's home or in other venues, including while providing transportation to and from other appointments.

Eligible: Pregnant women and women with dependent children, including women who are attempting to regain custody of their children.

Fetal Alcohol Spectrum Disorder (FASD): an umbrella term describing the range of effects that can occur in an individual whose mother drank during pregnancy. These effects may include physical, mental, behavioral and/or learning disabilities with possible lifelong implications. The term FASD is not intended for use as a clinical diagnosis. It refers to conditions such as fetal alcohol syndrome (FAS), fetal alcohol effects (FAE), alcohol-related neurodevelopment disorder (ARND) and alcohol related birth defects (ARBD).

Gender Competent: capacity to identify differences on the basis of gender is significant, and to provide services that appropriately address gender differences and enhance positive outcomes for the population.

Gender Responsiveness (Designated Women's Program): creating an environment through site selection, staff selection, program development, content and material that reflects an understanding of the realities of the lives of women and girls, and that addresses and responds to their strengths and challenges. (Bloom and Covington, 2000)

Individual Assessment: a face-to-face service for the purpose of identifying functional and treatment needs, and to formulate the basis for the Individualized Treatment Plan to be implemented by the provider.

Individual Treatment Planning: direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current level of care, to ensure true and realistic needs are being addressed and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each client and be specific to the diagnostic impression and assessment.

Michigan Department of Health and Human Services: MDHHS

Recovery: a highly individualized journey of healing and transformation where the person gains control over his/her life. It involves the development of new meaning and purpose, growing beyond the impact of addiction or a diagnosis. This journey may include the pursuit of spiritual, emotional, mental and physical well-being.

Recovery Planning: a process that highlights and organizes a person's goals, strengths and capacities to determine the barriers to be removed or problems to be resolved in order to

help people achieve their goals. This should include an asset and strength-based assessment of the client.

Substance Use Disorder (SUD): a term inclusive of substance abuse and dependence, which also encompasses problematic use of substances.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

## V. POLICY

This policy establishes that all services are to be gender and culturally competent, understanding the client and their environment and embrace the values of a recovery oriented system of care with a full continuum of services. It is the expectation that all *eligible* clients are evaluated for referral to specialty services where indicated

## VI. STANDARDS

The CMHPSM is dedicated to the following fundamental principles as the foundation for integrating women-specific substance use disorder treatment services and non-gender specific services, and non-gender specific services, while focusing on effective and comprehensive treatment of women and their families.

Background:
The Substance Abuse Prevention and Treatment (SAPT) Block Grant requires states to spend a set minimum amount each year for treatment-and ancillary services for eligible women. Eligible women have been defined as, "pregnant women and women with dependent children, including women who are attempting to regain custody of their children." (42 U.S.c. 96.124 [e]). Pregnant women are identified as a priority population under the SAPT Block Grant regulations. Michigan Public Act 368 of 1978, part 62, section 333.6232, identifies "a parent whose child has been removed from the home under the child protection laws of this state or is in danger of being removed from the home under the child protection laws of this state because of the parent's substance abuse," as a priority population for substance use disorder services above others with substantially similar clinical conditions.

Michigan law extends priority population status to men whose children have been removed from the home or are at danger of being removed under the child protection laws. To support their entrance into and success in treatment, men who are shown to be the primary caregivers for their children are also eligible to access ancillary services such as child care, transportation, case management, therapeutic interventions for children, and primary medical and pediatric care, as defined by 45 CFR Part 96.

MDHHS Vision is to implement a change in the practice of women's substance use disorder treatment providers and system transformation in Michigan. This will be accomplished by having a strength-based coordinated system of care, driven by a shared set of core values that is reflected and measured in the way we interact with, and deliver supports and services for families who require substance abuse, mental health, and child welfare services.

Core Values

- Family-Centered: A family centered approach means that the focus is on the family, as defined by the client themselves. Families are responsible for their children and are respected and listened to as we support them in working toward meeting their needs, reducing system barriers, and promoting changes that can be sustained over time. The goal of a family-centered team and system is to move away from the focus of a single client represented in a system, to a focus on the functioning, safety and well-being of the family as a whole.
- Family Involvement: The family's involvement in the process is empowering and increases the likelihood of cooperation, ownership and success. Families are viewed as full and meaningful partners in all aspects of the decision-making process affecting their lives, including decisions made about their service plans. It is important to recognize that a woman defines her own family and that this definition may not be traditional.
- Build on Natural and Community Supports: Recognize and utilize all resources in our communities creatively and flexibly, including formal and informal supports and service systems. Every attempt should be made to include the family's relatives, neighbors, friends, faith community, co-workers or anyone the family would like to include in the team process. Ultimately families will be empowered and have developed a network of informal, natural, and community supports so that formal system involvement is reduced or not needed at all.
- Strength-Based: Strength-based planning builds on the family's unique qualities and identified strengths that can then be used to support strategies to meet the family's needs. Strengths should also be found in the family's environment through their informal support networks, as well as in attitudes, values, skills, abilities, preferences and aspirations. Strengths are expected to emerge, be clarified and change over time as the family's initial needs are met and new needs emerge, with strategies discussed and implemented.
- Unconditional Care: Means that we care for the family, not that we will care "if." It means that it is the responsibility of the service team to adapt to the needs of the family - not of the family to adapt to the needs of a program. If difficulties arise, the individualized services and supports change to meet the family's needs.
- Collaboration Across Systems: An interactive process in which people with diverse expertise, along with families, generate solutions to mutually defined needs and goals building on identified strengths. All systems working with the family have an understanding of each other's programs and a commitment and willingness to work together to assist the family in obtaining their goals. The substance use disorder, mental health, child welfare and other identified systems collaborate and coordinate a single system of care for families involved within their services.
- Team Approach Across Agencies: Planning, decision-making and strategies rely on the strengths, skills, mutual respect, and creative and flexible resources of a diversified, committed team. Team member strengths, skills, experience and resources are utilized to select strategies that will support the family in meeting their needs. Team members may include representatives from the multiple agencies a family is involved in, as well as any who offer support and resources to families. All family, formal and informal team members share responsibility, accountability, and authority; while understanding and respecting each other's strengths, roles and limitations.
- Ensuring Safety: When Children's Protective Services, foster care agencies, or domestic violence shelters are involved, the team will maintain a focus on family and child safety. Consideration will be given to whether the identified threats to safety

are still in effect, whether the child is being kept safe by the least intrusive means possible and whether the safety services in place are effectively controlling those threats. In situations involving domestic violence, the team will need to work with the family to develop and maintain a viable safety plan.

- Gender, Age, Culturally Responsive Treatment: Services reflect an understanding of the issues specific to gender, age, disability, race, ethnicity and sexual orientation, and also reflect support, acceptance, and understanding of cultural and lifestyle diversity.
- Self-sufficiency: Families will be supported, resources shared and team members held responsible for achieving self-sufficiency in essential life domains (including, but not limited to safety, housing, employment, financial, educational, psychological, emotional and spiritual).
- Education and Work Focus: Dedication to positive, immediate and consistent education, employment and or employment-related activities that result in resiliency and self-sufficiency, improved quality of Life: for self, family and the community.
- Belief in Growth, Learning and Recovery: Family improvement begins by integrating formal and informal supports that instill hope and are dedicated to interacting with individuals with compassion, dignity and respect. Team members operate from a belief that every family desires change and can take steps toward attaining a productive and self-sufficient life.
- Outcome Oriented: From the onset of family team meetings, levels of personal formal and informal supports, are discussed, agreed upon and maintained. Identified outcomes are understood and shared by all team members. Legal, education, employment, child-safety and other applicable mandates are considered in developing outcomes. Progress is monitored and each team member participates in defining success. Selected outcomes are standardized, measurable and based on the life of the family and its individual members.

Developing a Philosophy of Working with Women with Substance Use Disorders:

Program Structure:

1. Treatment revolves around the role women have in society, therefore treatment services must be gender specific.
    - Gender-responsive programs are not simply "female only" programs that were designed for males.
    - A woman's sense of self develops differently in women-specific groups as opposed to co-ed groups.
    - Because women place so much value on their role in society and relationships, to not take this into consideration in the recovery process is to miss a large component of a woman's identity.
    - Equality does not mean sameness; in other words, equality of service delivery is not simply about allowing women access to services traditionally reserved for men. Equality must be defined in terms of providing opportunities that are relevant to each gender so that treatment services may appear very different depending on to whom the service is being delivered.
    - The unique needs and issues (e.g., physical/sexual/emotional victimization, trauma, pregnancy and parenting) of women should be addressed in a safe, trusting and supportive environment.

- Treatment and services should build on women's strengths/competencies and promote independence and self-reliance.

2. A relational model, based on the psychological growth of women shall be the foundation for recovery (e.g., the Self-in-Relation model). The recognition that, for women, the primary experience of self is relational; that is, the self is organized and developed in the context of important relationships. (Surrey, 1985)
   - A model that emphasizes the importance of relationships in a woman's life, and attempts to address the strengths as well as the problems arising for women from a relational orientation.

3. A collaborative philosophy, driven by the woman and her family, shall be used.
   - Utilizing cross-systems collaboration and the involvement of informal supports to promote a woman's recovery.
   - A client-centered, goal-oriented approach to accessing and coordinating services across multiple systems by:
     i. assessing needs, resources and priorities,
     ii. planning for how the needs can be met
     iii. establishing linkages to enhance a woman's access to services to meet those identified needs
   - Coordinating and monitoring service provision through active cross-system communication and coordinated treatment plans and services.
   - Removing barriers to treatment and advocating for services.
   - A woman's needs determine the connections with agencies and systems that impact her life or her family's life, despite the number of agencies or systems involved.
   - Ideally, each woman will have a single, collaborative treatment plan or service plan used across systems. When this is not possible, coordination of as many systems as possible will lessen the confusion and stress this creates in a woman's life.
   - Care coordination and case management are the key to a woman's progress in recovery.

4. A model of empowerment is utilized in treatment and recovery planning.
   - The client is shown and taught how to access services, advocate for herself and her family, and request services that are of benefit to her and her family.
   - This process is woven into recovery, and could be taught by a recovery coach or women's case manager
   - The ultimate goal for the service system is to weave the woman so well into the informal support systems that the role of formal services is very small or not needed.
5. Employment is recommended as an important component in recovery and serves as an important therapeutic tool.
   - The structure of work is a benefit to recovery, and treatment providers need to be aware of the work requirements of Temporary Assistance for Needy Families/Work First. Historically, treatment providers have been reluctant to encourage clients to return to work or engage in work related activities during

the early stages of recovery. However, waiting to address employment concerns may create further challenges for the client facing Work First requirements.

6. A multi-system approach that is culturally aware shall be employed in the recovery process.
   - Gender specificity and cultural competence go hand-in-hand. There are a number of gender and cultural competencies that allow people to assist others more effectively. This requires a willingness and ability to draw on community-based values, traditions and customs, and to work with knowledgeable people of and from the community.

Education/Training of Staff:

In addition to current credentialing standards, individuals working and providing direct service within a designated women's program (gender responsive) must have completed a minimum of 12 semester hours, or the equivalent, of gender specific substance use disorder training or 2080 hours of supervised gender specific substance use disorder training/work experience within a designated women's program. Those not meeting the requirements must be supervised by another individual working within the program, and be working towards meeting the requirements. Documentation is required to be kept in personnel files.

Those working and providing direct service within a gender competent program must have completed a minimum of 8 semester hours, or the equivalent, of gender specific substance use disorder training or 1040 hours of supervised gender specific substance use disorder training. Those not meeting the requirements must be supervised by another individual working within the program and be working towards meeting the requirements. Documentation is required to be kept in personnel files. Other arrangements can be approved by the Office of Recovery Oriented Systems of Care (OROSC) Women's Treatment Coordinator.

Appropriate topics for gender specific substance use disorder training include, but are not limited to:

| | |
|---|---|
| Women's studies | Child Development |
| Trauma | Self-esteem/empowerment |
| Grief | Relational treatment model |
| Relationships | Women in the criminal justice system |
| Parenting | Women and addiction |

Admissions:

Treatment providers must follow the priority population guidelines identified in the State contract with the PIHP, listed below, for admitting women to treatment:

| Population | Admission Requirement | Interim Service Requirement |
|---|---|---|
| Pregnant Injecting Drug User | 1) Screened and referred within 24 hours.<br>2) Detoxification, methadone or residential- offer admission within24 business hours.<br>3) Other Levels of Care- offer admission within 48 business hours. | Begin within 48 hours:<br>1. Counseling and education on:<br>a. HIV and TB.<br>b. Risks of needle sharing.<br>c. Risks of transmission to sexual partners and infants.<br>d. Effects of alcohol and drug use on the fetus.<br>2. Referral for pre-natal care.<br>3. Early Intervention Clinical Services. |
| Pregnant with Substance Use Disorder | 1) Screened and referred within 24 hours.<br>2) Detoxification, methadone or residential- offer admission within 24 business hours.<br>Other Levels of Care – offer admission within 48 business hours. | Begin within 48 hours:<br>1. Counseling and education on:<br>a. HIV and TB.<br>b. Risks of transmission to sexual partners and infants.<br>c. Effects of alcohol and drug use on the fetus.<br>2. Referral for pre-natal care.<br>3. Early Intervention Clinical Services. |
| Injecting Drug User | Screened and referred within 24 hours. Offer admission within 14 days. | Begin within 48 hours – maximum waiting time 120 days:<br>1. Counseling and education on:<br>a. HIV and TB.<br>b. Risks of needle sharing.<br>c. Risks of transmission to sexual partners and infants.<br>2. Early Intervention Clinical Services. |
| Parent at Risk of Losing Children | Screened and referred within 24 hours. Offer admission within 14 days. | Begin within 48 business hours:<br>Early Intervention Clinical Services. |
| All Others | Screened and referred within seven calendar days. Capacity to offer admission within 14 days. | Not Required. |

* The full table can be found in the MDHHS contract with CMHPSM.

The admission standards listed in the table should be considered minimum standards.

Those programs interested in providing the best possible treatment to families should be meeting a higher standard for admission and interim service provision.

Treatment:

Programs that are designed to meet women's needs tend to be more successful in retaining women clients. For a provider to be able to offer women-specific treatment, its programs shall include the following criteria:

1. Accessibility
   Women's case managers and providers must demonstrate a process to reduce barriers to treatment by ensuring that priority population requirements are met, as well as providing ancillary services or ensuring that appropriate referrals to other community agencies are made.
   - There are many barriers that may critically inhibit attendance and follow-through for women with children. They may include child care, transportation, hours of operation and mental health concerns.

2. Assessment
   Assessment shall be a continuous process that evaluates the client's psychosocial needs and strengths within the family context, and through which progress is measured in terms of increased stabilization/functionality of the individual/family. In addition, all assessments shall be strength-based.
   - Women with children need to be assessed and treated as a unit. Women often both enter and leave treatment because of their children's needs. By assessing the family and addressing areas that need strengthening, providers give women a better chance at becoming stable in their recovery.

3. Psychological Development
   Providers shall demonstrate an understanding of the specific stages of psychological development and modify therapeutic techniques according to client needs, especially to promote autonomy.
   - Many of the traditional therapeutic techniques reinforce women's guilt, powerlessness and "learned helplessness," particularly as they operate in relationships with their children and significant others.

4. Abuse/Violence/Trauma
   Providers must develop a process to identify and address abuse/violence/trauma issues. Services will be delivered in a trauma-informed setting and provide safety from abuse, stalking by partners, family, other participants, visitors and staff.
   - A history of abuse, violence and trauma often contributes to the behavior of substance abusing and dependent women. A provider who does not take this history into consideration when treating the woman is not fully addressing the addiction or resulting behaviors.

5. Family Orientation
   Providers must identify and address the needs of family members through direct service,

referral or other processes. Families are a family of choice defined by the clients themselves. Agencies will include informal supports in the treatment process when it is in the best interest of the client.

- Many women present in a family context with major family ties and responsibilities that will continue to define their sense of self. Drug and alcohol use in a family puts children at risk for physical and emotional growth and developmental problems. Early identification and intervention for the children's problems is essential.

6. Mental Health Issues

Providers must demonstrate the ability to identify concurrent mental health disorders and develop a process to have the treatment for these disorders take place, in an integrated fashion, with substance use disorder treatment and other health care. It is important to note that treatment for both mental health issues and substance use disorders may lead to the use of medication as an adjunct to treatment.

- Women with substance abuse problems often present with concurrent mood disorders and other mental health problems.

7. Physical Health Issues

Providers shall:

- inquire about health care needs of the client and her children, including completing the Fetal Alcohol Syndrome Disorder (MDHHS: FASD POLICY #11, 2009) screening as appropriate
- make appropriate referrals, and document client and family health needs, referrals, and outcomes.
    - Women with a substance use disorder and their children are at high risk for significant health problems. They are at a greater risk for communicable diseases such as HIV, TB, hepatitis and sexually transmitted diseases. Prenatal care for women using/abusing substances is especially important, as their babies are at risk for serious physical, neurological and behavioral problems. Early identification and intervention for children's physical and emotional growth and development, and for other health issues in a family is essential.

8. Legal Issues

Providers shall document each client's compliance and facilitate required communication to appropriate authorities within the guidelines of federal confidentiality laws. Additionally, programs will individualize treatment in such a way as to help a client manage compliance with legal authorities.

- Women entering treatment may be experiencing legal problems including custody issues, civil actions, criminal charges, probation and parole. This adds another facet to the treatment and recovery planning process and reinforces the need for case management associated with women's services. By helping a woman identify her legal issues, steps that need to be taken, and how to incorporate this information into goals for her individualized treatment plan, a provider can greatly reduce stress on the client and make this type of challenge seem more manageable.

9. Sexuality/Intimacy/Exploitation
   Providers shall:
   - conduct an assessment that is sensitive to sexual abuse issues,
   - demonstrate competence to address these issues,
   - make appropriate referrals,
   - acknowledge and incorporate these issues in the recovery plan, and
   - assure that the client will not be exposed to exploitive situations that continue abuse patterns within the treatment process (co-ed groups are not recommended early in treatment, physical separation of sexes is recommended in residential treatment settings).
     - A high rate of treatment non-compliance among females with substance use disorders, with a history of sexual abuse, has been documented. The frequent incidence of sexual abuse among women with substance use disorders necessitates the inclusion of questions specifically related to the topic during the initial evaluation (assessment) process. Lack of recognition of a sexual abuse history or improper management of disclosure can contribute to a high rate of non-compliance in this population.

10. Survival Skills
    Providers must identify and address the client's needs in the following areas, including but not limited to:
    - Education and literacy.
    - Job readiness and job search.
    - Parenting skills.
    - Family planning.
    - Housing.
    - Language and cultural concerns.
    - Basic living skills/self-care.

    The provider shall refer the client to appropriate services and document both the referrals and the outcomes.
      - Women's treatment is often complicated by a variety of problems that must be addressed and integrated into the therapeutic process. Many of these problems may be addressed in the community, utilizing community resources, which will in turn help the client build a supportive relationship with the community.

11. Continuing Care/Recovery Support
    Providers shall:
    - Develop a recovery/continuing care plan with the client to address and plan for the client's continuing care needs.
    - Make and document appropriate referrals as part of the continuing care/recovery plan and remain available to the client as a resource for support and encouragement for at least one year following discharge.
      - In order for a woman to maintain recovery after treatment, she needs to be able to retain a connection to treatment staff or women's case

managers and receive support from appropriate services in the community.

**Enhanced Women's Services:**

Agencies with the Women's Specialty Services Designation may apply to the PIHP and MDHHS to provide enhanced programming. Consultation with the CMHPSM is required to obtain approval for seeking this designation. Standards and program description are fully defined in Exhibit 1, "Enhanced Women's Services Treatment Technical Advisory, #08".

Purpose:
The purpose of this policy is to incorporate long-term case management and advocacy programming for pregnant, and up to twelve months post-partum, women with dependent children who retain parental rights to their children.

Traditional case management services offered through designated women's programs tend to be for the duration of the woman's treatment episode and only office-based interventions. These interventions are frequently performed by the assigned clinician,and involve linking and referring the client to the next level of care or other supportive services that are needed. Enhanced Women's Services are designed to encourage providers to take case management to the next level for designated women's providers. This is a long-term case management and advocacy program, and outcomes such as increased retention, decreased use, increased family planning, and a decrease in unplanned pregnancies have shown that the extended support time and commitment to keeping women involved serves this population well.

The Enhanced Women's Services Treatment model shares the same theoretical basis, relational theory, as women's specialty services. Relational theory emphasizes the importance of positive interpersonal relationships in women's growth, development and definition of self, and in their addiction, treatment and recovery. It is the relationship between the woman and the advocate that is the most important aspect of Enhanced Women's Services Treatment. The Enhanced Women's Services Treatment model uses both the Stages of Change model and motivational interviewing when working with individuals. The stage of change that the woman is at for each of the identified problem areas of her life is taken into consideration when developing the plan of service. The case manager/advocate uses motivational interviewing techniques to help the woman move along the path toward meeting her goals.

**Components Required for Enhanced Women's Services Programming**

1. Any Designated Women's Program is eligible to offer Enhanced Women's Services to the target population. Programs choosing to develop an Enhanced Women's Services program will be required to follow the guidelines of the Women's Treatment Policy (OROSC Treatment Policy #12), as well as those outlined here.

2. The Enhanced Women's Services model will use a three-pronged approach to target the areas where women have problems that directly impact the likelihood of future alcohol or drug exposed births:

- The first is to eliminate or reduce the use of alcohol or drugs. Individuals who are involved with Enhanced Women's Services are connected with the full continuum of substance use disorder services to help the woman and her children with substance use and abuse.
- The second is to promote the effective use of contraceptive methods. If a woman is

in control of when she becomes pregnant, there is a higher likelihood that the birth will be alcohol and drug-free. Referrals for family planning, connecting with a primary care physician, and appropriate use of family planning methods are all considered interventions for this aspect of programming.

- The third is to teach the woman how to effectively use community-based service providers, including accessing primary and behavioral health care. The peer advocate teaches women how to look for resources and get through the formalities of agencies in order to access needed services, and how to effectively use the services.

3. Peer advocates in Enhanced Women's Services must be peers, to the extent that they are also mothers and may have experienced similar circumstances as their potential clients. They do not need to have a substance use disorder (SUD), or be in recovery from a SUD. Agencies should also follow their cultural competency plan for hiring peer advocates. The peer advocate must meet current state training or certification requirements applicable to their position. An additional list of training requirements is provided later in this document.

4. One of the core components of Enhanced Women's Services is transportation. The program requires that peer advocates be community-based and provide reasonable transportation services for their enrolled clients to relevant appointments and services. Beyond the transportation assistance that this provides to the woman, this has proven to be an excellent time to exchange information.

5. A second core component is the persistence with which the peer advocates stay in touch with their clients. A woman is not discharged from Enhanced Women's Services because she has not been in contact with her peer advocate for a month or more. It is expected that the peer advocate will actively look for clients when they have unexpectedly moved and will utilize emergency contacts provided by the client to re-engage her in services.

**Enrollment Criteria**

Any woman who is pregnant, or up to twelve months post-partum with dependent children, is eligible for participation in Enhanced Women's Services. This includes women who are involved with child welfare services and are attempting to regain custody of their children. If a woman enrolled in Enhanced Women's Services permanently loses custody of her children, and is not currently pregnant, she must be transferred to other support services, as she is no longer eligible for women's specialty services.

As identified in the Individualized Treatment Policy (OROSC Treatment Policy #06), treatment must be individualized based on a biopsychosocial assessment, diagnostic impression and client characteristics that include, but are not limited to age, gender, culture, and development. As a client's needs change, the frequency, and/or duration of services may be increased or decreased as medically necessary. Client participation in referral and continuing care planning must occur prior to a move to another level of care for continued treatment.

**Service Requirements**

In addition to the services provided through Women's Specialty Services, the following are requirements of Enhanced Women's Services:

1. Maintain engaged and consistent contact for at least 18 to 24 months in a home visitation/community based services model, expandable up to three years.
2. Provide supervision twice monthly.
3. Require maximum case load of 15 per peer advocate.

4. Continue services despite relapse or setbacks, with consideration to increasing services during this time.
5. Initiate active efforts to engage clients who are “lost” or drop out of the program, and efforts made to re-engage the client in services.
6. Coordinate service plan with extended family and other providers in the client’s life.
7. Coordinate primary and behavioral health.
8. Utilize motivational interviewing and stages of change model tools and techniques to help clients define and evaluate personal goals every three months.
9. Provide services from a strength-based, relational theory perspective.
10. Link and refer clients to appropriate community services for clients and dependent children as needed, including schools.
11. Continue to offer services to a woman and her children no matter the custody situation, as long as mother is attempting to regain custody.
12. Provide community-based services; these are services that do not take place in an office setting.
13. Provide transportation assistance through peer advocates, including empowering clients to access local transportation and finding permanent solutions to transportation challenges.
14. Peer advocates’ billable time for transporting clients to and from relevant appointments is allowable and encouraged. 14. Develop referral agreement with community agency to provide family planning options and instruction.
15. Screen children of appropriate age using the Fetal Alcohol Syndrome (FAS) Pre-screen form attached to the Fetal Alcohol Spectrum Disorders Policy (OROSC Treatment Policy #11). 16. Identify clients in Enhanced Women’s Services programming with the “HD” modifier.

**Education/Training of Peer Advocates:**
Individuals working and providing direct services for Enhanced Women’s Services must complete training on the following topics within three months of hire:

- Fundamentals of Addiction and Recovery*
- Ethics (6 hours)
- Motivational Interviewing (6 hours)
- Individualized Treatment and Recovery Planning (6 hours)
- Personal Safety, including home visitor training (4 hours)
- Client Safety, including domestic violence (2 hours)
- Advocacy, including working effectively with the legal system (2 hours)
- Maintaining Appropriate Relationships (2 hours)
- Confidentiality (2 hours)
- Recipient Rights (2 hours, available online)

*Could be accomplished by successful completion of the MAFE if no other opportunity is available.

In addition, the following training must also be completed within the first year of employment:

- Relational Treatment Model (6 hours)
- Cultural Competence (2 hours)
- Women and Addiction (3 hours)
- FASD (including adult FASD) (6 hours)
- Trauma and Trauma Informed Services (6 hours)
- Gender Specific Services (3 hours)
- Child Development (3 hours)

- Parenting (3 hours)
- Communicable Disease (2 hours, available online)

Peer advocates must complete the above trainings as indicated. Any training provided by domestic violence agencies, the Michigan Department of Health & Human Services, or child abuse prevention agencies would be appropriate. If these trainings are not completed within the one-year time frame, the peer advocate would not be eligible to continue in the position until the requirements are met. Until training is completed, peer advocates must be supervised by another individual who meets the training requirements and is working within the program. Documentation is required and must be kept in personnel files. Other arrangements can be approved by the OROSC Women's Treatment Coordinator.

## VII. EXHIBITS

1. ENHANCED WOMEN'S SERVICES TECHNICAL ADVISORY #08
http://www.michigan.gov/documents/mdch/TA-T08_Enhanced_Women_Serv_375874_7.pdf

## VIII. REFERENCES

| Reference: | Check if applies: | Standard Numbers: |
|---|---|---|
| 42 CFR Parts 400 et al. (Balanced Budget Act) | X | |
| 45 CFR Parts 160 & 164 (HIPAA) | X | |
| 42 CFR Part 2 (Substance Abuse) | X | |
| Fetal Alcohol Spectrum Disorders Screening and Referral Policy | x | |
| Michigan Mental Health Code Act 258 of 1974 | X | |
| The Joint Commission - Behavioral Health Standards | | |
| Michigan Department of Health and Human Services (MDHHS) Medicaid Contract | X | |
| MDHHS Substance Abuse Contract | X | |
| Michigan Medicaid Provider Manual | X | |
| HITECH Act of 2009 | X | |
| | | |
| | | |

Bloom, B., & Covington, S. (2000, November). *Gendered justice: programming for women in correctional settings.* Paper presented to the American Society of Criminology, San Francisco, CA, p. 11.

Covington, S. & Surrey J. (2000). *The relational model of women's psychological development: implications/or substance abuse.* (Work in Progress, no. 91). Wellesley, MA: Stone Center, Working Paper Series.

Grant, T.M., Streissguth, A.P., & Ernst, CC. (2002), *Intervention with Alcohol & Drug Abusing Mothers and Their Children: The Role of the Paraprofessional.* The Source: Newsletter of the National Abandoned Infants Assistance Resource Center, 11(3):5-26

Mandell, K. & Werner, D. (2008). *Guidance to states: treatment standards for women with substance use disorders.* National Association of State Alcohol and Drug Abuse Directors.

Mee-Lee D., Shulman G.D., Fishman M., Gastfriend D.R., & Griffth J.H., eds. (2001). *ASAM patient placement criteria for the treatment of substance-related disorders.* (Second Edition-Revised) (ASAM PPC-2R). Chevy Chase, MD: American Society for Addiction Medicine, Inc.

Mee-Lee,,David, Shulman, G.D., Fishman, M., Gastfriend, D.R, et.al. (2013). *Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions:* Chevy Chase, MD: American Society of Addiction Medicine, Inc.

Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services (MDCHIBSAAS). (2009). Substance *Abuse Treatment Policy #**II**: Fetal Alcohol Spectrum Disorders.* Retrieved from http://www.michigan.gov/mdch/0,1607,7-132-2941 4871 4877-133156--,00.html.

Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services. (2006). *Treatment Policy #6, Individualized Treatment Planning.* Retrieved from http://www.michigan.gov/documents/mdch/Policy_Treatment_06_Invd_Tx_Planning_175180_7.pdf.

Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services. (2008). *Treatment Policy #8, Substance Abuse CASE Management Program Requirements*. Retrieved from http://www.michigan.gov/documents/mdch/P-T-08_case_Management_218836_7.pdf

Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services. (2009). *Treatment Policy #11, Fetal Alcohol Spectrum Disorders.* Retrieved from http://www.michigan.gov/documents/mdch/TX_Policy_11_FASD_295506_7.pdf

Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services. (2010). *Treatment Policy #12, Women's Treatment Services*. Retrieved from http://www.michigan.gov/documents/mdch/P-T-12_Women_Srv_eff_100110_338279_7.pdf

Michigan Department of Community Health, Bureau of Substance Abuse and Addiction

Services. (2008). *Treatment Technical Advisory #7, Peer Recovery/Recovery Support Services*. Retrieved from http://www.michigan.gov/documents/mdch/TA-T-07_Peer_Recovery-Recovery_Support_230852_7.pdf.

State of Michigan, State Office of Administrative Hearings and Rules. (1981). Michigan *administrative code, substance use disorder service programs.* Retrieved from http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Single&AdminNum=3251
4101

Surrey, J. (1985). *Self in relation: a theory of women's development.* Retrieved November 20, 2009 from www.wcwonline.org.

| | |
|---|---|
| **Community Mental Health Partnership of Southeast Michigan PIHP** | ***Policy*** **Women's Specialty Treatment Services** |
| **Department: Substance Use Disorders** **Author: M. Scalera/A. Marshall** | **Local Policy Number (if used)** |
| **Regional Operations Committee Approval Date 9/14/2016** | **Implementation Date 10/1/16** |

Formatted: Header distance from edge: 0.3"

## I. PURPOSE

The purpose of this policy is to describe the philosophy and requirements for women's treatment services (designated as both women's programs and gender competent programs) and to describe the contracting of specialized services for women and their children. Women's specific funding is restricted to assuring access for chemically dependent pregnant women, post-partum women and single men who are in treatment while raising their children. Services offered include the provision of transportation, child care and medical care assistance, as well as needed treatment service and coordination.

## II. REVISION HISTORY

| DATE | REV. NO. | MODIFICATION |
|---|---|---|
| 1/2016 | 1 | Revised language |
| 9/2016 | 2 | Language updates |
| 11/2019 | 3 | Language updates |
| | | |

## III. APPLICATION

This policy applies to all staff, students, volunteers, and contracted organizations receiving any funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM), who would either provide designated women's specialty treatment services *or* refer individuals who meet criteria for Women's Specialty Treatment services.

Deleted: specialty

## IV. DEFINITIONS

Care Management/Care Coordination: an administrative function performed at the PIHP or through the access system, via the core provider

Case Management: a SUD program that coordinates, plans, provides, evaluates and monitors services or recovery from a variety of resources on behalf of and in collaboration with a client who has a substance use disorder. A SUD Women's case management program offers these services through designated staff working in collaboration with the SUD treatment team and as guided by the individualized treatment planning process.

Deleted: Women's

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Community Based: the provision of services outside of an office setting. Typically these services are provided in a client's home or in other venues, including while providing transportation to and from other appointments.

Eligible: Pregnant women and women with dependent children, including women who are attempting to regain custody of their children.

Fetal Alcohol Spectrum Disorder (FASD): an umbrella term describing the range of effects that can occur in an individual whose mother drank during pregnancy. These effects may include physical, mental, behavioral and/or learning disabilities with possible lifelong implications. The term FASD is not intended for use as a clinical diagnosis. It refers to conditions such as fetal alcohol syndrome (FAS), fetal alcohol effects (FAE), alcohol-related neurodevelopment disorder (ARND) and alcohol related birth defects (ARBD).

Gender Competent: capacity to identify differences on the basis of gender is significant, and to provide services that appropriately address gender differences and enhance positive outcomes for the population.

Gender Responsiveness (Designated Women's Program): creating an environment through site selection, staff selection, program development, content and material that reflects an understanding of the realities of the lives of women and girls, and that addresses and responds to their strengths and challenges. (Bloom and Covington, 2000)

Individual Assessment: a face-to-face service for the purpose of identifying functional and treatment needs, and to formulate the basis for the Individualized Treatment Plan to be implemented by the provider.

Individual Treatment Planning: direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current level of care, to ensure true and realistic needs are being addressed and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each client and be specific to the diagnostic impression and assessment.

Michigan Department of Health and Human Services: MDHHS

Recovery: a highly individualized journey of healing and transformation where the person gains control over his/her life. It involves the development of new meaning and purpose, growing beyond the impact of addiction or a diagnosis. This journey may include the pursuit of spiritual, emotional, mental and physical well-being.

Recovery Planning: a process that highlights and organizes a person's goals, strengths and capacities to determine the barriers to be removed or problems to be resolved in order to help people achieve their goals. This should include an asset and strength-based assessment of the client.

Substance Use Disorder (SUD): a term inclusive of substance abuse and dependence, which also encompasses problematic use of substances.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

## V. POLICY

This policy establishes that all services are to be gender and culturally competent, understanding the client and their environment and embrace the values of a recovery oriented system of care with a full continuum of services. It is the expectation that all *eligible* clients are evaluated for referral to specialty services where indicated

## VI. STANDARDS

The CMHPSM is dedicated to the following fundamental principles as the foundation for integrating women-specific substance use disorder treatment services and non-gender specific services, and non-gender specific services, while focusing on effective and comprehensive treatment of women and their families.

Background: The Substance Abuse Prevention and Treatment (SAPT) Block Grant requires states to spend a set minimum amount each year for treatment-and ancillary services for eligible women. Eligible women have been defined as, "pregnant women and women with dependent children, including women who are attempting to regain custody of their children." (42 U.S.c. 96.124 [e]). Pregnant women are identified as a priority population under the SAPT Block Grant regulations. Michigan Public Act 368 of 1978, part 62, section 333.6232, identifies "a parent whose child has been removed from the home under the child protection laws of this state or is in danger of being removed from the home under the child protection laws of this state because of the parent's substance abuse," as a priority population for substance use disorder services above others with substantially similar clinical conditions.

Deleted: d

Michigan law extends priority population status to men whose children have been removed from the home or are at danger of being removed under the child protection laws. To support their entrance into and success in treatment, men who are shown to be the primary caregivers for their children are also eligible to access ancillary services such as child care, transportation, case management, therapeutic interventions for children, and primary medical and pediatric care, as defined by 45 CFR Part 96.

MDHHS Vision is to implement a change in the practice of women's substance use disorder treatment providers and system transformation in Michigan. This will be accomplished by having a strength-based coordinated system of care, driven by a shared set of core values that is reflected and measured in the way we interact with, and deliver supports and services for families who require substance abuse, mental health, and child welfare services.

Core Values

- Family-Centered: A family centered approach means that the focus is on the family, as defined by the client themselves. Families are responsible for their children and are respected and listened to as we support them in working toward meeting their

needs, reducing system barriers, and promoting changes that can be sustained over time. The goal of a family-centered team and system is to move away from the focus of a single client represented in a system, to a focus on the functioning, safety and well-being of the family as a whole.

- Family Involvement: The family's involvement in the process is empowering and increases the likelihood of cooperation, ownership and success. Families are viewed as full and meaningful partners in all aspects of the decision-making process affecting their lives, including decisions made about their service plans. It is important to recognize that a woman defines her own family and that this definition may not be traditional.
- Build on Natural and Community Supports: Recognize and utilize all resources in our communities creatively and flexibly, including formal and informal supports and service systems. Every attempt should be made to include the family's relatives, neighbors, friends, faith community, co-workers or anyone the family would like to include in the team process. Ultimately families will be empowered and have developed a network of informal, natural, and community supports so that formal system involvement is reduced or not needed at all.
- Strength-Based: Strength-based planning builds on the family's unique qualities and identified strengths that can then be used to support strategies to meet the family's needs. Strengths should also be found in the family's environment through their informal support networks, as well as in attitudes, values, skills, abilities, preferences and aspirations. Strengths are expected to emerge, be clarified and change over time as the family's initial needs are met and new needs emerge, with strategies discussed and implemented.
- Unconditional Care: Means that we care for the family, not that we will care "if." It means that it is the responsibility of the service team to adapt to the needs of the family - not of the family to adapt to the needs of a program. **If** difficulties arise, the individualized services and supports change to meet the family's needs.
- Collaboration Across Systems: An interactive process in which people with diverse expertise, along with families, generate solutions to mutually defined needs and goals building on identified strengths. All systems working with the family have an understanding of each other's programs and a commitment and willingness to work together to assist the family in obtaining their goals. The substance use disorder, mental health, child welfare and other identified systems collaborate and coordinate a single system of care for families involved within their services.
- Team Approach Across Agencies: Planning, decision-making and strategies rely on the strengths, skills, mutual respect, and creative and flexible resources of a diversified, committed team. Team member strengths, skills, experience and resources are utilized to select strategies that will support the family in meeting their needs. Team members may include representatives from the multiple agencies a family is involved in, as well as any who offer support and resources to families. All family, formal and informal team members share responsibility, accountability, and authority; while understanding and respecting each other's strengths, roles and limitations.
- Ensuring Safety: When Children's Protective Services, foster care agencies, or domestic violence shelters are involved, the team will maintain a focus on family and child safety. Consideration will be given to whether the identified threats to safety are still in effect, whether the child is being kept safe by the least intrusive means possible and whether the safety services in place are effectively controlling those threats. In situations involving domestic violence, the team will need to work with the family to develop and maintain a viable safety plan.

- Gender, Age, Culturally Responsive Treatment: Services reflect an understanding of the issues specific to gender, age, disability, race, ethnicity and sexual orientation, and also reflect support, acceptance, and understanding of cultural and lifestyle diversity.
- Self-sufficiency: Families will be supported, resources shared and team members held responsible for achieving self-sufficiency in essential life domains (including, but not limited to safety, housing, employment, financial, educational, psychological, emotional and spiritual).
- Education and Work Focus: Dedication to positive, immediate and consistent education, employment and or employment-related activities that result in resiliency and self-sufficiency, improved quality of Life: for self, family and the community.
- Belief in Growth, Learning and Recovery: Family improvement begins by integrating formal and informal supports that instill hope and are dedicated to interacting with individuals with compassion, dignity and respect. Team members operate from a belief that every family desires change and can take steps toward attaining a productive and self-sufficient life.
- Outcome Oriented: From the onset of family team meetings, levels of personal formal and informal supports, are discussed, agreed upon and maintained. Identified outcomes are understood and shared by all team members. Legal, education, employment, child-safety and other applicable mandates are considered in developing outcomes. Progress is monitored and each team member participates in defining success. Selected outcomes are standardized, measurable and based on the life of the family and its individual members.

Deleted: .

Developing a Philosophy of Working with Women with Substance Use Disorders:

Program Structure:

1. Treatment revolves around the role women have in society, therefore treatment services must be gender specific.
   - Gender-responsive programs are not simply "female only" programs that were designed for males.
   - A woman's sense of self develops differently in women-specific groups as opposed to co-ed groups.
   - Because women place so much value on their role in society and relationships, to not take this into consideration in the recovery process is to miss a large component of a woman's identity.
   - Equality does not mean sameness; in other words, equality of service delivery is not simply about allowing women access to services traditionally reserved for men. Equality must be defined in terms of providing opportunities that are relevant to each gender so that treatment services may appear very different depending on to whom the service is being delivered.
   - The unique needs and issues (e.g., physical/sexual/emotional victimization, trauma, pregnancy and parenting) of women should be addressed in a safe, trusting and supportive environment.
   - Treatment and services should build on women's strengths/competencies and promote independence and self-reliance.

2. A relational model, based on the psychological growth of women shall be the foundation for recovery (e.g., the Self-in-Relation model). The recognition that,

for women, the primary experience of self is relational; that is, the self is organized and developed in the context of important relationships. (Surrey, 1985)

- A model that emphasizes the importance of relationships in a woman's life, and attempts to address the strengths as well as the problems arising for women from a relational orientation.

3. A collaborative philosophy, driven by the woman and her family, shall be used.
   - Utilizing cross-systems collaboration and the involvement of informal supports to promote a woman's recovery.
   - A client-centered, goal-oriented approach to accessing and coordinating services across multiple systems by:
     i. assessing needs, resources and priorities,
     ii. planning for how the needs can be met
     iii. establishing linkages to enhance a woman's access to services to meet those identified needs
   - Coordinating and monitoring service provision through active cross-system communication and coordinated treatment plans and services
   - Removing barriers to treatment and advocating for services.
   - A woman's needs determine the connections with agencies and systems that impact her life or her family's life, despite the number of agencies or systems involved.
   - Ideally, each woman will have a single, collaborative treatment plan or service plan used across systems. When this is not possible, coordination of as many systems as possible will lessen the confusion and stress this creates in a woman's life.
   - Care coordination and case management are the key to a woman's progress in recovery.

4. A model of empowerment is utilized in treatment and recovery planning.
   - The client is shown and taught how to access services, advocate for herself and her family, and request services that are of benefit to her and her family.
   - This process is woven into recovery, and could be taught by a recovery coach or women's case manager
   - The ultimate goal for the service system is to weave the woman so well into the informal support systems that the role of formal services is very small or not needed.
5. Employment is recommended as an important component in recovery and serves as an important therapeutic tool.
   - The structure of work is a benefit to recovery, and treatment providers need to be aware of the work requirements of Temporary Assistance for Needy Families/Work First. Historically, treatment providers have been reluctant to encourage clients to return to work or engage in work related activities during the early stages of recovery. However, waiting to address employment concerns may create further challenges for the client facing Work First requirements.

6. A multi-system approach that is culturally aware shall be employed in the recovery process.

Deleted:
Deleted:
Deleted:
Deleted:
Formatted: Indent: Left: 1.75", Hanging: 0.19", Numbered + Level: 1 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 0.25" + Indent at: 0.5"
Deleted: 3.
Deleted: E
Formatted: Font: (Default) Arial
Deleted:
Formatted: Font: (Default) Arial
Deleted:
Deleted:
Deleted:
Deleted:
Deleted:
Deleted:
Deleted:

- Gender specificity and cultural competence go hand-in-hand. There are a number of gender and cultural competencies that allow people to assist others more effectively. This requires a willingness and ability to draw on community-based values, traditions and customs, and to work with knowledgeable people of and from the community.

Education/Training of Staff:

In addition to current credentialing standards, individuals working and providing direct service within a designated women's program (gender responsive) must have completed a minimum of 12 semester hours, or the equivalent, of gender specific substance use disorder training or 2080 hours of supervised gender specific substance use disorder training/work experience within a designated women's program. Those not meeting the requirements must be supervised by another individual working within the program, and be working towards meeting the requirements. Documentation is required to be kept in personnel files.

Those working and providing direct service within a gender competent program must have completed a minimum of 8 semester hours, or the equivalent, of gender specific substance use disorder training or 1040 hours of supervised gender specific substance use disorder training. Those not meeting the requirements must be supervised by another individual working within the program, and be working towards meeting the requirements. Documentation is required to be kept in personnel files. Other arrangements can be approved by the Office of Recovery Oriented Systems of Care (OROSC) Women's Treatment Coordinator.

Deleted: Other arrangements can be approved by the MDHHS/OROSC Women's Treatment Coordinator.

Appropriate topics for gender specific substance use disorder training include, but are not limited to:

| | |
|---|---|
| Women's studies | Child Development |
| Trauma | Self-esteem/empowerment |
| Grief | Relational treatment model |
| Relationships | Women in the criminal justice system |
| Parenting | Women and addiction |

Admissions:
Treatment providers must follow the priority population guidelines identified in the State contract with the PIHP, listed below, for admitting women to treatment:

| Population | Admission Requirement | Interim Service Requirement |
|---|---|---|
| | | |
| Pregnant Injecting Drug User | 1) Screened and referred within 24 hours.<br>2) Detoxification, methadone or residential- offer admission within24 business hours.<br>3) Other Levels of Care- offer admission within 48 business hours. | Begin within 48 hours:<br>1. Counseling and education on:<br>a. HIV and TB.<br>b. Risks of needle sharing.<br>c. Risks of transmission to sexual partners and infants.<br>d. Effects of alcohol and drug use on the fetus.<br>2. Referral for pre-natal care.<br>3. Early Intervention Clinical Services. |
| | | |
| Pregnant with Substance Use Disorder | 1) Screened and referred within 24 hours.<br>2) Detoxification, methadone or residential- offer admission within 24 business hours.<br>Other Levels of Care – offer admission within 48 business hours. | Begin within 48 hours:<br>1. Counseling and education on:<br>a. HIV and TB.<br>b. Risks of transmission to sexual partners and infants.<br>c. Effects of alcohol and drug use on the fetus.<br>2. Referral for pre-natal care.<br>3. Early Intervention Clinical Services. |
| | | |
| Injecting Drug User | Screened and referred within 24 hours. Offer admission within 14 days. | Begin within 48 hours – maximum waiting time 120 days:<br>1. Counseling and education on:<br>a. HIV and TB.<br>b. Risks of needle sharing.<br>c. Risks of transmission to sexual partners and infants.<br>2. Early Intervention Clinical Services. |
| | | |
| Parent at Risk of Losing Children | Screened and referred within 24 hours. Offer admission within 14 days. | Begin within 48 business hours:<br>Early Intervention Clinical Services. |
| | | |
| All Others | Screened and referred within seven calendar days. Capacity to offer admission within 14 days. | Not Required. |

* The full table can be found in the MDHHS contract with CMHPSM.

The admission standards listed in the table should be considered minimum standards.

Deleted:

Those programs interested in providing the best possible treatment to families should be meeting a higher standard for admission and interim service provision.

Treatment:

Programs that are designed to meet women's needs tend to be more successful in retaining women clients. For a provider to be able to offer women-specific treatment, its programs shall include the following criteria:

1. Accessibility
   Women's case managers and providers must demonstrate a process to reduce barriers to treatment by ensuring that priority population requirements are met, as well as providing ancillary services or ensuring that appropriate referrals to other community agencies are made.
   - There are many barriers that may critically inhibit attendance and follow-through for women with children. They may include child care, transportation, hours of operation and mental health concerns.

2. Assessment
   Assessment shall be a continuous process that evaluates the client's psychosocial needs and strengths within the family context, and through which progress is measured in terms of increased stabilization/functionality of the individual/family. In addition, all assessments shall be strength-based.
   - Women with children need to be assessed and treated as a unit. Women often both enter and leave treatment because of their children's needs. By assessing the family and addressing areas that need strengthening, providers give women a better chance at becoming stable in their recovery.

3. Psychological Development
   Providers shall demonstrate an understanding of the specific stages of psychological development and modify therapeutic techniques according to client needs, especially to promote autonomy.
   - Many of the traditional therapeutic techniques reinforce women's guilt, powerlessness and "learned helplessness," particularly as they operate in relationships with their children and significant others.

4. Abuse/Violence/Trauma
   Providers must develop a process to identify and address abuse/violence/trauma issues. Services will be delivered in a trauma-informed setting and provide safety from abuse, stalking by partners, family, other participants, visitors and staff.
   - A history of abuse, violence and trauma often contributes to the behavior of substance abusing and dependent women. A provider who does not take this history into consideration when treating the woman is not fully addressing the addiction or resulting behaviors.

Deleted:
Deleted:
Deleted:
Deleted:
Deleted:
Deleted:
Deleted:
Deleted:
Deleted:
Deleted:

5. Family Orientation

Providers must identify and address the needs of family members through direct service, referral or other processes. Families are a family of choice defined by the clients themselves.

Agencies will include informal supports in the treatment process when it is in the best interest of the client.

- Many women present in a family context with major family ties and responsibilities that will continue to define their sense of self. Drug and alcohol use in a family puts children at risk for physical and emotional growth and developmental problems. Early identification and intervention for the children's problems is essential.

6. Mental Health Issues

Providers must demonstrate the ability to identify concurrent mental health disorders, and develop a process to have the treatment for these disorders take place, in an integrated fashion, with substance use disorder treatment and other health care. It is important to note that treatment for both mental health issues and substance use disorders may lead to the use of medication as an adjunct to treatment.

- Women with substance abuse problems often present with concurrent mood disorders and other mental health problems.

7. Physical Health Issues

Providers shall:

- inquire about health care needs of the client and her children, including completing the Fetal Alcohol Syndrome Disorder (MDHHS: FASD POLICY #11, 2009) screening as appropriate
- make appropriate referrals, and document client and family health needs, referrals, and outcomes.
    - Women with a substance use disorder and their children are at high risk for significant health problems. They are at a greater risk for communicable diseases such as HIV, TB, hepatitis and sexually transmitted diseases. Prenatal care for women using/abusing substances is especially important, as their babies are at risk for serious physical, neurological and behavioral problems. Early identification and intervention for children's physical and emotional growth and development, and for other health issues in a family is essential.

8. Legal Issues

Providers shall document each client's compliance and facilitate required communication to appropriate authorities within the guidelines of federal confidentiality laws. Additionally, programs will individualize treatment in such a way as to help a client manage compliance with legal authorities.

- Women entering treatment may be experiencing legal problems including custody issues, civil actions, criminal charges, probation and parole. This adds another facet to the treatment and recovery planning process and reinforces the need for case management associated with women's services. By helping a woman identify her legal issues, steps that need to be taken, and how to incorporate

Deleted:
Deleted:
Deleted:
Deleted:
Deleted:
Deleted:
Deleted:
Deleted:
Deleted:
Deleted:
Deleted:
Deleted:

this information into goals for her individualized treatment plan, a provider can greatly reduce stress on the client and make this type of challenge seem more manageable.

9. Sexuality/Intimacy/Exploitation

Providers shall:

- conduct an assessment that is sensitive to sexual abuse issues,
- demonstrate competence to address these issues,
- make appropriate referrals,
- acknowledge and incorporate these issues in the recovery plan, and
- assure that the client will not be exposed to exploitive situations that continue abuse patterns within the treatment process (co-ed groups are not recommended early in treatment, physical separation of sexes is recommended in residential treatment settings).
    - A high rate of treatment non-compliance among females with substance use disorders, with a history of sexual abuse, has been documented. The frequent incidence of sexual abuse among women with substance use disorders necessitates the inclusion of questions specifically related to the topic during the initial evaluation (assessment) process. Lack of recognition of a sexual abuse history or improper management of disclosure can contribute to a high rate of non-compliance in this population.

Deleted:

Deleted:

Deleted:

Deleted:

Deleted: .

10. Survival Skills

Providers must identify and address the client's needs in the following areas, including but not limited to:

- Education and literacy.
- Job readiness and job search.
- Parenting skills.
- Family planning.
- Housing.
- Language and cultural concerns.
- Basic living skills/self-care.

The provider shall refer the client to appropriate services and document both the referrals and the outcomes.

- Women's treatment is often complicated by a variety of problems that must be addressed and integrated into the therapeutic process. Many of these problems may be addressed in the community, utilizing community resources, which will in turn help the client build a supportive relationship with the community.

11. Continuing Care/Recovery Support

Providers shall:

- Develop a recovery/continuing care plan with the client to address and plan for the client's continuing care needs.

- Make and document appropriate referrals as part of the continuing care/recovery plan, and remain available to the client as a resource for support and encouragement for at least one year following discharge.
    - In order for a woman to maintain recovery after treatment, she needs to be able to retain a connection to treatment staff or women's case managers, and receive support from appropriate services in the community.

**Enhanced Women's Services:**

Deleted:

Agencies with the Women's Specialty Services Designation may apply to the PIHP and MDHHS to provide enhanced programming. Consultation with the CMHPSM is required to obtain approval for seeking this designation. Standards and program description are fully defined in Exhibit 1, "Enhanced Women's Services Treatment Technical Advisory, #08".

Purpose:
The purpose of this policy is to incorporate long-term case management and advocacy programming for pregnant, and up to twelve months post-partum, women with dependent children who retain parental rights to their children.

Traditional case management services offered through designated women's programs tend to be for the duration of the woman's treatment episode and only office-based interventions. These interventions are frequently performed by the assigned clinician, and involve linking and referring the client to the next level of care or other supportive services that are needed. Enhanced Women's Services are designed to encourage providers to take case management to the next level for designated women's providers. This is a long-term case management and advocacy program, and outcomes such as increased retention, decreased use, increased family planning, and a decrease in unplanned pregnancies have shown that the extended support time and commitment to keeping women involved serves this population well.

The Enhanced Women's Services Treatment model shares the same theoretical basis, relational theory, as women's specialty services. Relational theory emphasizes the importance of positive interpersonal relationships in women's growth, development and definition of self, and in their addiction, treatment and recovery. It is the relationship between the woman and the advocate that is the most important aspect of Enhanced Women's Services Treatment. The Enhanced Women's Services Treatment model uses both the Stages of Change model and motivational interviewing when working with individuals. The stage of change that the woman is at for each of the identified problem areas of her life is taken into consideration when developing the plan of service. The case manager/advocate uses motivational interviewing techniques to help the woman move along the path toward meeting her goals.

Components Required for Enhanced Women's Services Programming

1. Any Designated Women's Program is eligible to offer Enhanced Women's Services to the target population. Programs choosing to develop an Enhanced Women's Services program will be required to follow the guidelines of the Women's Treatment Policy (OROSC Treatment Policy #12), as well as those outlined in this technical advisory.

2. The Enhanced Women's Services model will use a three-pronged approach to target the areas where women have problems that directly impact the likelihood of future alcohol or drug

exposed births:
• The first is to eliminate or reduce the use of alcohol or drugs. Individuals who are involved with Enhanced Women's Services are connected with the full continuum of substance use disorder services to help the woman and her children with substance use and abuse.
• The second is to promote the effective use of contraceptive methods. If a woman is in control of when she becomes pregnant, there is a higher likelihood that the birth will be alcohol and drug-free. Referrals for family planning, connecting with a primary care physician, and appropriate use of family planning methods are all considered interventions for this aspect of programming.
• The third is to teach the woman how to effectively use community-based service providers, including accessing primary and behavioral health care. The peer advocate teaches women how to look for resources and get through the formalities of agencies in order to access needed services, and how to effectively use the services.

3. Peer advocates in Enhanced Women's Services must be peers, to the extent that they are also mothers and may have experienced similar circumstances as their potential clients. They do not need to have a substance use disorder (SUD), or be in recovery from a SUD. Agencies should also follow their cultural competency plan for hiring peer advocates. The peer advocate must meet current state training or certification requirements applicable to their position. An additional list of training requirements is provided later in this document.

4. One of the core components of Enhanced Women's Services is transportation. The program requires that peer advocates be community-based and provide reasonable transportation services for their enrolled clients to relevant appointments and services. Beyond the transportation assistance that this provides to the woman, this has proven to be an excellent time to exchange information.

5. A second core component is the persistence with which the peer advocates stay in touch with their clients. A woman is not discharged from Enhanced Women's Services because she has not been in contact with her peer advocate for a month or more. It is expected that the peer advocate will actively look for clients when they have unexpectedly moved, and will utilize emergency contacts provided by the client to re-engage her in services.

Enrollment Criteria

Any woman who is pregnant, or up to twelve months post-partum with dependent children, is eligible for participation in Enhanced Women's Services. This includes women who are involved with child welfare services and are attempting to regain custody of their children. If a woman enrolled in Enhanced Women's Services permanently loses custody of her children, and is not currently pregnant, she must be transferred to other support services, as she is no longer eligible for women's specialty services.

As identified in the Individualized Treatment Policy (OROSC Treatment Policy #06), treatment must be individualized based on a biopsychosocial assessment, diagnostic impression and client characteristics that include, but are not limited to age, gender, culture, and development. As a client's needs change, the frequency, and/or duration of services may be increased or decreased as medically necessary. Client participation in referral and continuing care planning must occur prior to a move to another level of care for continued treatment.

Service Requirements

In addition to the services provided through Women's Specialty Services, the following are requirements of Enhanced Women's Services:
1. Maintain engaged and consistent contact for at least 18 to 24 months in a home visitation/community based services model, expandable up to three years.
2. Provide supervision twice monthly.
3. Require maximum case load of 15 per peer advocate.
4. Continue services despite relapse or setbacks, with consideration to increasing services during this time.
5. Initiate active efforts to engage clients who are "lost" or drop out of the program, and efforts made to re-engage the client in services.
6. Coordinate service plan with extended family and other providers in the client's life.
7. Coordinate primary and behavioral health.
8. Utilize motivational interviewing and stages of change model tools and techniques to help clients define and evaluate personal goals every three months.
9. Provide services from a strength-based, relational theory perspective.
10. Link and refer clients to appropriate community services for clients and dependent children as needed, including schools.
11. Continue to offer services to a woman and her children no matter the custody situation, as long as mother is attempting to regain custody.
12. Provide community-based services; these are services that do not take place in an office setting.
13. Provide transportation assistance through peer advocates, including empowering clients to access local transportation and finding permanent solutions to transportation challenges. Peer advocates' billable time for transporting clients to and from relevant appointments is allowable and encouraged. 14. Develop referral agreement with community agency to provide family planning options and instruction.
15. Screen children of appropriate age using the Fetal Alcohol Syndrome (FAS) Pre-screen form attached to the Fetal Alcohol Spectrum Disorders Policy (OROSC Treatment Policy #11).
16. Identify clients in Enhanced Women's Services programming with the "HD" modifier.

Education/Training of Peer Advocates:

Individuals working and providing direct services for Enhanced Women's Services must complete training on the following topics within three months of hire:
• Fundamentals of Addiction and Recovery*
• Ethics (6 hours) • Motivational Interviewing (6 hours)
• Individualized Treatment and Recovery Planning (6 hours)
• Personal Safety, including home visitor training (4 hours)
• Client Safety, including domestic violence (2 hours)
• Advocacy, including working effectively with the legal system (2 hours)
• Maintaining Appropriate Relationships (2 hours)
• Confidentiality (2 hours)
• Recipient Rights (2 hours, available online)
*Could be accomplished by successful completion of the MAFE if no other opportunity is available.

In addition, the following training must also be completed within the first year of employment:
• Relational Treatment Model (6 hours)
• Cultural Competence (2 hours)

• Women and Addiction (3 hours)
• FASD (including adult FASD) (6 hours)
• Trauma and Trauma Informed Services (6 hours) • Gender Specific Services (3 hours)
• Child Development (3 hours)
• Parenting (3 hours)
• Communicable Disease (2 hours, available online)

Peer advocates must complete the above trainings as indicated. Any training provided by domestic violence agencies, the Michigan Department of Health & Human Services, or child abuse prevention agencies would be appropriate. If these trainings are not completed within the one year time frame, the peer advocate would not be eligible to continue in the position until the requirements are met. Until training is completed, peer advocates must be supervised by another individual who meets the training requirements and is working within the program. Documentation is required and must be kept in personnel files. Other arrangements can be approved by the OROSC Women's Treatment Coordinator.

## VII. EXHIBITS

1. ENHANCED WOMEN'S SERVICES TECHNICAL ADVISORY #08
http://www.michigan.gov/documents/mdch/TA-T08_Enhanced_Women_Serv_375874_7.pdf

## VIII. REFERENCES

| Reference: | Check if applies: | Standard Numbers: |
|---|---|---|
| 42 CFR Parts 400 et al. (Balanced Budget Act) | X | |
| 45 CFR Parts 160 & 164 (HIPAA) | X | |
| 42 CFR Part 2 (Substance Abuse) | X | |
| Fetal Alcohol Spectrum Disorders Screening and Referral Policy | x | |
| Michigan Mental Health Code Act 258 of 1974 | X | |
| The Joint Commission - Behavioral Health Standards | | |
| Michigan Department of Health and Human Services (MDHHS) Medicaid Contract | X | |
| MDHHS Substance Abuse Contract | X | |
| Michigan Medicaid Provider Manual | X | |
| HITECH Act of 2009 | X | |
| | | |
| | | |

Bloom, B., & Covington, S. (2000, November). *Gendered justice: programming for women in correctional settings.* Paper presented to the American Society of Criminology, San Francisco, CA, p. 11.

Covington, S. & Surrey J. (2000). *The relational model of women's psychological development: implications/or substance abuse.* (Work in Progress, no. 91). Wellesley, MA: Stone Center, Working Paper Series.

Grant, T.M., Streissguth, A.P., & Ernst, CC. (2002), *Intervention with Alcohol & Drug Abusing Mothers and Their Children: The Role of the Paraprofessional.* The Source: Newsletter of the National Abandoned Infants Assistance Resource Center, 11(3):5-26

Mandell, K. & Werner, D. (2008). *Guidance to states: treatment standards for women with substance use disorders.* National Association of State Alcohol and Drug Abuse Directors.

Mee-Lee D., Shulman G.D., Fishman M., Gastfriend D.R., & Griffth J.H., eds. (2001). *ASAM patient placement criteria for the treatment of substance-related disorders.* (Second Edition-Revised) (ASAM PPC-2R). Chevy Chase, MD: American Society for Addiction Medicine, Inc.

Mee-Lee,,David, Shulman, G.D., Fishman, M., Gastfriend, D.R, et.al. (2013). *Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions:* Chevy Chase, MD: American Society of Addiction Medicine, Inc.

Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services (MDCHIBSAAS). (2009). Substance *Abuse Treatment Policy #II: Fetal Alcohol Spectrum Disorders.* Retrieved from http://www.michigan.gov/mdch/0,1607,7-132-2941 4871 4877-133156--,00.html.

Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services. (2006). *Treatment Policy #6, Individualized Treatment Planning.* Retrieved from http://www.michigan.gov/documents/mdch/Policy_Treatment_06_Invd_Tx_Planning_175180_7.pdf.

Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services. (2008). *Treatment Policy #8, Substance Abuse CASE Management Program Requirements*. Retrieved from http://www.michigan.gov/documents/mdch/P-T-08_case_Management_218836_7.pdf

Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services. (2009). *Treatment Policy #11, Fetal Alcohol Spectrum Disorders.* Retrieved from http://www.michigan.gov/documents/mdch/TX_Policy_11_FASD_295506_7.pdf

Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services. (2010). *Treatment Policy #12, Women's Treatment Services*. Retrieved from

http://www.michigan.gov/documents/mdch/P-T-12_Women_Srv_eff_100110_338279_7.pdf

Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services. (2008). *Treatment Technical Advisory #7, Peer Recovery/Recovery Support Services*. Retrieved from http://www.michigan.gov/documents/mdch/TA-T-07_Peer_Recovery-Recovery_Support_230852_7.pdf.

State of Michigan, State Office of Administrative Hearings and Rules. (1981). Michigan *administrative code, substance use disorder service programs.* Retrieved from http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Single&AdminNum=3251
4101

Surrey, J. (1985). *Self in relation: a theory of women's development.* Retrieved November 20, 2009 from www.wcwonline.org.

| **Community Mental Health Partnership of Southeast Michigan/PIHP** | ***Policy***<br><br>**Welcoming Policy** |
|---|---|
| **Department: Substance Use Services**<br>**Author: Marci Scalera/Anne Marshall** | **Local Policy Number (if used)** |
| **Regional Operations Committee Approval Date**<br>**9/14/2016** | **Implementation Date**<br>**10/1/2016** |

## I. PURPOSE

To establish expectations and standards for the implementation of a welcoming philosophy across the Community Mental Health Partnership of Southeast Michigan (CMHPSM) where individuals and their family members receive meaningful, non-judgmental interactions from staff within the Recovery Oriented System of Care.

## II. REVISION HISTORY

| DATE | REV. NO. | MODIFICATION |
|---|---|---|
| 10/2006 | | Original policy |
| 10/2009 | 001 | Language modification |
| 2/2012 | 002 | Language modification |
| 8/2016 | 003 | Language modification |
| 11/2019 | 004 | Language modification |

## III. APPLICATION

This policy applies to the CMHPSM and its provider network. It is expected that all CMHPSM and provider network staff involved in the provision of services understand and take action to operate within these welcoming principles. These actions consist of reviewing business practices, identifying areas in need of improvement, and implementing identified changes.

## IV. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Co-Occurring Disorder: Have both a mental health and substance use diagnosis or a developmental disability (DD) (in some instances, both a DD diagnosis and mental health diagnosis) and a substance use diagnosis.

Recipient: The person requesting, accepting, receiving or being referred for services through the CMHPSM

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

.

## V. POLICY

A welcoming philosophy is based on the core belief of dignity and respect for all people while in turn following good business practice. In this context welcoming was determined to be an important factor in contributing to successful recipient outcomes.

The goal of Substance Use Disorder (SUD) treatment is to move individuals along the path of recovery. There are two main features of the recovery perspective. It acknowledges that recovery is a long-term process of internal change and it recognizes that these internal changes proceed through various stages. As SUD is a chronic disease, it is characterized by acute episodes or events that precipitate a heightened need for an individual to change their behavior. It is important for the system to understand and support the treatment-seeking client by providing an environment including actions/behavior that foster entry and engagement throughout the treatment process and supports recovery.

Welcoming principles extend to include all customers of an agency (agency staff, referral sources, the individual and their family). In accordance with Network for Improvement of Addiction Treatment (NIATx) "Key Paths to Recovery" the CMHPSM aims of reduced waiting, reduced no shows, increased admissions and increased continuation in treatment, all incorporate an expectation for a welcoming philosophy.

## VI. STANDARDS

Welcoming is conceptualized as an accepting attitude and understanding of how people 'present' for treatment and a capacity on the part of that location to address their needs in a manner that accepts and fosters a service and treatment relationship that meets the needs and interests of the recipient.

The following principles list the characteristics/attitudes/beliefs that can be found at a program or agency that is fostering a welcoming environment:

General Principles Associated with Welcoming

- Welcoming is a continuous process throughout the agency/program and involves access, entry, and on-going services.
- Welcoming applies to all "clients" of an agency. Beside the individual seeking services and their family, an individual also includes the public seeking services; other providers seeking access for their clients; agency staff; and the community in which the service is located and/or the community resides.
- Welcoming is comprehensive and evidenced throughout all levels of care, all systems and service authorities.
- A welcoming system is 'seamless'. It enables service regardless of original entry point, provider and current services.
- In a welcoming system, when resources are limited, or eligibility requirements are not met, the provider ensures a connection is made to community supports.

- A welcoming system is culturally competent and able to provide access and services to all recipients seeking treatment.

Welcoming – Service Individual

- There is openness, acceptance and understanding of the presenting behaviors and characteristics of persons with substance use disorders.
- For persons with co-occurring mental health problems, there is an openness, acceptance and understanding of their presenting behaviors and characteristics.
- Welcoming is individually based and incorporates meaningful individual participation and 'individual satisfaction' that includes consideration to the family members/significant others.
- Services are provided in a timely manner to the meet the needs of the individual and/or their families.
- Individuals must be involved in the development of their treatment plans and goals.

Welcoming – Organization

- The organization demonstrates an understanding and responsiveness to the variety of help seeking behaviors related to various cultures and ages.
- All staff within the agency incorporates and participates in the welcoming philosophy.
- The program is efficient in sharing and gathering authorized information between involved agencies rather than having the recipient repeat it at each provider.
- The organization has an understanding of the local community, including community differences, local community involvement and opportunities for recovery support and inclusion by the service recipient.
- Consideration is given to administrative details such as sharing paperwork across providers, ongoing review to streamline paperwork to essential and necessary information.
- A welcoming system is capable of providing follow-up and assistance to a recipient as they navigate the provider and the community network(s).
- Welcoming is incorporated into continuous quality improvement initiatives.
- Hours of operation meet the needs of the population(s) being served.
- Personnel that provide the initial contact with a recipient receive training and develop skills that improve engagement in the treatment process.
- All paperwork has purpose and represent added value. Ingredients to managing paperwork are the elimination of duplication, quality forms design and efficient processing, transmission, and storage.

Welcoming – Environmental and Other Considerations

- The physical environment provides seating, space, and consideration to privacy, a drinking fountain and/or other 'amenities' to foster an accepting, comfortable environment.
- The service location is considered with regard to public transportation and accessibility.
- Waiting areas include consideration for family members or others accompanying the recipient seeking services.

Staff Competency Principles

- Skills and knowledge appropriate to staff in their roles throughout the system (reception, clinical, treatment support, administrative).
- Staff should have the knowledge and skill to be able to differentiate between the person and their behaviors.
- Staff should be respectful of recipient boundaries in regards to personal questions and personal space.
- Staff uses attentive behavior, listening with empathy not sympathy.

It is expected all CMHSPs implement and maintain welcoming principles.

Client satisfaction surveys are expected to incorporate questions that address the 'welcoming' nature of the agency and its services.

Welcoming principles will be reviewed as part of site visit protocols.

## VII. EXHIBITS

None

## VIII. REFERENCES

*5 Promising Practices Improving Timeliness.* Retrieved July 6, 2006, from Network for the Improvement of Addiction Treatment website: www.NIATx.net

*5 Promising Practices Reducing No Shows.* Retrieved July 6, 2006, from Network for the Improvement of Addiction Treatment website: www.NIATx.net

*5 Promising Practices Increasing Admissions.* Retrieved July 6, 2006, from Network for the Improvement of Addiction Treatment website: www.NIATx.net

*5 Promising Practices Increasing Continuation.* Retrieved July 6, 2006, from Network for the Improvement of Addiction Treatment website: www.NIATx.net

Center for Substance Abuse Treatment. (2005). *Substance Abuse Treatment for Persons With Co-Occurring Disorders,* Treatment Improvement Protocol (TIP) Series 42. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

*Key Pathways to Recovery*. Retrieved July 6, 2006, from University of Wisconsin Madison website: https://chess.chsra.wisc.edu/pathstorecovery/PathsToRecovery/TopPaths.asp

*Key Pathways to Recovery – First Request for Service*. Retrieved July 6, 2006, from University of Wisconsin Madison website: https://chess.chsra.wisc.edu/pathstorecovery/PathsToRecovery/FirstRequest.asp

*Key Pathways to Recovery - Intake*. Retrieved July 6, 2006, from University of Wisconsin Madison website: https://chess.chsra.wisc.edu/pathstorecovery/PathsToRecovery/Intake.asp

*Key Pathways to Recovery – Moving Patients Into and Through Appropriate Levels of Care*. Retrieved July 6, 2006, from University of Wisconsin Madison website: https://chess.chsra.wisc.edu/pathstorecovery/PathsToRecovery/LevelsCare.asp

*Key Pathways to Recovery - Paperwork*. Retrieved July 6, 2006, from University of Wisconsin Madison website: https://chess.chsra.wisc.edu/pathstorecovery/PathsToRecovery/Paperwork.asp

*Key Pathways to Recovery - Scheduling*. Retrieved July 6, 2006, from University of Wisconsin Madison website: https://chess.chsra.wisc.edu/pathstorecovery/PathsToRecovery/Scheduling.asp

*Key Pathways to Recovery – Therapeutic Engagement*. Retrieved July 6, 2006, from University of Wisconsin Madison website: https://chess.chsra.wisc.edu/pathstorecovery/PathsToRecovery/Therapeutic.asp

*Key Pathways to Recovery – Social Support*. Retrieved July 6, 2006, from University of Wisconsin Madison website: https://chess.chsra.wisc.edu/pathstorecovery/PathsToRecovery/SocialSupport.asp

*Key Pathways to Recovery - Outreach*. Retrieved July 6, 2006, from University of Wisconsin Madison website: https://chess.chsra.wisc.edu/pathstorecovery/PathsToRecovery/Outreach.asp

Mee-Lee, David. (2004). *Tips and Topics,* Volume 2, No.7. Retrieved July 6, 2006, from David Mee-Lee, M.D. Training & Consulting website: http://www.dmlmd.com/2004.11.ezine.html

Owens, Betta H. (2006). *Network for the Improvement of AddictionSUD Treatment Update.* Retrieved July 6, 2006, from Network for the Improvement of Treatment website: www.NIATx.net

White, William. (2005). *Recovery Management: What If We Really Believed That Addiction Was A Chronic Disorder?.* Retrieved from Great Lakes Addiction Technology Transfer Center website: http://www.glattc.org

White, W.L., Kurtz, E., Sanders, M. (2006). *Recovery Management*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

| **Reference:** | **Check if applies:** | **Standard Numbers:** |
|---|---|---|
| 42 CFR Parts 400 et al. (Balanced Budget Act) | | |
| 45 CFR Parts 160 & 164 (HIPAA) | | |
| 42 CFR Part 2 (Substance Abuse) | X | |
| Michigan Mental Health Code Act 258 of 1974 | | |
| The Joint Commission - Behavioral Health Standards | | |
| Michigan Department of Health and Human Services (MDHHs) Medicaid Contract | X | |
| MDHHS Contract | X | |
| Michigan Medicaid Provider Manual | | |

| **Community Mental Health Partnership of Southeast Michigan/PIHP** | ***Policy***<br><br>**Welcoming Policy** |
|---|---|
| **Department: Substance Use Services**<br>**Author: Marci Scalera/Anne Marshall** | **Local Policy Number (if used)** |
| **Regional Operations Committee Approval Date**<br>**9/14/2016** | **Implementation Date**<br>**10/1/2016** |

## I. PURPOSE

To establish expectations and standards for the implementation of a welcoming philosophy across the Community Mental Health Partnership of Southeast Michigan (CMHPSM) where individuals and their family members receive meaningful, non-judgmental interactions from staff within the Recovery Oriented System of Care.

Deleted: Washtenaw Community Health Organization

Deleted: r

Deleted: o

Deleted: s

Deleted: c

## II. REVISION HISTORY

| DATE | REV. NO. | MODIFICATION |
|---|---|---|
| 10/2006 | | Original policy |
| 10/2009 | 001 | Language modification |
| 2/2012 | 002 | Language modification |
| 8/2016 | 003 | Language modification |

## III. APPLICATION

This policy applies to the CMHPSM and its provider network. It is expected that all CMHPSM and provider network staff involved in the provision of services understand and take action to operate within these welcoming principles. These actions consist of reviewing business practices, identifying areas in need of improvement, and implementing identified changes.

## IV. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Co-Occurring Disorder: Have both a mental health and substance use diagnosis or a developmental disability (DD) (in some instances, both a DD diagnosis and mental health diagnosis) and a substance use diagnosis.

Recipient: The person requesting, accepting, receiving or being referred for services through the CMHPSM

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

## V. POLICY

A welcoming philosophy is based on the core belief of dignity and respect for all people while in turn following good business practice. In this context welcoming was determined to be an important factor in contributing to successful recipient outcomes.

The goal of Substance Use Disorder (SUD) treatment is to move individuals along the path of recovery. There are two main features of the recovery perspective. It acknowledges that recovery is a long-term process of internal change and it recognizes that these internal changes proceed through various stages. As SUD is a chronic disease, it is characterized by acute episodes or events that precipitate a heightened need for an individual to change their behavior. It is important for the system to understand and support the treatment-seeking client by providing an environment including actions/behavior that foster entry and engagement throughout the treatment process and supports recovery.

Welcoming principles extend to include all customers of an agency (agency staff, referral sources, the individual and their family). In accordance with Network for Improvement of Addiction Treatment (NIATx) "Key Paths to Recovery" the CMHPSM aims of reduced waiting, reduced no shows, increased admissions and increased continuation in treatment, all incorporate an expectation for a welcoming philosophy.

Deleted: The goal of mental health and SUD substance use disorder (SUD) treatment is to move individuals along the path of recovery. For individuals with a developmental disability, the goal is independence. There are two main features of the recovery perspective. It acknowledges that recovery and independence is a long-term process of internal change and it recognizes that these internal changes proceed through various stages. As SUD, mental health and developmental disabilities is a chronic disease/disability, it is characterized by acute episodes or events that precipitate a heightened need for a recipient to change their behavior. It is important for the system to understand and support the individual in seeking treatment by providing an environment including actions/behavior that foster entry and engagement throughout the treatment process and supports recovery and independence.¶

Deleted: addiction

Deleted: addiction

Deleted:

## VI. STANDARDS

Welcoming is conceptualized as an accepting attitude and understanding of how people 'present' for treatment and a capacity on the part of that location to address their needs in a manner that accepts and fosters a service and treatment relationship that meets the needs and interests of the recipient.

The following principles list the characteristics/attitudes/beliefs that can be found at a program or agency that is fostering a welcoming environment:

General Principles Associated with Welcoming

- Welcoming is a continuous process throughout the agency/program and involves access, entry, and on-going services.
- Welcoming applies to all "clients" of an agency. Beside the individual seeking services and their family, an individual also includes the public seeking services; other providers seeking access for their clients; agency staff; and the community in which the service is located and/or the community resides.
- Welcoming is comprehensive and evidenced throughout all levels of care, all systems and service authorities.
- A welcoming system is 'seamless'. It enables service regardless of original entry point, provider and current services.

- In a welcoming system, when resources are limited, or eligibility requirements are not met, the provider ensures a connection is made to community supports.
- A welcoming system is culturally competent and able to provide access and services to all recipients seeking treatment.

Welcoming – Service Individual

- There is openness, acceptance and understanding of the presenting behaviors and characteristics of persons with substance use disorders.
- For persons with co-occurring mental health problems, there is an openness, acceptance and understanding of their presenting behaviors and characteristics.
- Welcoming is individually based and incorporates meaningful individual participation and 'individual satisfaction' that includes consideration to the family members/significant others.
- Services are provided in a timely manner to the meet the needs of the individual and/or their families.
- Individuals must be involved in the development of their treatment plans and goals.

Welcoming – Organization

- The organization demonstrates an understanding and responsiveness to the variety of help seeking behaviors related to various cultures and ages.
- All staff within the agency incorporates and participates in the welcoming philosophy.
- The program is efficient in sharing and gathering authorized information between involved agencies rather than having the recipient repeat it at each provider.
- The organization has an understanding of the local community, including community differences, local community involvement and opportunities for recovery support and inclusion by the service recipient.
- Consideration is given to administrative details such as sharing paperwork across providers, ongoing review to streamline paperwork to essential and necessary information.
- A welcoming system is capable of providing follow-up and assistance to a recipient as they navigate the provider and the community network(s).
- Welcoming is incorporated into continuous quality improvement initiatives.
- Hours of operation meet the needs of the population(s) being served.
- Personnel that provide the initial contact with a recipient receive training and develop skills that improve engagement in the treatment process.
- All paperwork has purpose and represent added value. Ingredients to managing paperwork are the elimination of duplication, quality forms design and efficient processing, transmission, and storage.

Welcoming – Environmental and Other Considerations

- The physical environment provides seating, space, and consideration to privacy, a drinking fountain and/or other 'amenities' to foster an accepting, comfortable environment.
- The service location is considered with regard to public transportation and accessibility.

Deleted: And, f

- Waiting areas include consideration for family members or others accompanying the recipient seeking services.

Staff Competency Principles

- Skills and knowledge appropriate to staff in their roles throughout the system (reception, clinical, treatment support, administrative).
- Staff should have the knowledge and skill to be able to differentiate between the person and their behaviors.
- Staff should be respectful of recipient boundaries in regards to personal questions and personal space.
- Staff uses attentive behavior, listening with empathy not sympathy.

It is expected all CMHSPs implement and maintain welcoming principles.

Client satisfaction surveys are expected to incorporate questions that address the 'welcoming' nature of the agency and its services.

Welcoming principles will be reviewed as part of site visit protocols.

Deleted: ¶

Deleted:

## VII. EXHIBITS

None

Deleted: .

## VIII. REFERENCES

*5 Promising Practices Improving Timeliness.* Retrieved July 6, 2006, from Network for the Improvement of Addiction Treatment website: www.NIATx.net

*5 Promising Practices Reducing No Shows.* Retrieved July 6, 2006, from Network for the Improvement of Addiction Treatment website: www.NIATx.net

*5 Promising Practices Increasing Admissions.* Retrieved July 6, 2006, from Network for the Improvement of Addiction Treatment website: www.NIATx.net

*5 Promising Practices Increasing Continuation.* Retrieved July 6, 2006, from Network for the Improvement of Addiction Treatment website: www.NIATx.net

Center for Substance Abuse Treatment. (2005). *Substance Abuse Treatment for Persons With Co-Occurring Disorders,* Treatment Improvement Protocol (TIP) Series 42. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

*Key Pathways to Recovery*. Retrieved July 6, 2006, from University of Wisconsin Madison website: https://chess.chsra.wisc.edu/pathstorecovery/PathsToRecovery/TopPaths.asp

*Key Pathways to Recovery – First Request for Service*. Retrieved July 6, 2006, from University of Wisconsin Madison website: https://chess.chsra.wisc.edu/pathstorecovery/PathsToRecovery/FirstRequest.asp

*Key Pathways to Recovery - Intake*. Retrieved July 6, 2006, from University of Wisconsin Madison website: https://chess.chsra.wisc.edu/pathstorecovery/PathsToRecovery/Intake.asp

*Key Pathways to Recovery – Moving Patients Into and Through Appropriate Levels of Care*. Retrieved July 6, 2006, from University of Wisconsin Madison website: https://chess.chsra.wisc.edu/pathstorecovery/PathsToRecovery/LevelsCare.asp

*Key Pathways to Recovery - Paperwork*. Retrieved July 6, 2006, from University of Wisconsin Madison website: https://chess.chsra.wisc.edu/pathstorecovery/PathsToRecovery/Paperwork.asp

*Key Pathways to Recovery - Scheduling*. Retrieved July 6, 2006, from University of Wisconsin Madison website: https://chess.chsra.wisc.edu/pathstorecovery/PathsToRecovery/Scheduling.asp

*Key Pathways to Recovery – Therapeutic Engagement*. Retrieved July 6, 2006, from University of Wisconsin Madison website: https://chess.chsra.wisc.edu/pathstorecovery/PathsToRecovery/Therapeutic.asp

*Key Pathways to Recovery – Social Support*. Retrieved July 6, 2006, from University of Wisconsin Madison website: https://chess.chsra.wisc.edu/pathstorecovery/PathsToRecovery/SocialSupport.asp

*Key Pathways to Recovery - Outreach*. Retrieved July 6, 2006, from University of Wisconsin Madison website: https://chess.chsra.wisc.edu/pathstorecovery/PathsToRecovery/Outreach.asp

Mee-Lee, David. (2004). *Tips and Topics,* Volume 2, No.7. Retrieved July 6, 2006, from David Mee-Lee, M.D. Training & Consulting website: http://www.dmlmd.com/2004.11.ezine.html

Owens, Betta H. (2006). *Network for the Improvement of AddictionSUD Treatment Update.* Retrieved July 6, 2006, from Network for the Improvement of Treatment website: www.NIATx.net

White, William. (2005). *Recovery Management: What If We Really Believed That Addiction Was A Chronic Disorder?.* Retrieved from Great Lakes Addiction Technology Transfer Center website: http://www.glattc.org

White, W.L., Kurtz, E., Sanders, M. (2006). *Recovery Management*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

| **Reference:** | **Check if applies:** | **Standard Numbers:** |
|---|---|---|
| 42 CFR Parts 400 et al. (Balanced Budget Act) | | |
| 45 CFR Parts 160 & 164 (HIPAA) | | |
| 42 CFR Part 2 (Substance Abuse) | X | |
| Michigan Mental Health Code Act 258 of 1974 | | |
| The Joint Commission - Behavioral Health Standards | | |
| Michigan Department of Health and Human Services (MDHHs) Medicaid Contract | X | |
| MDHHS Contract | X | |

| | | |
|---|---|---|
| Michigan Medicaid Provider Manual | | |
| | | |
| | | |
| | | |

**CMHPSM SUD OVERSIGHT POLICY BOARD**

**ACTION REQUEST**

**Board Meeting Date:** December 5, 2019

**Action Requested**: Approve Revised Engagement Center Budget for Catholic Charities of Southeast Michigan for FY20.

**Background:** Catholic Charities of Southeast MI (CCSEM) is in the second full year of operating the Engagement Center in Monroe. At the end of the first year of operations, the associated outcomes and service level outpaced expectations and thus the expenses exceeded the initial budget. Funding was increased at the end of FY19 to allow for increased expenses. In FY 19, a total of 766 admissions occurred for 197 unique individuals. For FY20, a total allocation of $395,449 is needed to cover operational and staffing costs. This request is an increase of $110,436 from the original contract for $285,013.

**Connection to PIHP/MDHHS Contract, Regional Strategic Plan or Shared Governance Model:**

Improving access to SUD services for individuals utilizing the Engagement Center.

**Recommendation**:

Approval of Block Grant/PA2 funding to increase the CCSEM Engagement Center budget to a total of $395,449 FY20.

# COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

**Serving Lenawee, Livingston, Monroe, and Washtenaw Counties**

| *Request for MINI GRANT Funds*<br>*Mini-Grants: A specific amount of funds per county set aside annually for small initiatives that arise during the fiscal year in the amount not to exceed $1000. There is a limit of $5000 per county each fiscal year. Mini-Grants may only be awarded for special activities or initiatives related to substance use disorders education, awareness, community activities and events, etc., and not be used for staffing purposes. The applicant must identify a source of other matching funds or in-kind effort to receive the grant. Once an award is made, the applicant will not be eligible to receive other mini-grant funding for any additional project during the fiscal year.* | |
|---|---|
| Date: | 11/7/2019 |
| Contact Person:<br>(Name, email, phone) | Misty Frank, misty.frank@promedica.org 734-240-1760 |
| Requestor: | ProMedica Monroe Regional Outpatient Behavioral Health |
| Amount of Request: | $1,000.00 |
| Type of Request: | ☒Community event ☐ Other: _____<br>☐Staff Training<br>☐Coalition Support Attach information as needed. |
| Describe Program Request: | ProMedica Monroe Regional Outpatient Behavioral Health in collaboration with Monroe County agencies, including but not limited to, the Monroe County Substance Abuse Coalition and Monroe County schools, is hosting #IMatter summit. At this event, the Outpatient Behavioral Health department at ProMedica Monroe Regional Hospital is providing a Wellness Center for the #IMatter Youth Summit on December 3, 2019. There will be over 500 students from 12 different high schools attending this event. The mission for the summit is to provide prevention, awareness, and post treatment services in the area of substance abuse. This year we are adding the Wellness Center to the agenda to provide students with the opportunity to create "wellness kits" to take home. The goal for this aspect of the event is to provide further awareness and the use of what they have been taught throughout the day. The kits will contain items that teach positive coping strategies that they can use at home and school that will allow them to use positive strategies for a healthy life style. Some of these strategies include age appropriate meditation, relaxation, journals, mini coloring books with pencils, stress balls, and thought putty. |
| Targeted Community: | (Geographic area) Monroe County High School students and Middle College students |
| Describe how and where matching funds will be applied. If in-kind, describe: | Monroe County Community College has donated the use of the La-Z-Boy Center for the all-day summit. The value of the in-kind donation is $1,965.00. In addition, ProMedica Monroe Regional Hospital is donating $7,000.00 and Monroe County Substance Abuse Coalition funding has allocated $4,000.00 towards the summit. Other sponsorships have been sought as well. |
| Identify Key People, Coalitions, and/or Community Partners involved in program: | Monroe County Mental Health Authority, Monroe County Substance Abuse Coalition, United Way of Monroe County, ProMedica Monroe Regional Hospital, Catholic Charities of SE Michigan, Student Prevention Leadership Teams, Monroe County Public and Parochial High Schools, Monroe County Middle College, Monroe County |

| | |
|---|---|
| | Intermediate School District, Family Medical Center, Monroe County Health Department and Monroe county Community College. |
| *Please note*:<br>All programming must be consistent with the implementation of Recovery-Oriented Systems of Care (ROSC). *Recovery-oriented systems support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to take responsibility for their sustained health, wellness and recovery from alcohol and drug problems* (Center for Substance Abuse Treatment, 2005). | |
| *CMHPSM Office Use Only* | |
| Amount Recommended & Comments: | Click or tap here to enter text.<br><br>Approved $1,000. |

**COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN**
**REGULAR BOARD MEETING MINUTES**
**November 13, 2019**

**Members Present:** Judy Ackley, Greg Adams, Susan Fortney, Roxanne Garber, Sandra Libstorff, Charles Londo, Gary McIntosh, Sharon Slaton, Caroline Richardson, Ralph Tillotson

**Members Absent:** Charles Coleman, Bob King, Katie Scott

**Staff Present:** Nicole Adelman, James Colaianne, Connie Conklin, Dana Darrow, Lisa Jennings, Kathryn Szewczuk, Stephannie Weary,

**Others Present:** Lori Lutomski

I. Call to Order
Meeting called to order at 6:00 p.m. by Board Chair S. Slaton.

II. Roll Call
- A quorum of members present was confirmed.

III. Consideration to Adopt the Agenda as Presented

**Motion by R. Tillotson, supported by J. Ackley, to approve the agenda as presented**
**Motion carried**

IV. Consideration to Approve the Minutes of the October 9, 2019 Regular Meeting and Waive the Reading Thereof

**Motion by R. Garber, supported by S. Fortney, to approve the minutes of October 9, 2019 Regular Meeting and waive the reading thereof**
**Motion carried**

V. Audience Participation
None

VI. Old Business
a. November Finance Report
- J. Colaianne presented. Discussion followed.

VII. New Business
a. Board Action Request
Consideration to approve the CEO to execute the presented contracts/amendments

**Motion by C. Richardson, supported by J. Ackley, to approve the CEO to execute the presented contracts/amendments.**
**Motion carried**

b. Board Action Request {Att. #4}
Proclamations for Five Years of Service at the CMHPSM for
Jane Goerge (October) and Teresa Sharp (November)

**Motion by R. Tillotson, supported by G. McIntosh, recognize Jane Goerge and Teresa Sharp for five years of service at the CMHPSM**
**Motion carried**

VIII. Reports to the CMHPSM Board

a. Report from the SUD Oversight Policy Board
- J. Colaianne provided an overview of the recent OPB meeting. See the OPB minutes in the Regional Board meeting packet for details.

b. CEO Report to the Board
- J. Colaianne will share the FY20 Risk Strategy, with the Board, once it's done.
- 298 has officially been cancelled.
- J. Colaianne was nominated for a statewide rate-setting workgroup, with Milliman and the state.
- See the CEO Report in the Regional Board meeting packet for more highlights and details.

c. Move Update
- December 1 is still the planned start date for the new office space lease.

IX. Adjournment

**Motion by R. Tillotson, supported by G. Adams, to adjourn the meeting**
**Motion carried**

Meeting adjourned at 6:45 p.m.

_____
Judy Ackley, CMHPSM Board Secretary