# OVERSIGHT POLICY BOARD

Teleconference Meeting
Thursday, September 23, 2021
9:30 a.m. – 11:30 a.m.

**Join by Phone:**
1-312-626-6799; 1-646-876-9923; or
1-346-248-7799
**Meeting ID: 133 461 219**

**Join by Computer:**
https://us02web.zoom.us/j/133461219
**Passcode: 513544**

## Agenda

1. Introductions & Welcome Board Members– 5 minutes
2. Approval of Agenda **(Board Action)** – 2 minutes
3. Approval of August 26, 2021 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. FY22 Block Grants Update (Discussion) – 15 minutes
6. New Business
   a. Behavioral Health Redesign Resolution (Discussion) – 15 minutes
   b. SUD Policy Updates {Att. #3a-3h} **(Board Action)** – 15 minutes
   c. Board Elections **(Board Action)** – 15 minutes
   d. November/December combined meeting (Discussion) – 10 minutes
7. Report from Regional Board (Discussion) {Att. #4} – 10 minutes
8. SUD Director Updates (Discussion) – 10 minutes
   a. CEO Update {Att. #5}
   b. Staffing Update
   c. Back to office plans
   d. Rerelease of STR media campaign
9. Adjournment **(Board Action)**

***Next meeting: Thursday, October 28, 2021**
**Location TBD: Zoom or 3005 Boardwalk, Suite 200; Patrick Barrie Room**

# Oversight Policy Board Minutes
## August 26, 2021
## Meeting held electronically via Zoom software

| | |
|---|---|
| Members Present: (physical location) | Mark Cochran (Monroe, MI), Kim Comerzan (Monroe, MI), Amy Fullerton (Lenawee County, MI), John Lapham (Lenawee County, MI), Susan Longsworth (Genoa Township, MI), Molly Welch Marahar (Ann Arbor, MI), Frank Nagle (Lenawee County, MI), Dave O'Dell (Monroe, MI), Carol Reader (Livingston County, MI), Monique Uzelac (Ann Arbor, MI), Tom Waldecker (Carlton, MI) |
| Members Absent: | Ricky Jefferson, Dianne McCormick, David Oblak, Ralph Tillotson |
| Guests: | |
| Staff Present: | Stephannie Weary, James Colaianne, Nicole Adelman, Matt Berg, CJ Witherow, Michelle Sucharski, Jackie Bradley (Lenawee) |

Board Chair M. Cochran called the meeting to order at 9:33 a.m.

1. Introductions

2. Approval of the Agenda
   **Motion by M. Uzelac, supported by K. Comerzan, to approve the agenda**
   **Motion carried**
   Voice vote, no nays

3. Approval of the June 24, 2021 Oversight Policy Board minutes
   **Motion by A. Fullerton, supported by T. Waldecker, to approve the June 24, 2021 OPB minutes**
   **Motion carried**
   Voice vote, no nays

4. Audience Participation
   - None

5. Old Business
   a. Finance Report
      - M. Berg presented.
   b. FY21/FY22 Block Grant Update(s)
      - N. Adelman provided an update on the grants the region has received so far, and what is anticipated.
   c. Approval of PA2 funding for FY22
      **Motion by C. Reader, supported by M. Welch Marahar, to approve FY22 expenditures for PA2 funds by county**
      **Motion carried**
      Vote
      Yes: Cochran, Comerzan, Fullerton, Lapham, Longsworth, Welch Marahar, Nagle, O'Dell, Reader, Uzelac, Waldecker
      No:
      Absent: Jefferson, McCormick, Oblak, Tillotson

      - M. Cochran noted that today's board action is based on what's known today. Recommendations are subject to change based on guidance and new information from the state.

6. New Business
   a. Core Provider Model Update
      - Staff is proposing to add a different point of access for Washtenaw County, using Washtenaw CMH instead of Home of New Vision (HNV) and Dawn Farm (DF) as the point of access.
      - HNV and DF will become fee for service, effective 4/1/22.
      - This change in Washtenaw County will standardize access services across the county. Washtenaw County CMH will become an Access point for Washtenaw SUD services along with HNV and DF for FY22 Q1, and will be the only Access point starting 1/1/2022.
      - OPB will receive data and updates on the transition as it progresses.
   b. Behavioral Health Redesign Resolution (Discussion) – 15 minutes
      - N. Adelman and J. Colaianne provided an overview of the 2 proposed legislations related to the redesign.
      - M. Cochran suggested that OPB adopting a resolution in support of the current public system to encourage legislators to engage and consider all options.
      - Discussion will continue at next month's OPB meeting.
   c. November/December combined meeting
      - Staff will send out a poll

7. Report from Regional Board
   - J. Colaianne provided an update on recent board meeting.

8. SUD Director Updates
   a. CEO Update {Att. #6}
      - OPB received the monthly CEO report for review.
   b. Staffing Update
      - 2 positions are posted (Veterans Peer, OHH Coordinator).
      - The SUD Program Coordinator position was recently filled. Danielle Brunk starts at the end of September.
   c. Back to office plans
      - Most staff are back in the office 2-3 days a week. The full opening of the office was pushed back to October 4.
   d. Rerelease of STR media campaign
      - Staff is hoping to re-release the media campaign, focusing on naloxone awareness piece and on personal stories of recovery.
   e. Gambling media campaign
      - A gambling media campaign targeted to youth is expected to be out by the end of the year.
   f. FY22 SUD Rates
      - The region has been having discussions about SUD rates. The region has some of the lowest rates across the state. The hope is to address the low rates and also standardize rates as much as possible as possible across the region.

9. Adjournment
   **Motion by M. Welch Marahar, supported by C. Reader, to adjourn the meeting**
   **Motion carried**

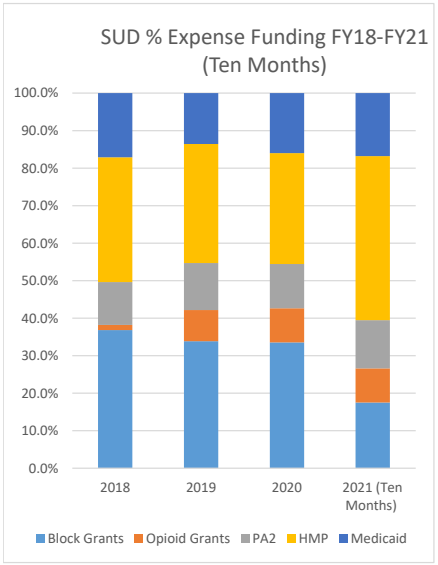
Voice vote, no nays

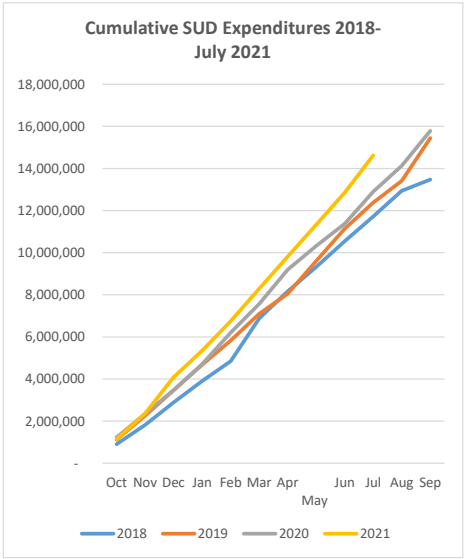
- Meeting adjourned at 10:46 a.m.

**Next meeting: September 23, 2021**
**Location Zoom**

**Community Mental Health Partnership Of Southeast Michigan**
**SUD SUMMARY OF REVENUE AND EXPENSE BY FUND**
**July 2021 Preliminary FYTD**

| Summary Of Revenue & Expense | Funding Source | | | | | | Total Funding Sources | FY20 YTD |
|---|---|---|---|---|---|---|---|---|
| | Medicaid | Healthy Michigan | SUD - CBG/WSS | SUD - SOR/SOR II | Gambling Prev | SUD-PA2 | | |
| **Revenues** | | | | | | | | |
| Funding From MDHHS | 2,882,036 | 7,501,078 | 3,007,720 | 1,555,217 | 101,566 | | **$ 15,047,616** | $ 10,954,672 |
| PA2/COBO Tax Funding Current Year | | | | | | 1,641,302 | **$ 1,641,302** | $ 1,550,049 |
| PA2/COBO Reserve Utilization | | | | | | 564,375 | **$ 564,375** | $ 368,852 |
| Other | - | - | - | - | - | - | **$ -** | $ 1,020,491 |
| **Total Revenues** | **$ 2,882,036** | **$ 7,501,078** | **$ 3,007,720** | **$ 1,555,217** | **$ 101,566** | **$ 2,205,677** | **$ 17,253,293** | $ 13,894,064 |
| **Expenses** | | | | | | | | |
| Funding for County SUD Programs | | | | | | | | |
| CMHPSM | | | | 1,555,217 | 101,566 | | **1,656,782** | 933,220 |
| Lenawee | 326,053 | 855,896 | 227,549 | | | 399,109 | **1,808,606** | 1,792,254 |
| Livingston | 183,232 | 617,210 | 690,958 | | | 311,270 | **1,802,670** | 1,885,501 |
| Monroe | 403,744 | 957,326 | 715,203 | | | 449,820 | **2,526,092** | 1,870,550 |
| Washtenaw | 677,730 | 2,701,481 | 1,071,739 | | | 1,045,477 | **5,496,427** | 6,388,160 |
| Total SUD Expenses | $ 1,590,758 | $ 5,131,912 | $ 2,705,448 | $ 1,555,217 | $ 101,566 | $ 2,205,676 | **$ 13,290,577** | $ 12,869,685 |
| Administrative Cost Allocation | 285,570 | 743,252 | 302,272 | | | - | **$ 1,331,094** | $ 600,563 |
| **Total Expenses** | **$ 1,876,328** | **$ 5,875,165** | **$ 3,007,720** | **$ 1,555,217** | **$ 101,566** | **$ 2,205,676** | **$ 14,621,671** | $ 13,470,248 |
| **Revenues Over/(Under) Expenses** | **$ 1,005,708** | **$ 1,625,913** | **$ -** | **$ -** | **$ -** | **$ 0** | **$ 2,631,621** | $ 423,816 |




**FY 21 Utilization of PA2**

| | Revenues | Expenditures | Revenues Over/(Under) Expenses |
|---|---|---|---|
| PA2 by County | | | |
| Lenawee | 134,740 | 399,109 | (264,369) |
| Livingston | 422,788 | 311,270 | 111,518 |
| Monroe | 314,884 | 449,820 | (134,936) |
| Washtenaw | 768,890 | 1,045,477 | (276,588) |
| Totals | $ 1,641,302 | $ 2,205,676 | $ (564,375) |

| Unallocated PA2 | FY 21 Beginning Balance | FY21 Projected Utilization | FY21 Projected Ending Balance | FY 20 YE Over/(Under) Expenses |
|---|---|---|---|---|
| Lenawee | 723,718 | (320,419) | 403,299 | (106,259) |
| Livingston | 3,647,264 | 124,821 | 3,772,085 | 293,315 |
| Monroe | 428,945 | (164,135) | 264,810 | (35,395) |
| Washtenaw | 2,039,452 | (367,591) | 1,671,861 | (302,772) |
| Total | $ 6,839,379 | $ (727,324) | $ 6,112,056 | $ (151,111) |

| Community Mental Health Partnership of Southeast Michigan/PIHP | *Policy*<br>*Individual Treatment and Planning Process* |
|---|---|
| **Department: Substance Use Services**<br>~~**Author:**~~ | **Regional Operations Committee Review Date**<br>**8/23/2021** |
| **Implementation Date** | **OPB Approval Date** |

## I. PURPOSE

The purpose of this policy is to establish the requirements for individualized treatment and recovery planning. Consistent with a recovery oriented system of care, treatment and recovery plans must be a product of the ~~client~~consumer/individual's active involvement and informed agreement. Direct ~~client~~consumer/individual served 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~~consumer/individual's motivation to participate in treatment. By participating in the development of their recovery plan, ~~client~~consumers/individuals served~~s~~ 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~~consumer/individual served is unique and each plan must be developed based upon the individual needs, goals, desires and strengths of each ~~client~~consumer/individual served.

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 that 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 | MODIFICATION |
|---|---|
| March, 2012 | |
| August 26, 2016 | Language updates |
| November 2019 | Language updates |
| April 3, 2020 | Language updates |
| 9/23/2021 | 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 o~~O~~f 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/individuals served for~~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~~consumer/individual served enters treatment – either directly or based on a referral from an access system, and ends when the ~~client~~consumer/individual served 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~~consumer/individual's needs change, the plan must be revised to meet the new needs of the ~~client~~consumer/individual served.

Recovery Planning is undertaken as a component of the treatment plan and should progress as the ~~client~~consumer/individual served moves through the treatment process. It is important that the recovery plan be a viable and workable plan for the ~~client~~consumer/individual served 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~~consumer/individual's planned discharge from treatment services.

The treatment and recovery plans are not limited to just the ~~client~~consumer/individual served and the counselor. The ~~client~~consumer/individual served can request any family members, friends or significant others to be involved in the process. Once each plan is completed, the ~~client~~consumer/individual served, 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~~consumer/individual served. From this assessment, the needs and strengths of the ~~client~~consumer/individual served are identified and it is this information that assists the counselor and the ~~client~~consumer/individual served 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~~consumer/individual served in using these strengths to accomplish the identified goals and objectives. Identifying strengths of the ~~client~~consumer/individual served can provide motivation to participate in treatment and may take the focus off any negative situations that surround the ~~client~~consumer/individual served 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~~consumer/individual'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~~consumer/individual served but do not have to be recorded in the ~~client~~consumer/individual'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~~consumer/individual served 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~~consumer/individual served in being able to accomplish the objective. What act or actions will the ~~client~~consumer/individual served take to achieve a goal and what action will the counselor take to assist the ~~client~~consumer/individual served in achieving the goal. Again, these actions must be mutually agreed upon to provide the best chance of success for the ~~client~~consumer/individual served.

Framework for Treatment

The individualized treatment and recovery plan provides the framework by which the services should be provided. This framework includes scope, frequency and duration of services. Scope, frequency and duration of services should relate to the appropriate ASAM level of care. Any individual or group sessions that the ~~client~~consumer/individual served 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~~consumer/individual served or with documentation of ~~client~~consumer/individual served approval.

Treatment Plan Progress Reviews

Plans must be reviewed and this review must be documented in the ~~client~~consumer/individual served record. The frequency of the reviews can be based on the time frame in treatment (~~60, 90 120~~14, 30, 60, 90 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/medical staff and recovery providers involved in the care of the ~~client~~consumer/individual served as well as any other individuals the ~~client~~consumer/individual served involved in their plan. This review should reflect on the progress the ~~client~~consumer/individual served 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~~consumer/individual served. Treatment plan reviews should include information on updated scope, duration and frequency of treatment services. As with the initial plan, the ~~client~~consumer/individual served, 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~~consumer/individual served, 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 ASAM placement dimensions
- 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~~consumer/individual's words and are unique to the ~~client~~consumer/individual served. No standard or routine goals that are used by all ~~client~~consumers/individuals served~~s~~
    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~~consumer/individual served, 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~~consumer/individual served, 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
    ~~2.~~3. Rationale for continuation at the appropriate ASAM level of care
    ~~3.~~4. New goals and objectives developed with ~~client~~consumer/individual served input
    ~~4.~~5. ~~Client~~Consumer/individual served participation/feedback present in the review
    ~~5.~~6. Signatures, i.e., ~~client~~consumer/individual served, 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:**

MDHHS Substance Use Disorder Services Policies, *Individualized Treatment and Recovery Planning (2012)*
https://www.michigan.gov/documents/mdch/Policy_Treatment_06_Invd_Tx_Planning_175180_7.pdf

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~~Consumer/individual served-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~~Consumer/individual served-Directed, Outcome Informed Clinical Work.* **Institute for the Study of Therapeutic Change, Chicago, Illinois.**

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| **Community Mental Health Partnership of Southeast Michigan/PIHP** | ***Policy*** ***Individual Treatment and Planning Process*** |
|---|---|
| **Department: Substance Use Services** | **Regional Operations Committee Review Date 8/23/2021** |
| **Implementation Date** | **OPB Approval Date** |

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Treatment Plan Progress Reviews

Plans must be reviewed, and this review must be documented in the consumer/individual served record. The frequency of the reviews can be based on the time frame in treatment (14, 30, 60, 90 days). The reviews must include input from all clinicians/treatment/medical staff and recovery providers involved in the care of the consumer/individual served as well as any other individuals the consumer/individual served involved in their plan. This review should reflect on the progress the consumer/individual served 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 consumer/individual served. Treatment plan reviews should include information on updated scope, duration and frequency of treatment services. As with the initial plan, the consumer/individual served, 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 consumer/individual served, but they also 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 ASAM placement dimensions
- 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 consumer/individual's words and are unique to the consumer/individual served. No standard or routine goals that are used by all consumers/individuals served
    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 consumer/individual served, 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 – consumer/individual served, 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. Rationale for continuation at the appropriate ASAM level of care
    4. New goals and objectives developed with consumer/individual served input
    5. Consumer/individual served participation/feedback present in the review
    6. Signatures, i.e., consumer/individual served, 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 | X | |

| | | |
|---|---|---|
| (MDHHS) Medicaid Contract | | |
| MDHHS Substance Abuse Contract | X | |
| Michigan Medicaid Provider Manual | X | |

**ADDITIONAL REFERENCES:**

MDHHS Substance Use Disorder Services Policies, *Individualized Treatment and Recovery Planning (2012)*
https://www.michigan.gov/documents/mdch/Policy_Treatment_06_Invd_Tx_Planning_175180_7.pdf

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: Consumer/individual served-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 Consumer/individual served-Directed, Outcome Informed Clinical Work.* **Institute for the Study of Therapeutic Change, Chicago, Illinois.**

| Community Mental Health Partnership of Southeast Michigan/PIHP | *Policy*<br>*SUD Media Campaign* |
|---|---|
| **Department: Substance Use Services**<br>~~**Author:**~~ | **Regional Operations Committee Review Date**<br>8/23/2021 |
| **Implementation Date** | **Oversight Policy Board Approval Date** |

## I. PURPOSE

To ensure that all media campaigns are compatible with MDHHS values; are coordinated with MDHHS campaigns whenever feasible; and associated costs are proportionate to likely outcomes.

## II. REVISION HISTORY

| DATE | MODIFICATION |
|---|---|
| 9/23/2021 | Language updates |
| | |
| | |
| | |

## III. APPLICATION

This policy applies to all contractual organizations receiving any SUD funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM), who are implementing a media campaign as part of their prevention or treatment service activities.

## IV. DEFINITIONS

Community Mental Health Partnership o~~O~~f 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.

Media Campaign: A media campaign, very broadly, is a message or series of messages conveyed through mass media channels including print, broadcast, social and electronic media. Messages regarding the availability of services in the PIHP region are not considered to be media campaigns.

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

Social Media: Social media is the collective of online communications channels dedicated to community-based input, interaction, content-sharing and collaboration. Examples include w~~W~~ebsites and applications dedicated to social networking. ~~forums, microblogging, social~~

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~~networking, social bookmarking, social curation, and wikis are among the different types of social media.~~

Field Code Changed

Field Code Changed

## V. POLICY

Media campaigns must be compatible with MDHHS values, be coordinated with MDHHS campaigns whenever feasible and costs must be proportionate to likely outcomes. All campaigns must be reviewed by the CMHPSM prior to use of MDHHS-administered funding and submitted to the MDHHS for approval.

## VI. STANDARDS

A. All mass media campaigns including, but not limited to billboards, bus panel messages, public service announcements (print, radio or TV); and social media messaging; ~~pharmacy bag campaigns;~~ are required to be submitted to the CMHPSM.
B. "Media Campaign Request Form" must be completed and associated materials (PSA Script, Media Message, Pictures, etc.) submitted to CMHPSM no less than four weeks prior to scheduled release.
C. No campaign may be initiated until receipt of approval by MDHHS is obtained.

## VII. EXHIBITS

Media Campaign Request Form

## VIII. REFERENCES

MDHHS supports and services contract; Part II (B) SUBSTANCE USE DISORDER (SUD) SERVICES; section 9.0 Media Campaigns

Attachment #3c – September 2021


# MEDIA CAMPAIGN REQUEST

MEDIA CAMPAIGNS

A media campaign, very broadly, is a message or series of messages conveyed through mass media channels including print, broadcast, and electronic media (i.e., billboards, PSAs, bus panels). Messages regarding the availability of services in the PIHP region are not considered to be media campaigns. Media campaigns must be compatible with Michigan Department of Health and Human Services' (MDHHS) values, be coordinated with MDHHS campaigns whenever feasible and costs must be proportionate to likely outcomes. **Prior written approval from MDHHS is required.**

| | |
|---|---|
| Provider: | Date: |
| Contact Person, Email, Phone: | |
| Mass Media Campaign Name: | |
| Type of Mass Media Mechanism to be Reviewed and Associated Cost: | |
| Target Message: | |
| Target Audience: | |
| Target Community: | |
| Targeted Outcome: | |
| **Please attach the actual media message, method, PSA script, etc., where applicable.** | |

| Community Mental Health Partnership of Southeast Michigan/PIHP | *Policy*<br>*SUD Media Campaign* |
|---|---|
| **Department: Substance Use Services** | **Regional Operations Committee Review Date**<br>**8/23/2021** |
| **Implementation Date** | **Oversight Policy Board Approval Date** |

## I. PURPOSE

To ensure that all media campaigns are compatible with MDHHS values; are coordinated with MDHHS campaigns whenever feasible; and associated costs are proportionate to likely outcomes.

## II. REVISION HISTORY

| DATE | MODIFICATION |
|---|---|
| 9/23/2021 | Language updates |
| | |
| | |
| | |

## III. APPLICATION

This policy applies to all contractual organizations receiving any SUD funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM), who are implementing a media campaign as part of their prevention or treatment service activities.

## 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.

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

Social Media: Social media is the collective of online communications channels dedicated to community-based input, interaction, content-sharing and collaboration. Examples include websites and applications dedicated to social networking.

## V. POLICY

Media campaigns must be compatible with MDHHS values, be coordinated with MDHHS campaigns whenever feasible and costs must be proportionate to likely outcomes. All campaigns must be reviewed by the CMHPSM prior to use of MDHHS-administered funding and submitted to the MDHHS for approval.

## VI. STANDARDS

A. All mass media campaigns including, but not limited to billboards, bus panel messages, public service announcements (print, radio or TV); and social media messaging; are required to be submitted to the CMHPSM.
B. "Media Campaign Request Form" must be completed and associated materials (PSA Script, Media Message, Pictures, etc.) submitted to CMHPSM no less than four weeks prior to scheduled release.
C. No campaign may be initiated until receipt of approval by MDHHS is obtained.

## VII. EXHIBITS

Media Campaign Request Form

## VIII. REFERENCES

MDHHS supports and services contract; Part II (B) SUBSTANCE USE DISORDER (SUD) SERVICES; section 9.0 Media Campaigns

# MEDIA CAMPAIGN REQUEST

MEDIA CAMPAIGNS

A media campaign, very broadly, is a message or series of messages conveyed through mass media channels including print, broadcast, and electronic media (i.e., billboards, PSAs, bus panels). Messages regarding the availability of services in the PIHP region are not considered to be media campaigns. Media campaigns must be compatible with Michigan Department of Health and Human Services (MDHHS) values, be coordinated with MDHHS campaigns whenever feasible and costs must be proportionate to likely outcomes. **Prior written approval from MDHHS is required.**

| | |
|---|---|
| Provider: | Date: |
| Contact Person, Email, Phone: | |
| Mass Media Campaign Name: | |
| Type of Mass Media Mechanism to be Reviewed and Associated Cost: | |
| Target Message: | |
| Target Audience: | |
| Target Community: | |
| Targeted Outcome: | |
| **Please attach the actual media message, method, PSA script, etc., where applicable.** | |

| Community Mental Health Partnership of Southeast Michigan PIHP | *Policy*<br>Women's Specialty Treatment Services |
|---|---|
| Department: Substance Use Disorders<br>~~Author: M. Scalera/A. Marshall~~ | Regional Operations Committee Review Date<br>8/2/2021 |
| Implementation Date | Oversight Policy Board Approval Date |

## 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 | MODIFICATION |
|---|---|
| 1/2016 | Revised language |
| 9/2016 | Language updates |
| 11/2019 | Language updates and addition of Enhanced Women's Services criteria |
| 9/23/2021 | Language and source document updates; addition of MDOC priority population |

## 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~~consumer/individual served 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~~consumer/individual's home or in other venues, including while providing transportation to and from other appointments.

Core Components - those elements of an evidence-based program that are integral and essential to assure fidelity to a project, and that must be provided.

Eligible: Pregnant women and women with dependent children, including women who are attempting to regain custody of their children. Men with dependent children are also eligible for this program's ancillary services; see VI. Standards below.

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~~consumer/individual served 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~~consumer/individual's motivation to participate in treatment. Treatment planning requires an understanding that each ~~client~~consumer/individual served is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each ~~client~~consumer/individual served and be specific to the diagnostic impression and assessment.

~~Michigan Department of Health and Human Services: MDHHS~~
OROSC – Office of Recovery Oriented Systems of Care, within the Behavioral Health and Developmental Disabilities Administration (BHDDA), 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~~consumer/individual served.

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~~consumer/individual served 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*** ~~client~~consumers/individuals served~~s~~ 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. The ancillary services in this program can also be provided to men who are primary caregivers. ~~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.~~

**Commented [NA1]:** This has been repealed and is now supported by BG according to OROSC.

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.

To be able to offer services that are gender and culturally competent, it is important to understand the ~~client~~consumer/individual served and their environment, and embrace values that promote the best services possible to the population. Successful recovery for women requires that the service delivery system integrates substance use disorder treatment, mental health services, recovery supports and, frequently, treatment for past traumatic events. When it is left to the woman seeking treatment to integrate these services, an unnecessary burden is placed on her and her potential for recovery.

To meet the specific needs of women, successful programs begin with an understanding of the emotional growth of women. Current thinking describes a woman's development in terms of the range of relationships in which a woman can engage. This is very different from the theories of emotional growth, which have been the basis of substance use disorder treatment, and which apply to the psychological growth of men. The relationship theories for women suggest that the best context for stimulating emotional growth comes from an immersion in empathic, mutual relationships.

The strongest impetus for women seeking treatment is problems in their relationships, especially with their children. A woman's self-esteem is often based on her ability to nurture relationships. Her motivation and willingness to continue treatment is likely to be fueled by her desire to become a better mother, partner, daughter, etc. Programs that meet the needs of women acknowledge this desire to preserve relationships as strength to be built upon, rather than as resistance to treatment. When a program operates from this theoretical point of view, the characteristics of the clinical treatment program, and its objectives and measures of success are defined very differently from those of traditional treatment programs.

The 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~~consumer/individual served 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~~consumer/individual served 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.

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

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~~ Equity does not mean sameness; in other words, ~~equality~~ equity of service delivery is not simply about allowing women access to services traditionally reserved for men. ~~Equality~~ Equity 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~~consumer/individual-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~~consumer/individual served 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 ~~client~~consumers/individuals served~~s~~ 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~~consumer/individual served 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<br>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. |

| | | |
|---|---|---|
| Individual Under Supervision of MDOC and Referred by MDOC or Individual Being Released Directly from an MDOC Without Supervision and Referred by MDOC | Screened & referred w/in 24 hours. Offer admission w/in 14 days. | Begin w/in 48 business hours: Early Intervention Clinical Services Recovery Coach Services~~Individual Under Supervision of MDOC and Referred by MDOC or Individual Being Released Directly from an MDOC Without Supervision and Referred by MDOC~~ |
| 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 ~~client~~consumers/individuals served~~s~~. 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~~consumer/individual's ~~'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~~consumer/individual served 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.
   - Incorporating Adverse Childhood Events (ACEs) into such work is an essential consideration; see Resources for a helpful tool from the CDC.

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 ~~client~~consumers/individuals served~~s~~ themselves. Agencies will include informal supports in the treatment process when it is in the best interest of the ~~client~~consumer/individual served.
   - 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~~consumer/individual served and her children, including completing the Fetal Alcohol Syndrome Disorder (MDHHS: FASD POLICY #11, 2009) screening as appropriate
   - make appropriate referrals, and document ~~client~~consumer/individual served 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~~infections. 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~~consumer/individual'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~~consumer/individual served 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~~consumer/individual served 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~~consumer/individual served 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~~consumer/individual'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~~consumer/individual served 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~~consumer/individual served build a supportive relationship with the community.

11. Continuing Care/Recovery Support
Providers shall:
- Develop a recovery/continuing care plan with the ~~client~~consumer/individual served to address and plan for the ~~client~~consumer/individual's continuing care needs.
- Make and document appropriate referrals as part of the continuing care/recovery plan and remain available to the ~~client~~consumer/individual served 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". Men with dependent children are also eligible for this program's ancillary services; see VI. Standards above.

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~~consumer/individual served 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.

As part of this work, a set of guiding principles has been developed to describe the values and elements that Michigan wants this new system to have. The Enhanced Women's Services Treatment model, with its peer focus and strategies that include treatment, prevention, and recovery services delivered in a community-based setting, demonstrates the critical components of a ROSC. The long-term support gives ~~client~~consumers/individuals served~~s~~ a stable basis for a future healthy lifestyle without the need to use or abuse alcohol and drugs. Enhanced Women's Services Treatment also fits into identified practices in the ROSC transformation process, including peer-based recovery support services, strengthening the relationship with community, promoting health and wellness, expanding focus of services and support, using appropriate dose/duration of services, and increasing post-treatment checkups and support.

As part of sustaining evidence-based practices and core components of the Enhanced Women's Services Treatment model, a technical advisory has been developed to provide guidance on implementing enhanced women's services in the state. This technical advisory identifies core components needed for implementation of enhanced women's services and should be considered as a supplement to the OROSC Women's Treatment Policy (OROSC Treatment Policy #12). In addition, implementation of these services can also serve as evidence of ROSC transformation.

**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 ~~client~~consumers/individuals served~~s~~. 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 ~~client~~consumers/individuals served~~s~~ 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. Another ~~second~~ core component is the persistence with which the peer advocates stay in touch with their ~~client~~consumers/individuals served~~s~~. 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 ~~client~~consumers/individuals served~~s~~ when they have unexpectedly moved and will utilize emergency contacts provided by the ~~client~~consumer/individual served 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~~consumer/individual served characteristics that include, but are not limited to age, gender, culture, and development. As a ~~client~~consumer/individual's needs change, the frequency,

and/or duration of services may be increased or decreased as medically necessary. ~~Client~~Consumer/individual served 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 ~~client~~consumers/individuals served~~s~~ who are "lost" or drop out of the program, and efforts made to re-engage the ~~client~~consumer/individual served in services.
6. Coordinate service plan with extended family and other providers in the ~~client~~consumer/individual's life.
7. Coordinate primary and behavioral health.
8. Utilize motivational interviewing and stages of change model tools and techniques to help ~~client~~consumers/individuals served~~s~~ define and evaluate personal goals every three months.
9. Provide services from a strength-based, relational theory perspective.
10. Link and refer ~~client~~consumers/individuals served~~s~~ to appropriate community services for ~~client~~consumers/individuals served~~s~~ 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 ~~client~~consumers/individuals served~~s~~ to access local transportation and finding permanent solutions to transportation challenges.
14. Peer advocates' billable time for transporting ~~client~~consumers/individuals served~~s~~ to and from relevant appointments is allowable and encouraged. ~~14.~~
~~14.~~15. Develop referral agreement with community agency to provide family planning options and instruction.
16. 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).
~~15.~~17. ~~16.~~ Identify ~~client~~consumers/individuals served~~s~~ in Enhanced Women's Services programming with the "HD" modifier.

**Education/Training of Staff, including 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~~
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 | |
| 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 | |
| | | |
| | | |

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| Community Mental Health Partnership of Southeast Michigan PIHP | *Policy*<br>Women's Specialty Treatment Services |
|---|---|
| Department: Substance Use Disorders | Regional Operations Committee Review Date<br>8/2/2021 |
| Implementation Date | Oversight Policy Board Approval Date |

## 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 | MODIFICATION |
|---|---|
| 1/2016 | Revised language |
| 9/2016 | Language updates |
| 11/2019 | Language updates and addition of Enhanced Women's Services criteria |
| 9/23/2021 | Language and source document updates; addition of MDOC priority population |

## 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 consumer/individual served 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 consumer/individual's home or in other venues, including while providing transportation to and from other appointments.

Core Components - those elements of an evidence-based program that are integral and essential to assure fidelity to a project, and that must be provided.

Eligible: Pregnant women and women with dependent children, including women who are attempting to regain custody of their children. Men with dependent children are also eligible for this program's ancillary services; see VI. Standards below.

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 consumer/individual served 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 consumer/individual's motivation to participate in treatment. Treatment planning requires an understanding that each consumer/individual served is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each consumer/individual served and be specific to the diagnostic impression and assessment.

OROSC – Office of Recovery Oriented Systems of Care, within the Behavioral Health and Developmental Disabilities Administration (BHDDA), 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 consumer/individual served.

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 consumer/individual served 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* consumers/individuals served 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, 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. The ancillary services in this program can also be provided to men who are primary caregivers.

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 childcare, transportation, case management, therapeutic interventions for children, and primary medical and pediatric care, as defined by 45 CFR Part 96.

To be able to offer services that are gender and culturally competent, it is important to understand the consumer/individual served and their environment and embrace values that promote the best services possible to the population. Successful recovery for women requires that the service delivery system integrates substance use disorder treatment, mental health services, recovery supports and, frequently, treatment for past traumatic

events. When it is left to the woman seeking treatment to integrate these services, an unnecessary burden is placed on her and her potential for recovery.

To meet the specific needs of women, successful programs begin with an understanding of the emotional growth of women. Current thinking describes a woman's development in terms of the range of relationships in which a woman can engage. This is very different from the theories of emotional growth, which have been the basis of substance use disorder treatment, and which apply to the psychological growth of men. The relationship theories for women suggest that the best context for stimulating emotional growth comes from an immersion in empathic, mutual relationships.

The strongest impetus for women seeking treatment is problems in their relationships, especially with their children. A woman's self-esteem is often based on her ability to nurture relationships. Her motivation and willingness to continue treatment is likely to be fueled by her desire to become a better mother, partner, daughter, etc. Programs that meet the needs of women acknowledge this desire to preserve relationships as strength to be built upon, rather than as resistance to treatment. When a program operates from this theoretical point of view, the characteristics of the clinical treatment program, and its objectives and measures of success are defined very differently from those of traditional treatment programs.

The 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 consumer/individual served 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 consumer/individual served 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.

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

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.
   - Equity does not mean sameness; in other words, equity of service delivery is not simply about allowing women access to services traditionally reserved for men. Equity 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 consumer/individual-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 consumer/individual served 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 consumers/individuals served 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 consumer/individual served 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
- Trauma
- Grief
- Relationships
- Parenting
- Child Development
- Self-esteem/empowerment
- Relational treatment model
- Women in the criminal justice system
- 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. 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: Early Intervention Clinical Services. |

| | | |
|---|---|---|
| Individual Under Supervision of MDOC and Referred by MDOC or Individual Being Released Directly from an MDOC Without Supervision and Referred by MDOC | Screened & referred w/in 24 hours.<br>Offer admission w/in 14 days. | Begin w/in 48 business hours:<br>Early Intervention Clinical Services<br>Recovery Coach Services |
| All Others | Screened and referred within seven calendar days.<br>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 consumers/individuals served. 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 childcare, transportation, hours of operation and mental health concerns.

2. Assessment
   Assessment shall be a continuous process that evaluates the consumer/individual'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 consumer/individual served 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.
   - Incorporating Adverse Childhood Events (ACEs) into such work is an essential consideration; see Resources for a helpful tool from the CDC.

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 consumers/individuals served themselves. Agencies will include informal supports in the treatment process when it is in the best interest of the consumer/individual served.
   - 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 consumer/individual served and her children, including completing the Fetal Alcohol Syndrome Disorder (MDHHS: FASD POLICY #11, 2009) screening as appropriate
- make appropriate referrals, and document consumer/individual served 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 infections. 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 consumer/individual'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 consumer/individual served 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 consumer/individual served 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 consumer/individual served 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 consumer/individual'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 consumer/individual served 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 consumer/individual served build a supportive relationship with the community.

11. Continuing Care/Recovery Support

Providers shall:

- Develop a recovery/continuing care plan with the consumer/individual served to address and plan for the consumer/individual's continuing care needs.
- Make and document appropriate referrals as part of the continuing care/recovery plan and remain available to the consumer/individual served 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". Men with dependent children are also eligible for this program's ancillary services; see VI. Standards above.

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 consumer/individual served 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.

As part of this work, a set of guiding principles has been developed to describe the values and elements that Michigan wants this new system to have. The Enhanced Women's Services Treatment model, with its peer focus and strategies that include treatment, prevention, and recovery services delivered in a community-based setting, demonstrates the critical components of a ROSC. The long-term support gives consumers/individuals served a stable basis for a future healthy lifestyle without the need to use or abuse alcohol and drugs. Enhanced Women's Services Treatment also fits into identified practices in the ROSC transformation process, including peer-based recovery support services, strengthening the relationship with community, promoting health and wellness, expanding focus of services and support, using appropriate dose/duration of services, and increasing post-treatment checkups and support.

As part of sustaining evidence-based practices and core components of the Enhanced Women's Services Treatment model, a technical advisory has been developed to provide guidance on implementing enhanced women's services in the state. This technical advisory identifies core components needed for implementation of enhanced women's services and should be considered as a supplement to the OROSC Women's Treatment Policy (OROSC Treatment Policy #12). In addition, implementation of these services can also serve as evidence of ROSC transformation.

**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 consumers/individuals served. 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 consumers/individuals served 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. Another core component is the persistence with which the peer advocates stay in touch with their consumers/individuals served. 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 consumers/individuals served when they have unexpectedly moved and will utilize emergency contacts provided by the consumer/individual served 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 consumer/individual served characteristics that include, but are not limited to age, gender, culture, and development. As a consumer/individual's needs change, the frequency, and/or duration of services may be increased or decreased as medically necessary. Consumer/individual served 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 consumers/individuals served who are “lost” or drop out of the program, and efforts made to re-engage the consumer/individual served in services.
6. Coordinate service plan with extended family and other providers in the consumer/individual’s life.
7. Coordinate primary and behavioral health.
8. Utilize motivational interviewing and stages of change model tools and techniques to help consumers/individuals served define and evaluate personal goals every three months.
9. Provide services from a strength-based, relational theory perspective.
10. Link and refer consumers/individuals served to appropriate community services for consumers/individuals served 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 consumers/individuals served to access local transportation and finding permanent solutions to transportation challenges.
14. Peer advocates' billable time for transporting consumers/individuals served to and from relevant appointments is allowable and encouraged.
15. Develop referral agreement with community agency to provide family planning options and instruction.
16. 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).
17. Identify consumers/individuals served in Enhanced Women’s Services programming with the “HD” modifier.

**Education/Training of Staff, including 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

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 | |
| 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 | |

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| Community Mental Health Partnership of Southeast Michigan/PIHP | *Policy*<br><br>Welcoming Policy |
|---|---|
| Department: Substance Use Services<br>~~Author: Marci Scalera/Anne Marshall~~ | Regional Operations Committee Review Date<br>8/2/2021 |
| Implementation Date | Oversight Policy Board Approval Date |

## 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 | MODIFICATION |
|---|---|
| 10/2006 | Original policy |
| 10/2009 | Language modification |
| 2/2012 | Language modification |
| 8/2016 | Language modification |
| 11/2019 | Language modification |
| 9/23/2021 | 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 o~~O~~f 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~~Consumer/individual served: 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.

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## 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~~consumer/individual served 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 ~~client~~consumer/individual served seeking treatment ~~seeking client~~consumer/individual served ~~-~~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 the MDHHS OROSC Technical Advisory on Welcoming (2020) and the 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. Welcoming principles extend to include all ~~client~~consumers/individuals served~~s~~ of an agency (the individual, their family/advocates, referral sources and agency staff)

## 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~~consumer/individual served. Welcoming is also considered a best practice for programs that serve ~~client~~consumers/individuals served~~s~~ with co-occurring mental health and substance use disorders.

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 "~~client~~consumers/individuals served~~s~~" 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 ~~client~~consumers/individuals served~~s~~; 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 ~~recipient~~consumers/individuals served~~s~~ 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~~challenges, 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 client~~consumer/individual served 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 ~~client~~consumer/individual served receiving service~~s recipient~~.
- Consideration is given to administrative details such as sharing ~~paperwork~~ information across providers, ongoing review to streamline ~~paperwork~~ information to what is essential and necessary ~~information~~.
- A welcoming system is capable of providing follow-up and assistance to a ~~client~~consumer/individual served ~~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~~consumer/individual served receive training and develop skills that improve engagement in the treatment process.

- All ~~paperwork~~ information collected has purpose and represents added value. Ingredients to managing ~~paperwork~~ such information 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 client~~consumer/individual served 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~~consumer/individual served ~~client~~consumer/individual's ~~s'~~ boundaries in regards to personal questions and personal space.
- Staff uses attentive behavior, listening with empathy not sympathy.
- Staff have cultural competence/humility and ensure services are accessible to ~~client~~consumers/individuals served~~s~~ in an equitable way that meets the cultural needs of ~~client~~consumers/individuals served~~s~~ as much as possible. Staff cultural competence training is required.

It is expected all CMHSPs and substance use disorder treatment providers implement and maintain welcoming principles.

It is essential that cultural competence/humility is addressed to ensure equitable access and feelings of welcoming across all cultures throughout all levels of services.

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**

| **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 | | |

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~~*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~~

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*National Institutes of Health "Clear Communication; Cultural Respect;" (2021)* https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/cultural-respect

*SAMHSA TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders (2020)* https://store.samhsa.gov/product/tip-42-substance-use-treatment-persons-co-occurring-disorders/PEP20-02-01-0

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|---|---|---|
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| Michigan Department of Health and Human | X | |

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|---|---|---|
| ~~Services (MDHHs) Medicaid Contract~~ | | |
| ~~MDHHS Contract~~ | ~~X~~ | |
| ~~Michigan Medicaid Provider Manual~~ | | |

| **Community Mental Health Partnership of Southeast Michigan/PIHP** | ***Policy***<br><br>**Welcoming Policy** |
|---|---|
| **Department: Substance Use Services** | **Regional Operations Committee Review Date 8/2/2021** |
| **Implementation Date** | **Oversight Policy Board Approval Date** |

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| 45 CFR Parts 160 & 164 (HIPAA) | | |
| 42 CFR Part 2 (Substance Abuse) | X | |

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| Michigan Department of Health and Human Services (MDHHs) Medicaid Contract | X | |
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| Michigan Medicaid Provider Manual | | |

*5 Promising Practices.* Network for the Improvement of Addiction Treatment website: www.NIATx.net

Mee-Lee, David. Training & Consulting website: https://www.davidmeelee.com/

MDHHS Substance Use Disorder Services Technical Advisories, *Treatment Policy #5, Welcoming* (2020) https://www.michigan.gov/documents/mdch/TA_Treatment_05_Welcoming_175207_7.pdf

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**COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN**
**REGULAR BOARD MEETING MINUTES**
**September 8, 2021**
***Meeting held electronically via Zoom**

**Members Present:** (physical location) Judy Ackley (Ann Arbor, MI), Susan Fortney (Ida, MI), Roxanne Garber (Howell, MI), Bob King (Ann Arbor, MI), Sandra Libstorff (Monroe, MI), Molly Welch Marahar (Ann Arbor, MI), Randy Richardville (Monroe, MI), Mary Serio (Howell, MI), Sharon Slaton (Brighton Township, MI), Ralph Tillotson (Adrian, MI)

**Members Absent:** Greg Adams, Katie Scott

**Staff Present:** Kathryn Szewczuk, Stephannie Weary, James Colaianne, CJ Witherow, Matt Berg, Lisa Jennings, Nicole Adelman, Connie Conklin, Mike Harding, Taylor Gerdman, Dana Darrow

**Guests Present:**

I. Call to Order
Meeting called to order at 6:06 p.m. by Board Chair S. Slaton.

II. Roll Call
- An electronic quorum of members present was confirmed.

III. Consideration to Adopt the Agenda as Presented
**Motion by R. Tillotson, supported by M. Serio, to approve the agenda**
**Motion carried**
Voice vote, no nays

IV. Consideration to Approve the Minutes of the August 11, 2021 Regular Meeting and Waive the Reading Thereof
**Motion by S. Fortney, supported by R. Garber, to approve the minutes of the August 11, 2021 regular meeting and waive the reading thereof**
**Motion carried**
Voice vote, no nays

V. Audience Participation
None

VI. Old Business
a. Board Review – September Finance Report – FY2021 as of July 31st
   - M. Berg presented. Discussion followed.

VII. New Business
a. Board Action – FY2021 Contracts
   **Motion by R. Garber, supported by B. King, to authorize the CEO to execute the contract amendment for MILO Detroit as presented**
   **Motion carried**

Vote
Yes: Ackley, Fortney, Garber, King, Libstorff, Welch Marahar, Richardville, Serio, Slaton, Tillotson
No:
Absent: Adams, Scott

b. Board Action - October 2021 Provider Premium Pay Extension
**Motion by R. Tillotson, supported by B. King to approve the pass through of $1,288,802.96 in funding from the CMHPSM to cover the regional extension of provider premium pay for the month of October 2021**
**Motion carried**
Vote
Yes: Ackley, Fortney, Garber, King, Libstorff, Welch Marahar, Richardville, Serio, Slaton, Tillotson
No:
Absent: Adams, Scott

c. Board Action - FY2022 Budget
**Motion by B. King, supported by R. Garber, to approve the Fiscal Year 2022 budget and allocations as presented, including authorization for the CMHPSM CEO to sign the included FY2022 expense contracts**
**Motion carried**
Vote
Yes: Ackley, Fortney, Garber, King, Libstorff, Welch Marahar, Richardville, Serio, Slaton, Tillotson
No:
Absent: Adams, Scott

d. Board Action - FY2022 Contract List
- The FY2022 Contract list was approved in the Board approval of the FY2022 Budget.

e. Board Action - CMHPSM Retirement Plan Vendor Change
**Motion by B. King, supported by M. Welch Marahar, to authorize the CMHPSM Regional Board Secretary to sign three distinct resolutions authorizing a transition of the CMHPSM's 401a and 457 defined contribution retirement plans to the Municipal Employees' Retirement System (MERS) effective September 8, 2021**
**Motion carried**
Vote
Yes: Ackley, Fortney, Garber, King, Libstorff, Welch Marahar, Richardville, Serio, Slaton, Tillotson
No:
Absent: Adams, Scott

f. Board Action - Employee Handbook
**Motion by B. King, supported by J. Ackley, to approve the CMHPSM employee handbook with the included revisions**
**Motion carried**
Vote
Yes: Ackley, Fortney, Garber, King, Libstorff, Welch Marahar, Richardville, Serio, Slaton, Tillotson

No:
Absent: Adams, Scott

g. Board Action - Election Chair/Committee for October Officers Election
   - Caroline Richardson has resigned from both the CMH and Regional Boards. The Regional Board would like to acknowledge Ms. Richardson's years of service on the board. Staff will develop a proclamation for the board's review and approval.
   - R. Garber volunteered to serve as the Election Chair for next month's election.

VIII. Reports to the CMHPSM Board
   a. Report from the SUD Oversight Policy Board (OPB)
      - J. Colaianne provided an overview of the August OPB meeting.
   b. CEO Report to the Board
      - J. Colaianne presented the CEO Report, which included updates from the CMHPSM, Region, and State. See CEO report in packet for details.

IX. Adjournment

**Motion by R. Tillotson, supported by M. Welch Marahar, to adjourn the meeting**
**Motion carried**

Meeting adjourned at 7:36 p.m.

_____
Judy Ackley, CMHPSM Board Secretary

# CEO Report

## Community Mental Health Partnership of Southeast Michigan

## Submitted to the CMHPSM Board of Directors

**September 1, 2021 for the September 8, 2021 Meeting**

## *CMHPSM Update*

- Our most recent CMHPSM all staff meeting was held on August 9, 2021.
- The CMHPSM leadership team is continuing to meet on a weekly basis while we are working remotely.
- Staff are continuing the redesign of the CMHPSM website and will begin an effort on standardizing formatting and design across our web presence. Updates with redesigned pages are published on Friday afternoons.

## *COVID-19 Update*

- The CMHPSM office continues to be closed to the public and recently moved backwards to the orange level on August 31, 2021. Washtenaw County has moved into a high transmissibility status and is recommending masks for everyone while indoors. We determined that the benefits of coming to the office in a hybrid status were lost if masks were required in our personal offices. The most recent version of the re-opening plan is continually shared with staff as it is updated. The leadership team is continuing to review statewide and county guidance related to best practices.
- We hope to move back to the hybrid capacity at the end of September and will continue to monitor recommendations around the projected return to full office capacity.

**Re-Opening Plan Phases as of August 31, 2021**

| **Phase:** | **Essential Only Capacity** | **Limited Capacity** | **Reduced Capacity** | **Full Capacity** |
|---|---|---|---|---|
| **Office:** | **Office Closed** | **Limited Office Attendance and Office Closed to Public** | **50% Capacity – 75% Capacity and Office Closed to Public** | **100% Capacity – Office Open to Public** |
| **Projected Date Range for Phase:** | | 8/31/2021-9/24/2021 (Projected) | 9/27/2021 (Projected) | |
| **Current Phase:** | | **X** | | |

## *CMHPSM Staffing Update*

- The CMHPSM recently hired a very strong candidate for the Substance Use Services Program Coordinator position. We are excited to have Danielle Brunk join our team later this month.
- We unfortunately have received notice from Victor Absil that he accepted another position and will be leaving us on September 10, 2021. We wish Victor well in his new position but will miss his valuable contributions to quality and compliance across the region.
- The CMHPSM has multiple open positions and is accepting applications for:
  - Supports Intensity Scale Assessor (Accepted applications through 9/17/2021)
  - Veteran Peer Support Specialist (Accepted applications through 9/17/2021)
  - Opioid Health Home Coordinator (Accepted applications through 8/30/2021)
  - Compliance and Quality Manager (Just Posted - Accepting applications)

More information and links to job descriptions and application information can be found here: https://www.cmhpsm.org/interested-in-employment

## *Regional Update*

- The CMHPSM continues to update our general COVID-19 resources and information on our website: https://www.cmhpsm.org/covid19
- We have also established a webpage for provider information related to service delivery changes during this pandemic: https://www.cmhpsm.org/covid19provider
- Individuals receiving Behavioral Health and/or Substance Use Disorder services can access targeted information at the following webpage: https://www.cmhpsm.org/covid19consumers
- Our regional committees continue to meet using remote meeting technology, the Regional Operations Committee will work with our committees to determine best practices moving forward related to in-person versus remote regional committee meetings.
- The Regional Operations Committee continues to meet on at least a weekly basis. The remote meetings are allowing our region to share best practices while obtaining a regional picture of our COVID-19 pandemic response.

## *Statewide Update*

- The CMHPSM submitted our regional provider network stabilization status update for August 2021. We will continue to work with the regional CMHSPs to maintain provider network stability. There has been an increase in turnover from providers and many reports of staffing struggles from providers to our Network Management committee. Our region continues to meet regionally and advocate with all stakeholders on the necessity of provider stability to the health and safety of our individuals.
- The PIHP has been represented at weekly meetings with BHDDA related to COVID-19 pandemic responses that began in mid-March 2020. These meetings have been helpful in ascertaining the MDHHS response to COVID-19 and to provide our region's input to BHDDA. Beginning in July the meetings have transitioned to a bi-weekly schedule.
- PIHP CEO meetings are being held remotely on a monthly basis. We last met on September 1, 2021 and our next meeting is scheduled for October 6, 2021.
- The most recent PIHP CEO / MDHHS operations meeting is scheduled for September 2, 2021 with BHDDA staff, our next meeting is scheduled for October 7, 2021. Included in the meetings are updates on the various emergency waivers and MDHHS COVID funding that impact our service delivery systems, funding, and requirements. I provide a summary of those meetings to our regional directors at our Regional Operations Committee meetings each month.
- Legislation was introduced on July 15, 2021 to the seldom used Senate Government Operations Committee by Senator Mike Shirkey. The proposed bills Senate Bills 597 and 598 are related to proposed behavioral health system redesign that is very similar to the failed 298 initiative. A Senate committee hearing was cancelled for August 31, 2021, another hearing is scheduled for September 14, 2021.
- The legislation in the House of Representatives is still expected to move out of the committee in the fall of 2021. More information on the legislation will likely come out this summer as revisions to the bills are undertaken. The House is set to come back into session the second week of September.
- The FY2022 State of Michigan budget has yet to be passed into law as of the writing of this report. The latest update we have is that there is still supposedly agreement on the inclusion of direct care wage passthrough funding for FY2022. Most sources are indicating that a budget will be passed in the first two weeks of September.

## *Future Business*

- Staff are attending many Certified Community Behavioral Health Clinic (CCBHC) meetings related to re-implementation in Washtenaw. We are working closely with Washtenaw CMH and MDHHS on this project.
- The SUD team is continuing to plan for the Opioid Health Home (OHH) project in Washtenaw, with a projected October 1, 2021 start date.

Respectfully Submitted,

James Colaianne, MPA