



Washtenaw County Community Mental Health (WCCMH) is the primary community mental health provider in Washtenaw County for individuals living with a serious mental illness, a developmental disability or children with a serious emotional disturbance. WCCMH is eligibility based and mandated to prioritize the needs of individuals who have Medicaid, no insurance and/or urgent or emergent needs.

**The starting point for services at WCCMH is the 24/7 Access/Crisis Department at 734-544-3050.**

Clients and interested parties can contact the Access/Crisis Department 24/7, 365 days per year to receive information, referral to community resources, access to crisis services and to complete brief screenings for WCCMH services and scheduling for a face to face eligibility determination/level of care determination for WCCMH services and supports.

### ***WCCMH Access/Crisis Services***

*Program Administrator: Lisa Gentz, MSW*

- 24/7 access to services
- 24/7 access to information and referral regarding behavioral health and substance abuse services
- 24/7 crisis line
- 24/7 mobile crisis services
- Eligibility determination and level of care assessments
- Inpatient authorization for Medicaid and uninsured individuals
- Suicide risk assessment
- Petition for involuntary hospitalization and pick up order services
- Crisis planning
- Crisis stabilization and support

24/7 phone services and mobile crisis services are available to any Washtenaw County Resident and can be accessed by calling 734-544-3050. WCCMH services are available to those individuals who meet criteria, have Medicaid and/or appear to have urgent/emergent needs which could result in harm if not addressed within 48 hours of the request. Michigan Department of Health and Human Services (MDHHS) and the

Medicaid Provider Manual set the three priority populations group definitions and priority categories for WCCMH.

**Crisis Residential Services (CRS)** is a six bed, 24/7 crisis home intended as a short term alternative to inpatient psychiatric services for individuals experiencing an acute psychiatric crisis. Individuals need to meet inpatient criteria but can be served in a setting that is less intensive than an inpatient hospital. CRS services include:

- Psychiatric supervision
- Therapeutic supports
- Nursing services
- Case management
- Behavioral services
- Medication management, stabilization and education

***WCCMH services generally fall under 4 major programs:***

- Adult Mental Health (includes co-occurring conditions)
- DD Services (Developmental Disabilities)
- Youth & Family Services
- Integrated Health

***WCCMH also has many specialty programs with three of note being:***

- Jail Services
- PORT/PATH
- OBRA

## ***Adults living with a Mental Health and/or Co-occurring Condition***

*Program Administrator: John Shovels, MSW*

### **Clinical Case Management**

Client Services Management (also known as case management - CSM) is provided in a range of intensities to meet individual needs. The CSM provides a leadership role to the entire clinical team by facilitating the development of the individual plan of service. In addition, they provide services including, assessment; linking and coordination (e.g. financial needs, entitlements, benefits, housing, relationships, food, health and safety, etc.); monitoring of supports and services; advocacy services; access and provision of emergency assistance; pro-active problem solving; and mobilizing natural supports including family.

### **Outpatient Medications**

WCCMH psychiatrists and nurse practitioners provide psychiatric evaluation, consultation, diagnostic, and psychotropic prescriptions. Medication review appointments assist with monitoring efficacy and clinical status. Nursing staff provide coordination of medication reviews, education regarding medication, benefits and side-effects, training of paid or non-paid caregivers in the handling and administration of medication, and coordination with primary health care. Consultation may occur in the context of team meetings, medication reviews, and informal and formal discussions regarding clients.

### **Assertive Community Treatment (ACT)**

Assertive Community Treatment (ACT) is a team of psychiatrists, nurses, peer support specialists and case managers that provide intensive community support and medication monitoring for adults with severe mental illness who require intensive services to maintain community living.

### **Residential Services**

Residential Services are designed to address the needs of consumers living in community housing settings including licensed group homes, specialized housing programs and home based settings (apartments, houses). The team includes psychiatrists, nurses, case managers, mental health professionals and psychologists.

### **Therapy**

WCCMH offers many different types of therapy services including Dialectical Behavior Therapy (DBT), Integrated Dual Disorders Treatment, Solution Focused Therapy, Trauma Specific Therapy and Acceptance and Commitment Therapy (ACT). Referrals for therapy come from all members of the clinical service teams.

## ***Adults with Developmental Disabilities***

*Program Administrator: Krista Diephuis, MSW*

### **Supports Coordination**

Case management services – linking to, coordinating with, follow-up of, and advocacy with all supports and services. They develop an Individual Plan of Service (IPOS) using the person-centered planning process and update as the individual desires.

### **Psychology**

Behavioral psychologists can provide behavioral assessments and behavior treatment plans as a way to reduce and eliminate maladaptive behaviors.

### **Psychiatry**

Psychiatrists can complete an evaluation and then ongoing monitoring of medications, their side effects and the need for continuing or changing medications for individuals with a need for psychiatry services.

### **Nursing**

Nurses will provide annual personal health reviews and provide guidelines for health related concerns an individual might have.

### **Occupational Therapy (OT)**

WCCMH currently has 1 OT on staff. The OT is available to complete assessments and provide guidelines for skilled OT interventions.

### **Dietary**

WCCMH DD service currently has 1 part-time dietician on staff. The dietician will assist with assessment and recommendations for nutritional changes to improve health related goals.

### **Community Living Supports (CLS)**

CLS is a service that facilitates an individual's independence, productivity, and promoted inclusion and participation. These hours are used to prompt, remind, observe, guide and train an individual with things such as; meal preparation, laundry, activities of daily living, shopping for food and other necessities, community activities and money management. CLS is a service the WCCMH will authorize and contracted providers will perform the service.

### **Respite**

Respite is short-term, intermittent support for a family that has an individual with a developmental disability living in their home with them. Respite is a service that WCCMH will authorize and contracted providers will perform the service.

### **Supported Employment**

Supported Employment services are to assist and enable individuals that are involved in paid employment in community-based, integrated settings. This could include job coaching for an individual at their worksite or job development to obtain a job. WCCMH has both an internal program and also contracted providers that perform this service.

### **Skill Building**

Skill building is a service that works with the individual to gain, retain or improve in the areas of self-help, socialization and adaptive skills. These skills can be developed with a goal of helping the individual engage in habilitation activities. WCCMH has both an internal program and also contracted providers that perform this service.

## ***Youth and Family Services***

*Program Administrator: Elizabeth Spring, RN, BSW*

### **Outpatient/Targeted Case Management**

Provides children and their families mental health services that are community oriented and family

centered, designed for children who have emotional/behavioral impairments that result in functional limitations in major life domains (Home, School, Work, Peers, etc.). Treatment services include individual and family therapy and case management and may involve multiple clinical/case management contacts per week.

### **Home-based Services**

Provide intensive services to children (age 0-17) and their families who have multiple needs. Services are delivered in the home/community in a manner that emphasizes assertive intervention through a strength based approach focused on the unique needs of the family.

### **Prevention and Home-based Level Infant Mental Health (IMH)**

IMH serves parents who have multiple needs involving children from infancy up to 3 years of age who are at high risk of developing emotional, developmental, or behavioral problems. The primary purpose of the intervention is to promote a positive family/child bond through a combination of case management and therapy to increase the protective factors for the child ensuring positive growth and development.

### **Medicaid Autism Benefit, Applied Behavioral Analysis (ABA)**

ABA services are for children with Medicaid or MIChild health insurance, 18 months through 5 years, with an Autism Spectrum Disorder (ASD) medical diagnosis. ABA treatment can be used to address a number of issues relevant to children with a diagnosis of ASD, including language acquisition, peer interactions and social skills, academic/cognitive skills, and reducing inappropriate behaviors.

### **Child Wavier Program (CWP)**

The CWP enables Medicaid to fund necessary home and community based waiver services for children under 18 who have a developmental disability and meet criteria for an Intermediate Care Facility. Parent income is not considered when the Medicaid eligibility determination is made. Services are family centered and supports are focused on developing skills for the child to function with as much independence as possible and/or to prevent the loss of current abilities.

### **Children's Serious Emotional Development Waiver (SEDW)**

The Children's SEDW enables Medicaid to fund necessary home and community-based services for children with SED who meet the criteria for admission to the state inpatient psychiatric hospital (Hawthorn Center) and are at risk of hospitalization without waiver services. The MDHHS operates the SEDW through contracts with the participating CMHSPs and serves children in foster care in the participating counties including Washtenaw County. The Wraparound Practice Model is the framework used to identify the child/family's strengths, needs and plan all services and interventions.

### **Wraparound Program**

Wraparound involves children who have been diagnosed with serious emotional disturbance and are at risk for out-of-home placement or are currently in out-of-home placement. These children are also being

served by at least two following sectors: Community Mental Health, Department of Human Services, Juvenile Justice, Special Education, and Public Health. Intensive services are provided through a multi-agency integrated plan of service to increase communication across agencies and to improve family positive outcomes identified by the family.

### **Psychiatric Services**

Psychiatric assessments, medication review, nursing services and stabilization are available when clinically appropriate. Referrals are made to primary care physicians when stabilized on medications.

### **Dialectical Behavioral Therapy (DBT)**

This program provides specialized DBT for high risk youths. Services include individual, group, and family treatment. The treatment team may include a psychiatrist, mental health nursing, master's level therapist, and clinical case manager. Outcomes are to improve the youth's functioning across home, school, and social domains while reducing the potential for self-harm and suicidality.

### **Parent Management Training Oregon (PMTO) and Parenting through Change Group (PTC)**

PMTO and PTC Group are evidenced based best practice approaches that recognize the vital role parents play as the primary change agents in their family. With the support and guidance of trained clinicians, parents learn skills to teach/encourage cooperation and pro-social behavior. The identified outcome is for increased positive communication and harmony within families.

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

TF-CBT is evidence based and utilizes best practice consisting of treatment components that are designed to be provided in a flexible and developmentally appropriate manner. Individual sessions and joint parent-child sessions help identify a range of emotions and teach skills for optimizing their children's emotional and behavioral health.

### **Peer Skill Building and Education Support Groups**

Group sessions are held throughout the year that support youth in achieving social, emotional, educational, and skill building goals. Examples include Gardening group; A New Look Girls Self Esteem; Young Males to promote overall health; Math and Science; and Art Groups.

## ***Integrated Health Services***

*Program Administrator: Brandie Hagaman, MPH*

### **Nursing Services**

WCCMH Nursing staffs provide coordination of medication reviews with psychiatrists, education regarding medication and health conditions, benefits and side-effects, training of paid or non-paid caregivers in the handling and administration of medication, and coordination with primary and specialty health care.

Consultation may occur in the context of team meetings, medication reviews, and informal and formal discussions regarding clients. Nursing staff may also liaise with outside and contracted pharmacies.

### **Health Home**

Health Home is a pilot project through MDHHS. This program is a Medicaid benefit program that has state determined eligibility based on chronic health conditions and healthcare utilization. There is a designated enrollment process and a mandatory monthly activity that generates a per member per month payment. The enrolled consumers receive monthly population health management and are tiered into 3 levels based on utilization of Emergency Room and/or Inpatient Admissions to receive additional nursing, peer or dietician services through the Health and Wellness team.

### **Health and Wellness**

The health and wellness team is a dedicated team of nurses, peers, a dietician and nurse practitioner who provide chronic disease management and care coordination activities through individual and/or group wellness activities. The staff offers weekly wellness groups at the Towner and Annex locations plus a variety of community sites. The wellness topics include nutrition, tobacco cessation, walking groups, physical activity, cooking, diabetes, pain management and a Health Matters group.

### **Integrated Health**

The Integrated Health program is a partnership with primary care community clinics to provide mental health services both social work and limited psychiatry by WCCMH staff at the designated sites. Currently, Packard Health is our only clinic due to a cut in funding. The WCCMH staff at Packard work in partnership with the providers to identify, treat and coordinate mental health services for the patients. Mental health services could include community resources, on site social work/psychiatry which provides brief therapy, psychiatry and medication evaluations, minimal case management or to coordinate with WCCMH if consumer meets eligibility for serious mental illness.

## ***Jail Services***

*Program Administrator: John Shovels, MSW*

Services for individuals with a mental illness involved in the criminal justice system is mandated in the Mental Health Code (MCL 330.2002a) and further defined by a 2005 DCH administrative directive. This includes jail diversion which is an essential collaborative service that brings the mental health and justice systems together to meet the needs of shared clients. WCCMH has provided services in the Washtenaw County Jail since the 1980s and formalized pre and post jail diversion since 2005.

**Criteria:** Single adults in Washtenaw County who have a mental illness, co-occurring, or developmental disability and in need of jail diversion or jail services.

**Requirements:** Early identification of individuals, pre-booking liaison to work with all agencies identified, written interagency agreements, cross training for law enforcement and mental health, maintaining a

management information system, jail screening in first 24-48 hours of detention, in-jail treatment and post jail diversion.

**Pre and post jail diversion services:** Includes collaboration with several entities to prevent incarceration or to obtain early release to more appropriate services.

Partners include:

- 14-A District Court Ypsilanti
- 14-B District Court Ypsilanti
- 15<sup>th</sup> District Court Ann Arbor
- Street Outreach Specialty Court
- Sobriety Specialty Court
- Mental Health Court
- 15<sup>th</sup> District Probation
- 22 Circuit Court Ann Arbor
- Ann Arbor Police Department
- Ypsilanti Police Department
- Saline Police Department
- Chelsea Police Department
- Milan Police Department
- Washtenaw County Sheriff's Office
- Community Corrections
- Washtenaw County Prosecutor
- Washtenaw County Public Defender

**WCCMH Jail services:**

- Every inmate is screened upon incarceration using the National GAINS Center Brief Jail Mental Health Screen
- Referrals are received from inmates, judges, probation officers, medical team, and jail officers.
- 15 hours of psychiatric clinic services
- 3 masters level mental health clinicians and a jail clinical supervisor at the jail
- Mental health assessments
- Suicide assessments
- Psychiatric assessments, treatment and medication
- Women's trauma groups
- Post jail diversion/ Discharge Planning



## ***PORT/PATH***

*Program Administrator: John Shovels, MSW*

The Project Outreach Team (PORT) is an intensive community outreach team that receives its funding from two distinct sources.

The first is a PATH grant (Projects for Assistance in Transition from Homelessness). This program is administered by the Center for Mental Health Services, a component of the Substance Abuse and Mental Health Services Administration (SAMHSA), which is one of eight Public Health Service agencies within the U.S. Department of Health and Human Services. The PATH program was authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990. The second funding source is the Coordinated Funding from the City of Ann Arbor and Washtenaw County.

PORT serves individuals in Washtenaw County who are homeless, suffer from a mental illness and are not already connected to services. Not expecting clients to come to us, PORT makes a commitment to meet the client where he or she is both physically, psychologically and socially. PORT's mission is to engage, treat, and transition clients to mainstream services. Positive engagement and outreach are the most important aspects of PORT's approach.

In addition to the intensive outreach and trust building, some of the services offered by PORT include:

- Housing Location-Assistance with Obtaining and Maintaining Housing
- Individual, Holistic Support Planning
- Integrated Psychiatric Services
- Crisis Management
- Community Based Advocacy
- Ongoing Case Management Services and help to Build Natural Supports in the Community
- Medical Assistance and help with Medical Appointments
- Referrals & Assistance with Various Community Supports and Services Including Mental Health Services
- Assistance with Obtaining & Maintaining Benefits/Entitlements & Insurance
- Assistance with Daily Organizing and Planning/Social Activities to Support Recovery
- Transportation Assistance
- Co-occurring Education & Referral to treatment services
- Peer supports to outreach, engage, and assist in all other aspects of treatment

PORT has the distinction of being the only outreach team in the State of Michigan to be awarded in 2005 the "National Innovative Program of the Year" by the Substance Abuse and Mental Health Services Administration in Washington D.C. PORT is a Michigan Statewide HMIS (Homeless Management Information System) participating agency.

## **OBRA**

*Program Administrator: Brandie Hagaman, MPH*

OBRA (Omnibus Budget Reconciliation Act of 1987) is a Federal mandate and a division of the Michigan Department of Health and Human Services (MDHHS). The Act provides screening for persons with a mental health diagnosis or developmental disability seeking admission to nursing facilities.

The Washtenaw County OBRA's mission is to provide consultation to aging and medically fragile persons and their support systems with the goal of maintaining the person's highest level of functioning in the community in the least restrictive environment. Staff includes social workers, nurses, psychiatrists, psychologists, and occupational therapists that work to comply with the conditions of the WCCMH contract to complete preadmission screenings and annual resident reviews. If an individual or their legal representative decides that there is a need for a nursing facility, a screening will determine the qualification for nursing facility level of care and/or if mental health services are required. The process requires two steps. First, based upon the decision that a nursing facility is needed, the individual's health care provider completes a LEVEL I screening which is a checklist that will aid in determining if they meet the criteria for a LEVEL II screening. Second, a Level II screening is needed if you:

- have a developmental disability
- have a current mental health diagnosis
- have received mental health treatment
- are currently prescribed psychotropic medication
- have behaviors indicating a need for mental health services

The LEVEL II screening is a comprehensive evaluation. It may be bypassed if the individual has a primary diagnosis of dementia (unless they have a developmental disability) or if the individual needs 30 days or less nursing facility placement from an inpatient medical hospitalization. The OBRA Federal mandate excludes Alzheimer's disease and other types of dementia from the definition of mental illness.

After The Screening the Michigan Department of Health and Human Services Lansing office will review the recommendations of the OBRA staff following a screening. They determine if a nursing facility placement is appropriate. OBRA staff will notify the individual's health care provider with the determination. An annual review is required to see if the individual still meets criteria. All decisions can be appealed. While the individual is in a nursing facility, OBRA staff may provide:

- mental health monitoring and advocacy
- individual counseling
- medication review and monitoring
- psychiatric case consultation
- Assistance resolving your acute mental health concerns based upon need



## ***WCCMH Vision, Mission and Values***

### ***Vision***

*Individuals have universal access to and participation in high quality, integrated healthcare.*

### ***Mission***

- *Provide high quality, effective integrated behavioral health, physical health, and social support services to persons with Chronic and/or Severe Mental Illness, Co-Occurring Disorders, Developmental Disabilities, Substance Use Disorders, and Severe Emotional Disturbances;*
- *Provide leadership and education to the community;*
- *Develop and provide models to make these integrated services available to all residents of Washtenaw County.*

### ***Values***

- *Consumer and Family Involvement*
  - *Comprehensive, Quality Services*
  - *Community-Based Services*
  - *Public Accountability*
  - *Integrated Care*
  - *Research and Medical Education*
  - *Adaptability*
  - *Washtenaw County Community Mental Health Board Policies*
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- *For more information, please visit our website: [www.ewashtenaw.org/wccmh](http://www.ewashtenaw.org/wccmh)*
  - *Or you may choose to contact Customer Services, Monday – Friday, 8:30 AM to 5:00 PM (excluding holidays) at 734-544-3050 or 1-877-9707*