POLICY

It is the policy of Detroit Wayne Mental Health Authority (DWMHA) that the Managers of Comprehensive Provider Networks (MCPN), the MCPN’s subcontractors, and direct contractors that provide services to children, adolescents, and their families will meet the standards for the Children’s Diagnostic and Treatment Services Program.

PURPOSE

The purpose of this policy is to provide direction to DWMHA contractors, subcontractors, direct contractors and MCPNs in assuring that a comprehensive array of services is available for children and their families.

APPLICATION

1. The following groups are required to implement and adhere to this policy: DWMHA Board, DWMHA Staff, Contractual Staff, Access Center, MCPN Staff, Network Providers, Crisis services vendor, Credentialing Verification Organization (CVO)

2. This policy serves the following populations: Adults, Children, I/DD, SMI/SEI, SED, SUD, Autism

3. This policy impacts the following contracts/service lines: Medicaid, SUD, Autism, Grants, General Fund

KEYWORDS

1. Additional Mental Health Services (B3S)
2. Best Practice
3. Centralized Access Center
4. Central Registry Clearance
5. Child Mental Health Professional (CMHP)
6. Coordination of Care
7. Core Training
8. Devereux Early Childhood Assessment (DECA)
9. Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT):
10. Emergency Referral
11. Evidence-Based Practice (EBP)
12. Family Member
13. Family-Driven
14. Home Based Services
15. Individual Plan of Service (IPOS)
16. Initial Evaluation
17. Initial Screening
18. Maintenance of Certification (MOC)
19. Managers of Comprehensive Provider Networks (MCPN)
20. Medical Necessity
21. Prevention Services
22. Promising Practice
23. Referral
24. Respite
25. Serious Emotional Disturbance (SED)
26. System of Care (SOC)
27. Training for Children’s Diagnostic and Treatment Services Clinicians
28. Wraparound
29. Youth Guided

**STANDARDS**

1. MCPNs, their subcontractors and DWMHA network of providers must ensure that, at a minimum, the following occurs:
   a. Develop and implement policies, procedures, practices and monitoring activities that comply with the Department of Community Health Administrative Rules (subpart 6), and DWMHA policies and procedures for Children’s Diagnostic and Treatment Program.
   b. Provide initial screening, intake evaluations, and emergency evaluations to ascertain the mental health needs of minors.
   c. Provide referrals to the appropriate Authority to meet immediate needs, protection and security for those minor’s located in Wayne County who are residents of another county. Describe how services not directly provided can be accessed.
   d. Have written agreements/arrangements that clarify the respective responsibilities for coordination and provision of services with public and private human service agencies which provide for the educational, judicial and child welfare and other health services agencies.
   e. Maintain a resource listing that identifies programs to which the minors and their families are referred. The listing indicates the types of services provide, eligibility criteria and names and location
of the referral sources.

f. Provide an array of services specifically oriented to meet the needs of minors and their families that include:

1. Diagnostic Services sufficient to develop a Plan of Services; including Screening, Evaluation, Emergency services, Emergency evaluations and Referrals.
2. Case management for the development, coordination, implementation and monitoring of the plan of service.
3. Crisis Stabilization and responses that reduce acute emotional disabilities and their physical and social manifestation in order to ensure safety of the minor, his or her family and others.
4. Out of home treatment that includes both inpatient treatment and community residential treatment.
5. Traditional outpatient mental health treatments for children and their families.
6. Clinical therapies provided for individuals, groups and families.
7. Prevention services and other treatments that provide opportunities to learn, improve and demonstrate specific skills that are appropriate to the child’s needs, which may include problem-solving skills, communication skills and acceptable social skills.
8. Home-based services that can be provided in the minor’s home and/or other community settings.
9. Respite Services providing temporary relief to the caregiver supporting the goal of maintaining the minor in home community.
10. Aftercare services including follow-up services to assist individuals/families after discharge from a hospital, residential facility, or who have received community mental health services.

g. Provide services in locations that are to be accessible through publicly available transportation and in a barrier-free environment.

h. Provide an array of B3 Services that assist the individual to attain outcomes that are typical in his/her community; and without such services and supports goals, and intended outcomes would be impossible to attain.

i. Develop a Family-Centered Plan that addresses the expressed desires and needs of the identified consumer and their family after they have participated in a pre-planning process and a comprehensive evaluation/assessment has been developed. Ensure that the actual provision of each service is documented on an individual basis in the case record according to Person/Family Centered Planning process. Each plan must include the amount, scope and duration of services. The plans will be reviewed according to services provided, as requested by the consumers, but no less than annually.

j. The Family Centered Plan (or IPOS) is the fundamental document in the individual’s record, and must be authenticated by the dated legible signatures of the recipient/authorized representative and the person chosen by the recipient, and named in the plan to be responsible for its implementation. The IPOS consists of a treatment plan and/or a support plan, and may be further characterized as follows:

1. It must satisfy MDHHS guidelines demonstrating adherence to the Person-Centered Planning process and principles.
2. It includes pertinent information from assessments necessary to address the expressed desires and needs prioritized by the recipient, and may include general physical, psychiatric (i.e., mental/psychological, emotional and behavioral) and social examinations. For persons under 26 years of age who have developmental disabilities, the mental examination includes psychometric and educational evaluations as well as assessment of adaptive behavior.

3. It addresses as either desired or required by the consumer/family, his or her need for housing, clothing, health care, employment opportunities, legal services, transportation, and recreation.

4. It is reviewed and updated at intervals specified in the plan which reflect the level of care and intensity of service needs and when requested by the consumer, or required as a result of identified health and safety conditions, but no less than annually. The documented reviews shall contain an analysis of progress regarding objectives and goals that were developed using the PCP process. Updates and the indicated changes are authenticated by the signature of the consumer/authorized representative and the dated legible signature of the person named in the plan as responsible for managing it.

5. It includes any restrictions or limitations of rights placed on the recipient only when these limitations or restrictions are essential to safeguarding the health and safety needs of the individual. All clinically appropriate attempts shall be made to limit or avoid such restrictions or limitations. Actions taken as part of the plan to ameliorate or eliminate the need for the restrictions in the future shall be documented and include specific intermediate and long-range goals, developed with the individual/authorized representative, that specifies the manner in which the facility can improve the consumer’s condition and the projected timetable for attainment of such goals.

6. The person/authorized representative shall receive a copy within 15-business days of the IPOS meeting. Includes, but is not limited to, core demographic and clinical elements.

k. Ensure that families are provided information about accessing respite services and community living supports during the Person/Family Centered Planning process. It should be documented on the pre-planning form, dated and initialed by the families, that they have been offered this service.

l. Shall ensure that all families of children and youth that are Medicaid eligible have information regarding their right to Early Periodic Screening, Diagnostic and Treatment Services (EPSDT). There must be documentation in the case record that is signed by family/guardians that they have been informed of this service, and if requested, assist with accessing this service. If families have accessed this service, clinicians should request copies to be included in the case record.

m. Standardized assessments tools will be utilized to determine level of function and level of care. All Child Mental Health Professionals who provide direct clinical services or supervise clinical Child Mental Health Professionals must be certified to administer the assessment tools specific to their service population. All tools must be administered baseline (30 days of intake), quarterly and discharge.

1. The LOCUS is a required assessment tool for all individuals in the CMHSP system over the age of 18. The LOCUS is to be completed at intake and at reassessment intervals for individuals over the age of 18 receiving services within the children’s mental health service provider network.

2. The CAFAS is a required assessment tool for all children in the CMHSP system, ages 7 through 17 years. The CAFAS is to be completed at intake, quarterly thereafter and at exit for children in this age range receiving behavioral health services.
i. For youth, ages 18-21, that are involved in the SED Waiver and Wraparound, the CAFAS is required.

ii. For a youth qualifying for services under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) from ages 18-21 are also required to have CAFAS.

3. The PECFAS is a required assessment tool for all children in the CMHSP system ages 4 through 6 years. The PECFAS is to be completed at intake, quarterly thereafter and at exit for children in this age range receiving behavioral health.

   i. For young children, ages 3-4, that are involved in the SED Waiver and Wraparound, the PECFAS is required.

4. DECA-I, DECA-T, DECA-C; is used for assessing the social and emotional needs of infants, toddlers and children ages 0 - 47 months.

   i. Infants (DECA I) 0 to 18 months of age
   ii. Toddlers: (DECA-T) 18 to 36 months of age
   iii. Children: (DECA-C) 37 to 47 months of age.

   iv. The DECA is to be completed at intake, quarterly thereafter and at exit for children in this age range receiving behavioral health.

n. Coordinate with other entities that service the youth and their families, i.e., primary care physicians, schools, child welfare, public health, substance use providers, and the juvenile justice system. Include documentation in the case record, which should be a signed release of information form that the coordination has occurred. There should also be documentation in progress notes indicating attempts made to get information from other human service entities including primary care physicians.

o. Maintain formalized workforce development program that assures professional development and training in identifying and treating the needs of minors and their families. Regular review of training requirements and recommendations will occur to ensure special emphasis is made on new and emerging material and practices and outdated material is removed.

p. Certified programs shall be clinically supervised by a Child Mental Health Professional who has at least a master’s degree in a mental health related field with 3 years of clinical experience working with minors and their families.

q. Employ clinicians that are qualified by training and have supervised experience to diagnose and treat children with serious emotional disturbance and/or developmental disabilities, and who meet the requirements for Child Mental Health Professional Credentials, Criminal Background Check and Central Registry. Clearance of the applicants shall be reviewed and verified by the service provider prior to the Clinician providing services to children and their families.

r. Ensure that Child Mental Health Professionals that are contractual staff are held to the same credentialing standards and have the same supporting documentation in their credentialing files of their employers as non-contractual staff.

s. Have Maintenance of Certification documentation in the credentials files of Board Certified Child Psychiatrists.

t. Include toll free, TTY, and TDD telephone numbers on all publicly distributed publications that are distributed to the public.
2. Array of services
   
a. **Home Based Services:** Services are provided in the family home or community. Any contacts that occur other than in the home or community must be clearly explained in case record documentation, the expected duration and the plan to address issues that are preventing the services from being provided in the home and community. Treatment is based on the child's needs, with the focus on the family unit. The service style must support a family-driven and youth-guided approach, emphasizing strength-based, culturally relevant interventions, parent/youth and professional teamwork, and connection with community resources and supports. The organizational structure through which the mental health home-based services program shall be delivered must be specified. The following requirements must be met:

1. Enrolled home-based services providers are available and sufficient to ensure home-based services meet the need across the entire catchment area.

2. Responsibility for directing, coordinating and supervising the staff/program must be assigned to a specific staff position. The supervisor of the staff/program must meet the qualifications of a Qualified Mental Health Professional and be a child mental health professional with three years of clinical experience.

3. Home-based services programs are designed to provide intensive services to children and families in their home and community. The degree of intensity will vary to meet the needs of families.

4. The maximum full-time home-based services worker-to-family ratio is 1:12. This can be adjusted to accommodate families transitioning out of home-based services. The maximum worker-to-family ratio in those circumstances is 1:15 (12 active/ 3 transitioning).

5. If providers wish to utilize clinicians who serve mixed caseloads (home-based services plus other services, e.g., outpatient, case management, etc.), the percentage of each position dedicated to home-based services must be specified. The number of home-based services cases assigned to each partial position cannot exceed the same percentage of the maximum active home-based services caseload. For example, a 50% home-based position could serve no more than 6 home-based cases. The total maximum caseload, including home-based and other services cases, for a full-time clinician serving a mixed caseload is 20 cases.

6. Home-based services professional staff must meet the qualifications of a child mental health professional. The initial training curriculum and 24 hours of annual child-specific training for home-based services staff should be relevant to the age groups served and the needs of the children and families receiving home-based services.

7. Home-based services must be provided in accordance with a plan of service that focuses on the child and his family. The plan of service is a comprehensive plan that identifies child and family strengths and individual needs, determines appropriate interventions and identifies supports and resources.

8. Home-based services programs combine services to restore or enhance social, psychological or biophysical functioning of individuals, couples, or families and/or individual therapy, family therapy, group therapy, crisis intervention, case management, and collateral contacts. The family is defined as immediate or extended family or individual(s) acting in the role of family.

9. Services provided in a home-based services program range from assisting beneficiaries to link to other resources that might provide food, housing, and medical care, as well as providing more therapeutic interventions such as family therapy or individual therapy, or services to
restore or enhance functioning for individuals, couples, or families.

10. Home-based services staff must receive weekly clinical supervision (one-on-one and/or group) to help them navigate the intense needs of the families receiving home-based services. Evidence of the provision of this clinical supervision must be recorded via supervision logs, sign-in sheets, or other methods of documentation. Supervision is provided by a Qualified Mental Health Professional and is a child mental health professional with three years of clinical experience.

11. The organization must have a policy or policies in place that support providing a comprehensive crisis/safety training curriculum that is required for all home-based services staff that includes de-escalation skills among other relevant trainings.

12. There must be an internal mechanism for coordinating and integrating the home-based services with other mental health services, as well as general community services relevant to the needs of the child and family.

13. A minimum of 4 hours of individual and/or family face-to-face home-based services per month will be provided by the primary home-based services worker or, if appropriate, the evidence-based practice therapist. In addition, it is expected that adequate collateral contacts, including non-face-to-face collateral contacts, with school, caregivers, child welfare, court, psychiatrist, etc. will be provided to implement the plan of service.

14. The amount and scope of home-based services to families as they transition out of home-based services into a less intensive service or to case closure can be determined by family-driven and youth-guided decision making to maintain continuity of treatment and ensure stability. Variation from the required intensity of services for families transitioning out of home-based services must be documented in the plan of service. This transition period is not to exceed 3 months.

15. Crisis intervention services must be available 24 hours a day, 7 days a week, via availability of home-based services staff or Authority on-call staff. If after hours crisis intervention services are provided to a family by staff other than the primary home-based services worker, procedures must be in place which provides the on-call staff access to information about any impending crisis situations and the family’s crisis and safety plans.

b. Infant Mental Health: A Home Based Services that is a best practice model that focuses on the caregiver-child dyad. The target population enrolled serves:

1. Women exhibiting psychosocial or medical risk during pregnancy or their infants and toddlers,
2. Adolescent parents and their infants and toddlers,
3. Parents/legal guardian engaged in suspected or substantiated child abuse and neglect and their infants/toddlers,
4. Mentally ill or emotionally disordered parents/legal guardians and their infants/toddlers,
   i. Eligible enrollments are Infants discharged from neonatal intensive care units and their parents, infants/toddlers with developmental delays, and infants/toddlers who are in situations which place them and their parents at risk.
   ii. Characteristics of intervention occur through the modality of home visits; home and office visits, group sessions with structured intervention activities.
   iii. Home visits are a necessary component of the infant mental health service model and all
infant mental health interventions have the following components:

a. The focus of assessment and intervention is the parent-infant dyad, in the context of the family system.

b. Intervention is designed to support and nurture the parent as the primary caregiver, including attention to parental needs, increase in parental self-esteem, and reinforcement of appropriate parent-infant interactions and parental capacity to empathize with infant and/or toddler’s needs.

c. Provision of developmental guidance and information about infant/toddler behavior and child care practices.

d. Facilitate management of real life problems including crisis resolution, linkage to community resources, advocacy, facilitation of problem-solving skills and linkage to informal support systems. Resolution of intra-psychic and family system issues impeding attachment.

c. Parent Management Training Oregon Model (PMTO): PMTO is an evidence-based best practice approach that recognizes the vital role parents play as being the primary change agents within their family. PMTO is tailored for serious behavior problems for youth from preschool through adolescence. In addition, PMTO can be applied to families with complex needs and challenges, e.g. mental health issues, poverty, divorce, etc. Parents are supported and encouraged as they learn skills they can utilize to provide appropriate care, instruction and supervision for their children. Clinicians utilize role-play and problem solving to promote the development of parents’ skills. There are five core components to the PMTO model. They are:

1. encouragement,
2. limit-setting,
3. problem-solving,
4. monitoring, and
5. positive involvement.

d. Serious Emotional Disturbance Waiver (SEDW): SED (Serious Emotional Disturbance) 1915 (c) Waiver is a Home and Community Based Waiver, whose specific purpose is to provide community based services and supports for children in foster care who are under the age of 18, diagnosed with a SED.

1. SEDW Benefits are intensive/enhanced community mental health services provided to all children/youth.
2. Services are provided in the community using the Wraparound approach to service coordination. If a child/youth is placed on “Inactive Status” due to their removal from the community, the assigned Community Mental Health Provider will monitor the child/youth for no more than 90 days, developing a plan to return the child/youth to the community.
3. Referrals and application are coordinated by an individual who works together with Child Welfare, MDHHS, other counties and service providers. The application includes; Cover Letter, Waiver Certification Form, Family Choice Assurance, Demographic Data Fern, CAFAS/PECAFAS, Annual Budget.
4. The Coordinator shall:
a. Review all referrals for appropriateness in collaboration with child welfare designated staff.

b. Provide oversight to the application process, ensuring all documentation is compiled and complete for submission to MDHHS.

c. Process, submit and track all applications.

d. Coordinate the SED Waiver of all eligible Wayne County children residing outside of Wayne County and eligible children who are residents of other counties residing in Wayne County and are in Child Welfare.

e. Enter all relevant data into SEDW Web Based Site.

5. Service providers shall:
   a. Submit budgets within 45 days of enrollment approval.
   b. Submitted billing thru CHAMPS using the SEDW Medicaid Fee Screen.

e. Trauma Focused Cognitive Behavioral Therapy: TF-CBT is a conjoint child and parent psychotherapy approach for children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles and techniques.

f. Wraparound: A promising practice that primarily provides support to youth with SED and their families. Wraparound is a family-driven, youth-guided planning process.
   1. The Wraparound process, facilitated by a Qualified Child Mental Health Professional, encourages the involvement of all service systems and natural supports in children and family life.
   2. Wraparound utilizes a Child and Family Team with team members determined by the family, often representing multiple agencies and informal supports.
   3. As a team planning process, Wraparound takes a holistic view of the lives of children, youth and families. The Wraparound model affirms that the best way to assist families is to listen to what they identify as their needs.
   4. The planning process provides families with a structure that builds upon their unique strengths and abilities as a means to meet those needs. The planning process identifies the child’s strengths and needs, as well as strategies and outcomes.
   5. The plan may also consist of other non-mental health services that are secured from and funded by other agencies in the community.
   6. The Wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values and preferences of the child and family and is developed in partnership with other community agencies.
   7. The Community Team, which consists of parents, Authority representatives, and other relevant community members, oversees Wraparound.

g. Youth in Transition: Services for youth supportive to the specific needs of young people ages 15-21 transitioning to adulthood. Youth in Transition services include:
   1. Group curriculum focused on development and mastery of practical life skills
   2. Inclusion of Youth Peer Support Services in treatment plan
3. Community-based learning opportunities

4. Individual clinical outpatient services with a therapist trained in transitional age youth service models

h. Youth Peer Support Services: Youth Peer Support is a service that is provided by young people who have lived experience receiving mental health services as a youth and who are willing and prepared to use their experience in helping others. Youth Peer Support provide support to other youth who are currently experiencing a serious emotional disturbance through shared activates and interventions. YPS is delivered in three ways:

1. Direct Support: Providing direct support based on building a relationship of shared partnership, strategic self-disclosure and finding common experiences that build connections between the YPSS and the young person involved in services;

2. Information Sharing: Sharing information with youth and family members in a way that increases the likelihood that the young person and their family develop resilience, take control of their own recovery and influences all services provided to them;

3. Skill Building: Through a supportive, equal partnership empowering the young person to build skills that allows them to successfully navigate services, systems and community activates.

i. Parent Support Partners (Family Support and Training): Family-focused services provided to family (natural or adoptive parents, spouse, children, siblings, relatives, foster family, in-laws, and other unpaid caregivers) of persons with serious mental illness, serious emotional disturbance or developmental disability for the purpose of assisting the family in relating to and caring for a relative with one of these disabilities. Parent Support Partner is a parent/caregiver of a child with emotional, behavioral or other mental health challenges. A PSP brings their own life experiences, skills and knowledge to support and empower other parents who are facing challenges and barriers. The services target the family members who are caring for and/or living with an individual receiving mental health services. The service is to be used in cases where the beneficiary is hindered or at risk of being hindered in his/her ability to achieve goals of a) performing activities of daily living; b) perceiving, controlling, or communicating with the environment in which he/she lives; or c) improving his or her inclusion and participation in the community or productive activity, or opportunities for independent living. The training and counseling goals, content, frequency and duration of the training must be identified in the beneficiary’s individual plan of service, along with the beneficiary’s goal(s) that are being facilitated by this service. PSP includes:

1. Education and training including instructions about treatment regimens, and use of assistive technology and/or medical equipment that are needed to safely maintain the person at home specified in the individual plan of service.

2. Counseling and peer support provided one-on-one or in group for assistance with identifying coping strategies for successfully caring for or living with a person with disabilities.

QUALITY ASSURANCE/IMPROVEMENT

DWMHA shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

The quality improvement programs of MCPNs, their subcontractors, and direct contractors must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.
COMPLIANCE WITH ALL APPLICABLE LAWS

DWMHA staff, MCPNs, contractors, and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

EXHIBITS

1. MDHHS Family Driven-Youth Guide Policy (12/14/2010)
4. Michigan Department of Community Health CAFAS and PECFAS Guidance to PIHPs and CMHSPs February 2015

LEGAL AUTHORITY

All of the following Authority policies refer to the most recent policy:

4. Department of Human Services Central (Perpetrator) Registry.
5. MDHHS Family Driven-Youth Guide Policy (12/14/2010)
6. SED WAIVER (A Home and Community-based Services Waiver for Children with Serious Emotional Disturbance) TECHNICAL ASSISTANCE MANUAL

RELATED POLICIES

1. Coordination of Care
2. Credentialing/Re-Credentialing.
3. Individualized Plan of Service.
4. Early Childhood Mental Health Services
5. Services to Minor Children
6. Parent Management Training Oregon Model
7. Respite
8. Wraparound

RELATED DEPARTMENTS

1. Administration
2. Claims Management
3. Clinical Practice Improvement
4. Compliance
5. Customer Service
6. Information Technology
7. Integrated Health Care
8. Managed Care Operations
9. Purchasing
10. Quality Improvement
11. Recipient Rights
12. Substance Use Disorders
13. Utilization Management

CLINICAL POLICY

INTERNAL/EXTERNAL POLICY

EXTERNAL

Attachments:

CSV 10001 - Exhibit B Relax Take a break Family Guide to Respite.pdf
CSV 10001 - Exhibit C DCH MH Admin R330 2105.pdf
Exhibit D MDCH PECFAS CASFAS Guidance April 2017

Approval Signatures

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December 15, 2010

TO: Executive Directors of Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs)

FROM: Michael J. Head, Director
Mental Health and Substance Abuse Administration

SUBJECT: Family-Driven and Youth-Guided Policy and Practice Guideline

Attached is the final version of the Family-Driven and Youth-Guided Policy and Practice Guideline that was forwarded for your review and comment in June 2010. We received comments from staff of seven CMHSPs, two advocacy organizations and one court staff person. We have reviewed all of the public comments and incorporated feedback and suggestions into this final version of the policy.

The purpose of this policy guideline is to provide guidance and support to PIHPs, CMHSPs and their contract agencies regarding the delivery of family-driven and youth-guided services and supports for children and their families. This guideline outlines essential elements of family-driven and youth-guided policy and practice at the child and family level, system level and peer-delivered level.

Family-driven means that families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community. Youth-guided means that young people have the right to be empowered, educated, and given a decision-making role in their own care as well as the policies and procedures governing the care of all youth in the community, state, and nation. A youth-guided approach views youth as experts and considers them equal partners in creating system change at the individual, state, and national level (SAMHSA).

It is the intent of the Michigan Department of Community Health (MDCH) to adopt a policy that promotes all publicly supported mental health agencies to engage in family-driven and youth-guided approaches to services with children and families. The attached policy is being issued as a technical advisory initially which MDCH encourages be used over the next year. MDCH does intend to incorporate this policy guideline/technical advisory into the Medicaid Provider Manual and into the contract negotiating process in the future. A technical companion guide will also be developed to assist in meeting the policy requirements.

If you have questions, please contact Connie Conklin at 517-241-5765 or at conklinc@michigan.gov, or Sheri Falvay at 517-241-5762 or at falvay@michigan.gov.

Attachment

c: Irene Kazieczko
Sheri Falvay
Connie Conklin
Mental Health and Substance Abuse Management Team
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH (MDCH)
MENTAL HEALTH & SUBSTANCE ABUSE ADMINISTRATION
FAMILY-DRIVEN AND YOUTH-GUIDED POLICY AND PRACTICE GUIDELINE

A. Summary/Background

The purpose of this policy guideline is to establish standards for the Prepaid Inpatient Health Plans (PIHPs), Community Mental Health Services Programs (CMHSPs) and their contract agencies regarding the delivery of family-driven and youth-guided services and supports for children and their families. This policy guideline will outline essential elements of family-driven and youth-guided policy and practice at the child and family level, system level and peer-delivered level.

Person-centered planning is the method for individuals served by the community mental health system to plan how they will work toward and achieve personally defined outcomes in their own lives. The Michigan Mental Health Code establishes the right for all individuals to develop individual plans of services through a person-centered planning process regardless of disability or residential setting.

For children and families, the Person-Centered Planning Policy Practice Guideline states: "The Michigan Department of Community Health (MDCH) has advocated and supported a family-driven and youth-guided approach to service delivery for children and their families. A family-driven and youth-guided approach recognizes that services and supports impact the entire family; not just the identified youth receiving mental health services. In the case of minors, the child and family is the focus of service planning, and family members are integral to a successful planning process. The wants and needs of the child and his/her family are considered in the development of the Individual Plan of Service." As the child matures toward transition age, services and supports should become more youth-guided.

As a result of the effort to develop family-driven and youth-guided services, the Substance Abuse and Mental Health Services Administration (SAMSHA) in partnership with the Federation of Families for Children's Mental Health, has developed a set of principles (described in section C of this policy) which serve as the basis for the delivery of family-driven and youth-guided services. These principles comprise the standards which should guide the delivery of services to children and their families and are essential to development of an effective system of care.

This policy is consistent with the "Application for Renewal and Recommitment (ARR) to Quality and Community in the Michigan Public Mental Health System," as issued by MDCH on February 1, 2009. The ARR formally introduced new and enhanced expectations of performance and revitalized MDCH's commitment to excellence in partnership with PIHPs and CMHSPs.

While agencies are expected to collaborate, they are not intended to be the primary decision-makers on behalf of a child or family. It is important for systems to actively engage families in leading all decisions about the care of their child. Similarly, as appropriate, based on their age and functioning, youth should have opportunities to make decisions about their own care. Family and youth involvement is also important on a broader level, with an expectation that they are active participants in system-level governance and planning (Wilder Foundation, Snapshot: Mental Health Systems of Care for Children, August 2009).
B. Policy

It is the policy of MDCH that all publicly-supported mental health agencies and their contract agencies shall engage in family-driven and youth-guided approaches to services with children and families and will engage family members and youth at the governance, evaluation, and service delivery levels as key stakeholders.

How this Policy will be supported:

- MDCH staff in partnership with the family organizations will work with PIHPs, CMHSPs, and contract agencies to support successful implementation of the family-driven and youth-guided policy guideline.
- MDCH will work with other system partners at the state level to ensure PIHPs, CMHSPs and contract agencies can build an effective system of care.
- Through ARR progress reviews, updates and technical assistance. The different sections of the ARR have applicability to family-driven and youth-guided care, e.g., stakeholder involvement, developing an effective system of care, improving the quality of services and supports, assuring active engagement, etc.

C. Family-Driven and Youth-Guided Principles

Family-driven and youth-guided principles should be measured at several different levels: the child and family level, the system level and the peer-to-peer level. These principles incorporate all levels, and will be detailed under section D: Essential Elements.

- Families and youth, providers and administrators share decision-making and responsibility for outcomes.
- Parents, caregivers and youth are given accurate, understandable, and complete information necessary to set goals and to make informed decisions and choices about the right services and supports for individual children and their family as a whole.
- All children, youth and families (parents) have a biological, adoptive, foster, or surrogate family voice advocating on their behalf.
- Families and family-run organizations engage in peer support activities to reduce isolation, gather and disseminate accurate information, and strengthen the family voice.
- Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports and advocate for families and youth to have choices.
- Providers take the initiative to change policy and practice from provider-driven to family-driven and youth-guided.
- Administrators allocate staff, training, support and resources to make family-driven and youth-guided practice work at the point where services and supports are delivered to children, youth, and families.
• Community attitude change efforts focus on removing barriers and discrimination created by stigma.

• Communities and public and private agencies embrace, value, and celebrate the diverse cultures of their children, youth, and families and work to eliminate mental health disparities.

• Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes so that the needs of diverse populations are appropriately addressed.

D. Essential Elements for Family-Driven and Youth-Guided Care

1. "Family-driven" means that families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community. This includes:

• Being given the necessary information to make informed decisions regarding the care of their children
• Choosing culturally and linguistically competent supports, services, and providers
• Setting goals
• Designing, implementing and evaluating programs
• Monitoring outcomes
• Partnering in funding decisions

2. "Youth-guided" means that young people have the right to be empowered, educated, and given a decision-making role in their own care as well as the policies and procedures governing the care of all youth in the community, state, and nation. A youth-guided approach views youth as experts and considers them equal partners in creating system change at the individual, state, and national level (SAMHSA).

3. "Family-run organization" means advocacy and support organizations that are led by family members with lived experience raising children with SED and/or DD thus creating a level of expertise. These organizations provide peer-to-peer support, education, advocacy, and information/referral services to reduce isolation for family members, gather and disseminate accurate information so families can partner with providers and make informed decisions, and strengthen the family voice at the child and family level, service delivery level, and systems level.

4. Child and Family-Level Action Strategies:

• Strength and Culture Discovery - Children, youth and family strengths will be identified and linked to treatment strategies within the plan of service.
• Cultural Preferences - The plan of service will incorporate the cultural preferences unique to each youth and family.
• Access - Children, youth and families are provided usable information to make informed choices regarding services and supports and have a voice in determining the services they receive. Services and supports are delivered in the home and community whenever possible.
• Voice - Children, youth and families are active participants in the treatment process, their voice is solicited and respected, and their needs/wants are written into the plan in language that indicates their ownership.
• Ownership - The plan compliments the strengths, culture and prioritized needs of the child, youth and family.
• Outcome-based - Plans are developed to produce results that the youth and family identify. All services, supports and interventions support outcome achievement.
• Parent/Youth/Professional Partnerships - Parents and youth are recognized for having expertise, are engaged as partners in the treatment process, and share accountability for outcomes.
• Increase Confidence and Resiliency - The plan will identify specific interventions that maximize the strengths of the child, youth, and family, increase the skills of the youth to live independently and advocate for self, and equip the family with skills to successfully navigate systems and manage the needs of their child and family.
• Participation in Planning Meetings - Youth and families determine who participates in the planning meetings.
• Crisis and Safety Planning - Crisis and safety plans should be developed to decrease safety risks, increase confidence of the youth and family, and respect the needs/wants of the youth and family.

5. System-level Action Strategies:

• Agencies have policies that ensure that all providers of services to children, youth and families incorporate parent/caregivers and youth on decision-making groups, boards and committees that support family-driven and youth-guided practice.
• Agencies have policies that ensure training, support, and compensation for parents and youth who participate on decision-making groups, boards and committees and serve as co-facilitators/trainers.
• Policies are in place within the agency to support employment of youth and parents.
• Youth and parents are part of the program and service design, evaluation, and implementation of services and supports.
• Children, youth and families are provided opportunities to participate in and co-facilitate training and education opportunities.
• Services are delivered where the children, youth and family feel most comfortable and in a way that is relevant to the family culture.
• All stakeholder groups include diverse membership including youth and family members who represent the population the agency/community serves.

6. Peer-delivered Action Strategies:

• Parents/caregivers, youth who have first-hand experience with the public mental health system are recruited, trained and supported in their role as parent/peer support partners.
• Family Organizations are involved in the recruiting, supporting, and training of family members and youth peer-to-peer support partners. They may also serve as the contract employers of the parent support partners.
• Peer-to-peer support models approved by MDCH for parents and youth are available.
E. Biography


http://www.samsha.gov

ACMH Youth Advisory Council Focus group (January 16, 2010)

ACMH Staff Retreat (December 14, 2009)
Relax. Take a Break:

A Family Guide to Respite for Children in Michigan

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This document was developed with funding from a Real Choice System Change Grant for Community Living-Respite for Children. While it specifically addresses respite for families of children 0-18 years of age, respite is also available to families of adult consumers.
What is respite?

Respite is a type of support available to families of children with developmental disabilities (DD) or serious emotional disturbance (SED). The word respite means “break” or “relief.” Respite care services are designed to offer families the opportunity for a break from care giving responsibilities.

Respite allows parents time to engage in activities that they find relaxing, entertaining, or restful while a trained respite provider cares for your child.

A respite break can mean an hour to take a walk while a respite provider stays in your home to care for your child. It may be a weekend away while your child is cared for outside of your home. It can also mean time to take a nap or chat with a friend while the respite provider takes your child on a community outing.

How is respite different from daycare?

Daycare or traditional childcare is needed by parents in order to go to work or school and it is provided on a daily or regular basis. Respite, on the other hand, is provided on an intermittent or short-term basis to provide the parent with a break from caring for their child with a disability.

How can respite help my family?

Parenting is a difficult job and every parent can benefit from time away from the responsibilities of caring for a child. Being the best parent possible requires getting the rest and relaxation that you need. Caring for a child with special needs presents additional challenges that go beyond the everyday stresses of being a parent. As a result, you may need longer rest periods or more down time. In addition, it may also be more difficult to find a qualified person to care for your child. Respite can help offset these challenges.

Respite can help strengthen your whole family and lead to a decrease in stress and an increase in your family’s health and well being. In addition to giving parents and caregivers a chance to rest, it may provide opportunities to spend more time with other members of your family improving relationships with children, spouses/partners, or other family members.

The overall goal of respite is to support parents or primary caregivers, so that families can
avoid an out of home placement and keep their child living with them in their home.

Is respite care right for my family?

Ask yourself the following questions.² If your answer is “yes” to several of these questions, respite care may be right for your family.

- Is finding temporary care for your child a problem?
- Is it important that you and your spouse/partner enjoy an evening alone or with friends, without the responsibility of caring for your child with special needs.³
- Do you need time to relax and refresh so that you will be better able to meet the care needs of your child?
- If you had appropriate care for your child with special needs, would you use the time for a special activity with your other children?
- Do you think that you would be a better parent if you had a break now and then?

³ Respite provides care for your child with a disability. In most cases, you will need to make other arrangements for the care of your other children.

- Are you concerned that in the event of a family emergency there is no one with whom you would feel secure about leaving your child?
- Do you avoid going out because you feel you would be asking too much of your family or friends to care for your child with a disability?
- Does your child require a caregiver who has specific experience and/or special training to meet his or her care needs? (Example: experience using specialized medical equipment)?
Relaxation
Respite gives families peace of mind, helps them relax, and renews their humor and energy.

Enjoyment
Respite allows families to enjoy favorite pastimes and pursue new activities.

Stability
Respite improves the family’s ability to handle daily responsibilities and increases stability.

Reservation
Respite helps preserve the family unit.

Involvement
Respite allows families to be more involved in community activities.

Time Off
Respite allows families to take a needed vacation, spend time together, or time alone.

Enrichment
Respite makes it possible for family members to enrich their own growth and development.

Is my family eligible for respite care services?

Community Mental Health Services Program

Your local Community Mental Health Services Program (CMHSP) can determine whether your family is eligible for Community Mental Health Services including respite care services. Eligibility for services is determined based on several factors including the nature and severity of your child’s disability. Priority is generally given to families with the greatest need for this service.

Non Medicaid Eligible

If your family is found to be eligible for respite, the cost of respite services will be decided based on your family’s ability to pay as determined by CMHSP guidelines.

The amount of respite that your family receives will vary depending on your family’s needs.

Respite may be the only support need identified by your family. You are not required to receive treatment from the CMHSP in order to receive respite.

Medicaid Eligible

If your child is Medicaid enrolled and your family is eligible for CMHSP services, your family may be eligible for respite. Respite care services must meet the “Medical Necessity Criteria” that is outlined by Medicaid. The concept of “Medical Necessity” does not mean that your child must be physically ill in order for you to receive respite services. If you would like more information about Medical Necessity Criteria, you can ask your supports coordinator or log on to the Department of Community Health Website: www.michigan.gov/mdch, Medicaid Policy Bulletins, MSA Bulletin 04-03.

For more information regarding Medicaid or CMHSP services, log on to the Association for Children’s Mental Health in Michigan Website at www.acmh-mi.org to download a copy of A Parent’s Guide to Obtaining Mental Health Services for Children in Michigan.

Person Centered Planning/Family Centered Practice

In order to receive respite services from the CMHSP, respite must be identified through a planning process referred to as Person Centered Planning (PCP)/ Family Centered Practice. Person Centered Planning/Family Centered Practice recognizes that the needs of your child with a disability are best met when the whole family receives the support they need.

The purpose of this process is to identify the needs of your family and honor your choices and preferences. However, keep in mind that the services offered by the CMHSP may not meet all of your needs and preferences as some needs may be better met by community and other natural supports.

Community supports may include other agencies or organizations in your area that offer services to families. Natural supports refer to your personal support network of friends, relatives, neighbors or other individuals with whom you share a trusting relationship.

The details regarding respite services should be decided during the Person Centered Planning/ Family Centered Practice Process. Both the type of respite as well as the amount of respite needed by your family should be included in a document referred to as the Individual Plan of Service (IPOS) or Family Plan of Service.
Types of respite care

There are many different ways respite may be provided. Respite care programs vary in the following ways:

- Who provides care for your child
  - Provider trained by your family
  - Provider trained by the respite program
  - Provider trained by the program and by your family

- Where respite takes place
  - In your home
  - Outside of your home
    - Out in the community
    - At a home, center, or facility

- What type of setting
  - Individual (your child + provider)
  - Group (group of children + provider(s))

The following types of respite programs may be available in your community.

**Family Friend**
Respite is provided by an individual chosen by your family. Respite can take place in your home, at the home of the respite provider, or in the community.

**One-to-One**
Respite is provided by an individual trained by the respite program and takes place in your home or in the community.

**Camps**
Day and overnight camps offer respite opportunities for parents while providing fun and/or educational experiences for children.

**Respite Home**
Respite is provided by individuals trained by the respite program in a licensed home or facility in the community.

**Group Settings**
Program trained staff provide care to a group of several children in a licensed facility such as a church, school, or community center.

**Table 1 Types of Respite Care**

<table>
<thead>
<tr>
<th>Type of Respite</th>
<th>Who?</th>
<th>How?</th>
<th>Where?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Friend</td>
<td>Family trained provider</td>
<td>Individual</td>
<td>In home or Out of home</td>
</tr>
<tr>
<td>One to One</td>
<td>Program trained provider</td>
<td>Individual</td>
<td>In home or Out of home</td>
</tr>
<tr>
<td>Camp</td>
<td>Program trained provider</td>
<td>Group Setting</td>
<td>Out of home</td>
</tr>
<tr>
<td>Respite Home</td>
<td>Program trained provider</td>
<td>Group Setting</td>
<td>Out of home</td>
</tr>
<tr>
<td>Group Setting</td>
<td>Program trained provider</td>
<td>Group Setting</td>
<td>Out of home</td>
</tr>
</tbody>
</table>
Planning respite

The type of respite that is right for your family will depend on what is available in your community as well as your family’s unique needs and preferences.

Identifying the specific reason that your family needs respite may help clarify the type of respite that will work best. For example, if your goal is to spend time at home relaxing or taking a nap, you may require privacy. In this case, out of home respite may be the best option. Identifying the reasons for respite will also help you plan how to use your respite time effectively.

1) Start by brainstorming a list of all of the reasons that you need respite.

2) Next, rank the reasons in order of importance. While all of your respite needs may not be met, prioritizing will help ensure that your most important needs will be addressed first.

3) Use a table like the example in Table 2 to help clarify the amount and type of respite you will need to meet each respite goal. Start with a blank table and fill in your own reasons for respite in order of importance. To calculate the total amount of respite needed, determine how often you need respite and the length of time required. Also include the type of respite that will best meet each respite need.

<table>
<thead>
<tr>
<th>Reason for respite</th>
<th>How often?</th>
<th>Length of Time</th>
<th>Total Amt.</th>
<th>Type of Respite (in home vs. out of home)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Caregiver would like to spend time with partner/spouse</td>
<td>One day per week</td>
<td>2 hrs</td>
<td>8 hrs/mo</td>
<td>Out of home</td>
</tr>
<tr>
<td>Primary Caregiver needs one on one time with other child</td>
<td>Twice a month</td>
<td>2 hrs</td>
<td>4 hrs/mo</td>
<td>No preference</td>
</tr>
<tr>
<td>Primary Caregiver would like time to relax at home.</td>
<td>Two days per week</td>
<td>2 hrs</td>
<td>8 hrs/mo</td>
<td>Out of home</td>
</tr>
<tr>
<td>Primary caregiver would like to join support group</td>
<td>One day per week</td>
<td>1 Hr</td>
<td>4 hrs/mo</td>
<td>In home</td>
</tr>
</tbody>
</table>

To discuss additional respite options that may be available to your family contact your caseworker.

The amount of respite available to families through CMHSP will vary depending on the needs of each individual family.
Finding the right fit for your family

Families often worry about the quality of care their children will receive during respite. Families may be concerned about how the respite provider will handle emergencies, deal with challenging behaviors, comfort their child, or manage their child’s special needs.

These are all valid concerns that are common among parents. If your family is to benefit from respite services you must have peace of mind when leaving your child in the care of the respite provider. In order for your family to feel comfortable, it is important to take the time to find the right fit for your family.

If you have concerns, as most parents do, it is important to begin addressing them by discussing them with your supports coordinator and/or the respite program.

The following is a list of questions that many parents need to have answered about respite services. Decide which questions are important for your family and be sure to ask your supports coordinator or the respite program.

- Can the respite worker come to my home?
- Can respite services take place outside of my home?
- Do providers have CPR/First Aid training?
- What other types of training do providers receive?
- How will my family be involved in preparing the provider to meet the specific needs of my child?
- Will my family be able to participate in training the provider?
- Can I meet/interview the provider beforehand?
- Will the provider care for my other child(ren)? If so, will there be an additional cost to me?
- Can I request the same respite worker every time?
- Is there a policy for emergency situations?
- How are out of home care facilities monitored for health/safety?
- When the provider comes to my home to care for my child, how is insurance and liability handled?

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What happens if the provider is not a good fit for my family?

In group respite situations, what is the staff to child ratio?

What qualifications are required for respite workers?

Are respite workers required to provide references?

Are sex offender checks or criminal history checks required for respite workers employed by your program?

What are the programs expectations for my child’s behavior?

What are the discipline policies?

If my child is upset or crying, how will the staff respond?

---

Choosing a Respite Program

Choosing a respite program is similar to shopping for quality childcare. There are many resources available to families on the subject of quality childcare. Families will want to consider the factors that indicate a quality program such as the skill of the individuals providing care to your child and the safety of an out-of-home facility. The following internet resources offer checklists and other valuable information to help parents find quality childcare and/or respite.

Michigan Association for Child Care Providers
www.childcareservices.com

Child Care Aware
www.childcareaware.org

Child Care Resources
www.childcare.org

Locating Respite Providers

To find out more about what programs and providers are available in your community, you may start by talking to your CMHSP supports coordinator. You may also try looking in your phone book or searching the internet. The Arch National Respite Locater Service is a good online resource. It allows you to search for...
providers in your area according to your child’s age and type of disability.

Arch National Respite Locater Service
http://www.respitelocator.org/locatorsearch/searchpage.htm

Hiring Your Own Respite Worker

Choosing and training your own respite provider may be an option available to your family. When hiring your own respite care provider, interviews should be focused on choosing a provider that is trustworthy, experienced, and a good fit for your family. Try using questions like the ones below:

- Tell me about yourself.
- What type of experience do you have caring for or working with children?
- Have you worked with children with special needs?
- Why are you interested in providing respite care?
- Why do you enjoy spending time with children?
- Tell me about your views regarding discipline.
- Tell me how you might handle a situation in which my child was upset, scared, or crying?
- Tell me about your interests and hobbies. Would you like to share any of these with my child?
- Can you provide contact information from individuals who have seen you interact with children who can serve as a reference?
- Would you feel comfortable taking my child out in the community?
- May I complete a background check?

Background Checks

Families hiring their own respite care provider may be interested in completing background checks.

Michigan criminal background checks can be completed at the following website:

http://mi-mall.michigan.gov/ichat

Sex offender checks are free and can be completed at:

http://www.mipsor.state.mi.us/

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Some of these questions were adapted from “Get good Child Care: 30 Revealing Questions to Ask,” Susan H. Kueffer, Working Mother, May 1989 in PARTners: A Manual for Family Centered Respite Care.
Observing the respite provider

Whether you plan to hire your own provider or use a respite care program, you may feel more comfortable leaving your child if you plan an opportunity to observe the respite worker interact with your child. You may choose to arrange a short meeting or trial run in which you are present while the provider cares for your child. When you observe the provider, look for signs that the provider feels comfortable caring for your child, interacts with your child in a positive and caring manner, and is attentive to his or her needs.

Preparing the respite provider

Parents are clearly the experts on caring for their own children and should have the responsibility of preparing the respite provider to meet the individual care needs of their child. This is true when choosing and training your own respite provider as well as preparing providers who work for a program.

You will need to provide basic information as well as more specific information about your child’s unique needs. You will probably need to meet with your provider in advance to discuss your child’s needs or to provide hands on training.

It is also helpful to provide written plans and instructions that are well organized and easy for your provider to reference at a moments notice. The following list outlines important topics to cover with your provider:

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Emergency Information
- Physician’s name and phone number
- Hospital address and phone number
- Fire department/ambulance/poison control
- Who to contact in an emergency

Medication
- List of medications/dosage information
- Medication side effects that may be observed
- Instructions for administering medication

Seizures
- Is a seizure likely to occur during respite?
- What happens before, during, after a seizure?
- Procedures provider should follow
- Should the provider contact you?

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Adaptive Equipment
- How is it used?
- When it is used?
- Is supervision required?

Discipline/Behavior
- What behaviors may be a challenge?
- How would you like provider to handle these behaviors?
- Are there any behaviors that your child may engage in that could be dangerous?

Meals
- Does your child require a special diet?
- Does your child feed him/herself?
- What type of assistance is required?
- Food likes and dislikes
- Special equipment/special food preparation

Naps/Bedtime
- Usual bedtime/naptime
- Is your child resistant at bedtime?
- Nighttime fears (dark, storms, noises etc.)
- Sleep difficulties (waking, falling asleep, nightmares, etc)

Toileting/Diapering
- Does your child need assistance in the bathroom?
- What type of assistance is required?
- If your child wears diapers, are there any special instructions?

Communication
- Does your child use any special communication equipment or techniques?
- Is your child verbal?
- Is it likely to be difficult to understand your child?
- Ways to interpret nonverbal communication

Emotional Needs
- Does your child have any specific fears?
- Is separation anxiety likely?
- Best ways to comfort your child
- Would you like to be contacted if your child is upset/crying?

Household Information
- Favorite games, toys, movies
- TV, computer use/rules
- Household rules
- Security alarms/locks
- Answering the phone/door
- Location of clothing, food, diapers, first aid
Respite follow-up

Families will want to talk to the respite provider to find out if everything went smoothly. If problems are identified, decide what steps can be taken to minimize these issues the next time the provider cares for your child. Be sure to provide the respite worker with feedback. He or she will need to know what is working well and what needs improvement.

Families should also take the time to talk to and observe their child after the respite care experience to make sure that he or she felt comfortable. If you notice that your child is unhappy or behaving out of character, be sure to take your child’s feelings seriously. Always discuss any concerns you may have with the respite care provider, respite program, or your supports coordinator.

The following is a list of questions that may be helpful to use when talking to your child.  

- Tell me about your time with ____?
- What did you do?
- Did you like ____?
- Was he/she nice to you?
- Would you like to spend time with ____ again?
- What did you like best/least?

References


Northwest Community Mental Health Affiliation. (2005). Natural supports: the right care, the right place, the right time. (1st ed.) [Brochure]. MI: Author.

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that person shall be deemed to meet the minimum education and experience requirements to be the county
director of that or any other county program.
(3) If a candidate does not meet the minimum education and experience qualifications and the board
requests review of this matter, the candidate may be deemed qualified by the department director to be a
county director if the candidate is found to have substantially met the education and experience
requirements of this rule.

History: 1990 AACS.

SUBPART 6. CHILDREN'S DIAGNOSTIC AND TREATMENT SERVICE

R 330.2105 Definitions.
Rule 2105. As used in this subpart:
(a) "Certified program" means a range of service, as required by this subpart, for which application for
certification has been voluntarily made and which has been certified by the department as a children's
diagnostic and treatment service.
(b) "Child mental health professional" means any of the following:
(i) A person who is trained and has 1 year of experience in the examination, evaluation, and
treatment of minors and their families and who is one of the following:
(A) A physician.
(B) A psychologist.
(C) A certified social worker or social worker.
(D) A registered professional nurse.
(ii) A person with at least a bachelor's degree in a mental health-related field from an accredited
school who is trained, and has 3 years of supervised experience, in the examination, evaluation,
and treatment of minors and their families.
(iii) A person with at least a master's degree in a mental health-related field from an accredited
school who is trained, and has 1 year of experience, in the examination, evaluation, and treatment
of minors and their families.
(c) "Emergency evaluation" means an immediate assessment by a child mental health professional
who is available for a face-to-face contact for the purpose of determining if a minor is emotionally
disturbed, as defined in section 498b of the act, and requires immediate intervention because of any of the
following situations:
(i) The minor is dangerous to himself or herself or others.
(ii) The minor will not allow for the provision of care to meet his or her basic needs.
(iii) The minor has experienced a severe emotional trauma which is identified by his or her parent or,
when the parent or guardian cannot be immediately contacted, by a person having physical custody of
the minor.
(d) "Emergency referral" means a referral for the purpose of having services provided immediately to
a minor or the minor's family pursuant to R 330.2006.
(e) "Initial screening" means providing for either a face-to-face or telephone interaction concerning a
minor in which a preliminary judgment is made regarding the need for mental health services for the
minor and whether the minor's situation is one requiring nonemergency mental health services or
emergency evaluation.
(f) "Intake evaluation" means social and psychological assessments which are appropriate in identifying
the problems of the minor, together with a mental history and other assessments as necessary to
ascertain the mental health needs of the minor.
(g) "Plan of service" means the written plan of service developed pursuant to R 330.7045 by a
child mental health professional with participation of the minor's family, where applicable, and is
based upon the assessment, recommendations, and, where necessary, consultations with other
professionals.
(h) "Primary therapist" means a child mental health professional who is responsible for the direct
treatment of a minor for the agency providing direct treatment services.
(i) "Referral" means facilitating access for the minor and the minor's family to the services of the
certified program or to the services of another agency for the purpose of meeting the minor's needs.
R 330.2110 Evaluation and screening.
   Rule 2110. (1) A certified program shall have the capacity to provide an initial screening, emergency evaluation, and intake evaluation to ascertain the mental health needs of a minor.
   (2) A mental health professional shall be available, by telephone consultation, to emergency service staff on a 24-hour basis to respond to potentially life-threatening or physically or emotionally damaging situations identified in an initial screening. An emergency evaluation shall be completed by a child mental health professional on the next regular working day from the day of an emergency referral.
   (3) Intake evaluations may occur during multiple contacts with the minor and his or her family and shall be conducted by a child mental health professional. These evaluations shall form the basis for the plan of service.
   (4) Intake evaluations for a nonemergency situation should be completed not more than 4 weeks from the date of the initial screening. If this time period cannot be met, the staff of a certified program shall document any reasons for further delay. Nothing in this rule shall prevent a certified program from ranking requests for nonemergency services based on need for the service.

R 330.2115 Referrals.
   Rule 2115. (1) The community mental health board from which emergency or short-term mental health services are requested from a minor shall be responsible for providing appropriate mental health services. However, if the minor is located in the county, but is a resident of a county served by another community mental health board, then the certified program may refer the minor to the appropriate community mental health board once the minor's immediate needs for protection or security are met.
   (2) Each certified program shall maintain a written list of resources it utilizes which indicates the types of services provided, eligibility criteria, and names and locations of the referral sources.
   (3) A certified program shall have written arrangements with public and private human service agencies which provide educational, judicial, child welfare, and other health services. These arrangements shall clarify the respective responsibilities for the coordination and provision of services.
   (4) A waiver by the department of the requirement of subrule (3) of this rule shall be granted when it is documented that the community mental health board does not have a contractual relationship with the child's human services agency due to that agency's failure to execute a proposed contract.

R 330.2120 Range of services.
   Rule 2120. (1) A certified program shall develop mechanisms for coordinating the delivery of a necessary range of services specifically oriented to meet the needs of minors and their families. The available range of services shall, at a minimum, include all of the following:
   (a) Diagnostic services sufficient to develop a plan of service.
   (b) Client case management by a child mental health professional who shall be responsible for the development, coordination, implementation, and monitoring of the plan of service. Client case management services shall assure that services are timely, appropriate, and updated in accordance with the minor's needs. Both the on-site review of the minor's progress and record documentation shall be conducted at least quarterly. The child mental health professional providing client case management shall attend interagency case conferences relating to the minor.
   (c) Crisis stabilization and responses that reduce acute emotional disabilities and their physical and social manifestation in order to ensure the safety of the minor, his or her family, and others.
   (d) Specialized mental health training and treatment, which shall include both of the following:
   (i) A range of clinical therapies which can be provided to individuals, groups, and families.
(ii) Opportunities to learn, improve, and demonstrate specific skills that are appropriate to the child's needs, which may include problem-solving skills, communication skills, and acceptable social interaction.

(e) Out-of-home treatment, which includes both inpatient and community residential treatment.

(2) Mental health service locations shall be accessible through publicly available transportation, if any. A family that indicates an inability to transport a minor to the service locations shall be evaluated for other assistance in transportation as a part of the plan of service.

(3) In addition to traditional clinic locations, certified programs shall provide mental health services in the minor's home or other community settings, if appropriate.

(4) Services of a certified program shall be available in a barrier-free environment.

(5) The certified program shall provide mental health services to emotionally disturbed minors located within its service area who are any of the following:

(a) Hearing impaired.
(b) Visually impaired.
(c) Developmentally disabled.
(d) Chronically ill.
(e) Physically handicapped.

History: 1990 AACS.

R 330.2125 Staffing and training.

Rule 2125. (1) The certified program shall provide for the establishment of a formalized staff development program to assure professional development and training in identifying and treating the needs of minors and their families.

(2) Each full-time staff member in the certified program shall complete not less than 24 clock hours annually of formalized professional development and training.

(3) Staff shall receive training before performing initial screenings.

(4) For persons who are hired after the effective date of this rule, the certified program shall be clinically supervised by a child mental health professional who has at least a master's degree in a mental health-related field and 3 years of clinical experience working with minors and their families.

History: 1990 AACS.

R 330.2130 Administration.

Rule 2130. (1) The community mental health board shall have contracts with all individuals and agencies which provide services for each component of the certified program outside of the community mental health board. The contracts shall provide for coordinated program planning and continuity of service delivery and shall clearly identify the responsibilities of both parties.

(2) A certified program shall designate a child mental health professional to act as liaison with all out-of-home treatment facilities to which minors are referred for care.

(3) The community mental health board plan and budget shall delineate a separate and distinct part designated for the certified program.

(4) The community mental health board shall implement a public information program to facilitate community awareness of the certified program. The public information program shall provide all of the following information:

(a) The services that are available.
(b) Hours of operation.
(c) Location.
(d) Access to public transportation, if any.
(e) Telephone numbers. Services provided shall be pursuant to the provisions of R 330.2011 and R 330.2005(f).

(5) The board shall establish procedures for evaluating its certified program, on an annual basis, which shall include client and agency consumer evaluations of services of the certified program. The
opportunity for client and consumer agency input shall be a part of this evaluation. The method and
results of the evaluation shall be available for departmental review at the time of certification renewal.
(6) The agencies under contract to the community mental health board which comprise the certified
program shall have the capacity to share confidential client information in order to provide for the
coordination of services for a minor or for the transition of the minor from one agency to another.
(7) Information to be shared with agencies having cooperative agreements with the certified program
shall be provided through appropriate releases of information.

History: 1990 AACS.

R 330.2135 Certification process.
Rule 2135. (1) A request for certification for a children's diagnostic and treatment services program
may be made to the department at any time by 1 or more county programs. If county programs
propose a combined children's diagnostic and treatment services program, the county programs shall
specify the administrative structure in the request and indicate who speaks for the proposed combined
program before certification.
(2) The department shall provide technical assistance to boards seeking certification.
(3) The community mental health board shall designate all agencies and services included in the
certified program.
(4) A determination on initial or renewal certification by the department shall be completed
within 6 months of a request for certification and submission of all necessary documentation or a
program shall be considered certified. Certification shall occur when a determination of substantial
compliance with the requirements of the act and this part has been made. If a program is certified
despite instances of noncompliance with the requirements of the act and this part, the certification
shall identify the items of noncompliance and the items shall be corrected. The department shall
require the county program to submit a plan to correct items of noncompliance before recertification
or sooner if required by the department. If the correction of items of noncompliance is dependent on
additional state or federal financial resources, recertification of a county program shall not be denied
solely on that basis.
(5) Certification shall expire after 3 years. Renewal requests shall be submitted to the department 6
months before the certification expiration date.
(6) Certification is not transferable to another program or agency.
(7) The director of the department shall designate a person who is responsible for the process of
certifying children's programs.
(8) An application for initial or renewal certification shall be on a form designated by the department.
Before an on-site inspection or review is scheduled, all required information shall be completed and
in the possession of the department. The department shall determine when an application is complete
and shall notify the community mental health board of any additional information required to complete the
application.
(9) By applying for or accepting certification, the community mental health board authorizes the
department to conduct the reviews it deems necessary to determine compliance with these rules.
(10) The community mental health board shall promptly notify the department of any changes in the
certified program.
(11) Reviews shall include at least both of the following:
(a) Inspections of the program to be certified and its operation.
(b) Inspection of program records, recipient clinical records, and other documents maintained by the
program which may otherwise be privileged or confidential information.
(12) Certification may be denied, suspended, or revoked for 1 or more of the following reasons:
(a) Substantial violation by the certified program, its director, or staff of any rule relating to
certification promulgated by the department.
(b) Conduct or practices found to be harmful to the welfare of a minor in the program or other family
members.
(c) Substantial deviation by the program from the plan of operation originally certified by the department.
Failure of an applicant to cooperate with the department in connection with a certification review.

When it has been determined that a certified program or an applicant for a certified program has committed an act or engaged in conduct or practices which justify the denial, suspension, or revocation of certification, the departmental certifying person shall notify the community mental health board, by certified mail, of the department's intent to suspend, deny, or revoke the certification.

The notice required by subrule (13) of this rule shall set forth the particular reasons for the proposed action and offer a hearing, if so requested by the county program, before the director of the department or his or her designee. The date of the hearing shall be not less than 30 days from the date of receipt of the request for a hearing.

The decision of the director of the department shall be based on the hearing or on the default of the board. A copy of the decision shall be sent, by certified mail, to the community mental health board not less than 45 days after the close of the hearing.

The revocation or suspension of a certificate shall become final when the determination of the director of the department is mailed, unless the community mental health board, within 60 days of the mailing or service of the decision, appeals the decision to a court and obtains a stay.

A reapplication for certification subsequent to a revocation or suspension of a certificate may be made. The application shall be accompanied by a description for certification and will be followed by an interview with the certifying staff of the department before commencement of the formal certification review process.

The certification shall expire on the date shown on its face, unless application has been made for renewal and application has not been denied or unless certification is terminated in accordance with these rules.

Instead of denying reapplication for certification, the department may issue provisional certification to a community mental health board for up to 6 months when the community mental health board has submitted a plan of correction and it has been accepted by the department. A provisional certificate shall expire on the date set forth on its face. The holder of a provisional certificate shall be reinspected for compliance with these rules not less than 60 days before the expiration date of the provisional certificate. The department may extend a provisional certificate for a period of not more than 6 months. A provisional certificate which has not been extended or which has been extended 1 time shall expire automatically on its expiration date without notice or hearings.

History: 1990 AACS.

SUBPART 7. CERTIFICATION PROCESS

Rule 2701. (1) As a condition of state funding, a single overall certification is required for each community mental health services program.

The certification process shall include a review of agencies or organizations that are under contract to provide mental health services on behalf of the mental health services program.

The governing body of a community mental health services program shall request certification by submitting a completed application to the department. If the department is already in receipt of information required for application, then submission of that information may be waived by the department. The application shall be submitted in the format specified by the department and shall include all of the following information:

(a) The legal name of the community mental health services program.

(b) The address for legal notice and correspondence.

(c) The governing structure of the community mental health services program.

(d) The current annual budget, including all sources of revenue, of the community mental health services program.

(e) The organizational chart of the community mental health services program.

(f) The name of the executive director of the community mental health services program.
(g) A list of all contracts with other agencies or organizations that provide mental health services under the auspices of the community mental health services program.

(h) A description of the services provided by the community mental health services program, including any services provided by contract with another agency or organization.

(i) If applicable, documentation of the community mental health services program's accreditation, including accreditation of any contract agency or organization, by an accrediting body deemed acceptable by the department as specified in R 330.2702(2).

(4) Upon receipt of an application, the department shall determine if the application is complete. The department shall acknowledge receipt of an application. If an application is incomplete, the department shall notify the applicant within 30 days from date of receipt of any corrections or additions needed, may return the materials to the applicant, or both. An incomplete application shall not be regarded as an application for certification. Return of the application materials or failure to take further action to issue a certificate shall not constitute denial of an application for certification.

(5) After the department's acceptance of a complete application, the department shall determine whether the applicant meets certification standards. The certification process may include conducting an on-site review.

(6) Failure of the community mental health services program to comply with the requirements of the certification process shall be grounds for the department to deny, suspend, revoke, or refuse to renew a program's certification.

History: 1997 AACS.

R 330.2702 Deemed status.
Rule 2702. (1) The department will accept, in whole or in part, the accreditation of a national accrediting organization deemed acceptable by the department as documentation of the community mental health services program's equivalent compliance with certification standards.

(2) The department shall not grant deemed status for matters related to the safeguarding and protection of recipient rights.

(3) The community mental health services program shall request deemed status in writing and shall include all of the following documents:
   (a) A copy of the official document indicating accreditation.
   (b) A copy of the written survey report from the accrediting body.
   (c) A copy of the program's response, if any, to the report from the accrediting body.

(4) The department may deem the community mental health services program to be in compliance with certification standards, in whole or in part, after reviewing the submitted documents.

History: 1997 AACS.

R 330.2703 Acceptance of licensure, certification, or other approval by governmental regulatory authority.
Rule 2703. The department may accept licensure, certification, or other regulatory approval by a government agency with regulatory jurisdiction in place of compliance with certification standards, or portions thereof, for any component of a community mental health services program.

History: 1997 AACS.

SUBPART 8. CERTIFICATION STANDARDS

R 330.2801 Compliance with certification standards.
Rule 2801. The department shall assess compliance with the following certification standards by determining the degree to which all of the following provisions apply:
Michigan Department of Health and Human Services  
Child and Adolescent Functional Assessment Scale (CAFAS) and  
Preschool and Early Childhood Functional Assessment Scale (PECFAS)  

Guidance to PIHPs and CMHSPs  
April 2017

To ensure that CMHSPs and PIHPs provide for the administration of the PECFAS and CAFAS to children served in the behavioral health system, this guidance is provided to clarify requirements for the administration of the tools, the training requirements, and the MDHHS support for the administration and training in the tools.

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<tr>
<th>Issue</th>
<th>CAFAS</th>
<th>PECFAS</th>
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<tbody>
<tr>
<td>Contract Requirements</td>
<td>In the MDHHS contract with the PIHPs/CMHSPs, the CAFAS is a required assessment tool for all children with Serious Emotional Disturbance (SED) in the CMHSP system, ages 7 through 17 years and/or as long as they are receiving children’s services. The CAFAS is to be completed at intake, quarterly thereafter and at exit from CMHSP for children in this age range receiving behavioral health services. The CAFAS is used as part of the determination of functional impairment that substantially interferes with or limits the minor’s role or results in impaired functioning in family, school, or community activities.</td>
<td>In the MDHHS contract with the PIHPs/CMHSPs, the PECFAS is a required assessment tool for all children with Serious Emotional Disturbance (SED) in the CMHSP system ages 4 through 6 years. The PECFAS is to be completed at intake, quarterly thereafter and at exit from CMHSP for children in this age range receiving behavioral health services. The PECFAS is used as part of the determination of functional impairment that substantially interferes with or limits the minor’s role or results in impaired functioning in the family, childcare/school or community activities.</td>
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<td>Submission of CAFAS and PECFAS data to MDHHS on an annual basis is a contract requirement (6.5.1.1).</td>
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**Using CAFAS/PECFAS to assess functioning as part of eligibility and level of care determination**

The CAFAS is used as part of the determination of functional impairment of the child with SED** to document that their mental health condition substantially interferes with or limits the minor’s role or results in impaired functioning in family, school, or community activities. This is defined as:
- A total score of 50 (using the eight subscale scores on the CAFAS, or
- Two 20s on any of the first eight subscales of the CAFAS, or
- One 30 on any subscale of the CAFAS, except for substance abuse only.

The CAFAS
- is used as a criteria to consider in determining the intensity of services needed, as an outcome measure (pre and post), as an aid to actively manage cases during a course of treatment, and for agency tracking

The PECFAS
- is used as a criteria to consider in determining the intensity of services needed, as an outcome measure (pre and post), as an aid to actively manage cases during a course of treatment, and for agency tracking

- measures seven subscales; School/Daycare, Home, Community, Behavior Towards Others,
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<th>Issue</th>
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<th>PEFCAS</th>
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|       | and quality improvement.  
- measures eight subscales: School, Home, Community, Behavior Towards Others, Moods/Emotions, Self-Harmful Behavior, Substance Use and Thinking/Communication. The CAFAS also includes Caregiver Resources Scale which is not included in the total score.* | Moods/Emotions, Self-Harmful Behavior and Thinking/Communication. The PEFCAS also includes Caregiver Resources Scale which is not included in the total score.* | For youth, ages 18-21, that are involved in the SED Waiver and Wraparound, the CAFAS is required.  
For young children, ages 3-4, that are involved in the SED Waiver and Wraparound, the PEFCAS is required. |
|       | * A comprehensive psychosocial assessment identifies the parent, family and caregiver’s strengths and needs which informs the treatment plan. Utilization of the Caregiver Resources Scale is encouraged to assist clinicians in identification of issues for planning purposes, but is not required nor scores reported to the Department. |   | ** Information on Eligibility Criteria for children with serious emotional disturbance is outlined in the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program FY 16 – Attachment P4.7.4  
Please Note: Do not use the CAFAS and PEFCAS to assess children with I/DD and do not use the online PEFCAS/CAFAS system to enter data on these children. |
| Transitioning from PEFCAS to CAFAS | When transitioning from the PEFCAS to the CAFAS during a treatment episode because the child will be continuing to receive services past the age of 7, it is recommended that an exit PEFCAS and an initial CAFAS be completed as close as possible to the child’s seventh birthday. If both an initial and exit score is not entered for either or both tools (as applicable) for a particular child, data is not captured for that child in state aggregate reports. |   | |
| Evidence Based Practice Labeling | Pre-post labels are to be identified for EBPs at the administration closest to the implementation of the EBP, including:  
- Parent Management Training-Oregon (PMTO) and Parenting Through Change (PTC)  
  All non-certified and certified PMTO/PTC clinicians must label the CAFAS and PEFCAS pre- and post-intervention for all children/youth receiving PMTO (individual) or PTC (group).  
  Caregiver Wish list must be completed pre- and post-intervention for all participating in PMTO and/or PTC.  
- Trauma Focused Cognitive Behavioral Therapy (TFCBT) and Trauma Assessment  
  All clinical supervisors and clinicians providing trauma assessment and TFCBT (during the Learning Collaborative/training, after completion of the training) are to use the TFCBT label on the web-based application. |   | Please note: Children/youth receiving the DHS Incentive Payment (DHIP) are labeled by the designated person after payment. |
| PIHP/CMHSP Responsibilities | PIHPs/CMHSPs are expected to establish and/or maintain access to CAFAS and PEFCAS trainers (employ them or contract with trainers) to ensure that their children’s staff have access to CAFAS and PEFCAS Rater Trainings and Rater Boosters. |   | |

Updated, March 2017
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<th>Issue</th>
<th>CAFAS</th>
<th>PECFAS</th>
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<tr>
<td>All CAFAS and PECFAS training and booster records for raters and trainers must be maintained by the CMHSP/PIHP.</td>
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<tr>
<td><strong>Training Requirements</strong></td>
<td><strong>Initial Rater Reliability for CAFAS and for PECFAS</strong></td>
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<td>Rater reliability training is required for all child mental health professionals providing assessment and treatment to children/youth beginning at four years of age. CAFAS or PECFAS raters must attend rater reliability training and pass the reliability test in order to become a reliable rater of CAFAS and/or PECFAS. The Multi-Health Systems online CAFAS training may be used to enhance face-to-face training but is not a substitute for face-to-face rater training.</td>
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<td><strong>Booster for Raters</strong></td>
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<td>Raters must maintain their reliability every two years by completing a booster training for CAFAS and/or PECFAS.</td>
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<td><strong>CAFAS or PECFAS Train the Trainers and Boosters for Trainers</strong></td>
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<td>MDHHS and MHS have an agreement that allows Michigan to continue to train trainers and raters in both tools. All training materials for the CAFAS and PECFAS are to display the following language, on every slide:</td>
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<tr>
<td>Copyright ©2006. Multi-Health Systems Inc. All rights reserved. Not to be translated or reproduced in whole or in part, stored in a retrieval system, or transmitted in any form or by any means, photocopying, mechanical, electronic, recording or otherwise, without prior permission in writing from Multi-Health Systems Inc. Applications for written permission should be directed in writing to Multi-Health Systems Inc. at 3770 Victoria Park Avenue, Toronto, Ontario M2H 3M6, Canada.</td>
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<td>In order to be considered a trainer of either/both the CAFAS and/or PECFAS; a person must have attended the two-day rater training for the tool, plus the two-day training of trainers for the tool. Trainers are then required to attend a trainer booster every two years.</td>
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<td><strong>MDHHS Support</strong></td>
<td><strong>Licensing Fee</strong></td>
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<td>MDHHS pays the licensing fee for the use of the web-based PECFAS and CAFAS (and Caregiver Wish List) for Michigan's CMHSPs and their provider agencies through a contract with Multi-Health Systems Inc. (MHS). Additional &quot;basic web services&quot; may be purchased by sites but &quot;fully integrated web services&quot; are not an available to Michigan sites because it prevents data from being included in the statewide aggregate data.</td>
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<td><strong>Training</strong></td>
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<td>MDHHS will continue to provide CAFAS and PECFAS Train the Trainer trainings and CAFAS and PECFAS Trainer Boosters through the Michigan Association of Community Mental Health Boards (MACMHB). Please go to the MACMHB's website for training details and registration, <a href="http://www.macmhb.org">www.macmhb.org</a></td>
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<td><strong>Questions</strong></td>
<td>Kim Batsche-McKenzie, LMSW</td>
<td>Mary Ludtke, Consultant, Division of Mental Health Services to Children and Families, MDHHS</td>
</tr>
<tr>
<td>Manager of Services to Children with SED, Division of Mental Health Services to Children and Families, MDHHS</td>
<td>T: (517) 241-5765 E: <a href="mailto:Batsche-mckenziek@michigan.gov">Batsche-mckenziek@michigan.gov</a></td>
<td>T: (517) 241-5769 E: <a href="mailto:Ludtkem@michigan.gov">Ludtkem@michigan.gov</a></td>
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