TEAM WELLNESS CENTER

Residential Treatment/Jail Diversion Program

Program Description

Team Wellness Center offers Jail Diversion programming in a Residential Treatment setting, which is organized and staffed to provide both general and specialized non-hospital-based inter-disciplinary services 24 hours a day, 7 days a week for persons with behavioral health or co-occurring needs, including intellectual or developmental disabilities. The program is provided in partnership with the individual (a direct acknowledgment to participate). The program provides an environment where the members reside and receive services from personnel who a trained in the delivery of services for persons with behavioral health disorders or related problems; who have experience arrest, jail, incarceration or the potential of being jailed, arrested or incarcerated.

These services are provided in a safe, trauma-informed, recovery-focused milieu designed to integrate the person served back into their home or community and living independently, engaging in productive activities without further interaction on the wrong side of the law. The program involves the family or other supports in services whenever possible.

The RT/JD program uses a clinically-based approach to provide treatment to people with mental illness and substance use disorders while addressing the social determinants that adversely affect their recovery; to assist them with avoiding infractions of laws and local ordinances. The goal of the program is to improve the mental, physical, emotional and economic well-being of participants by providing access to treatment services around the clock.

The program will include community safety needs in all judicial decisions and require that behavioral health programs are aware of the safety requirements of not only the individual, program staff members, and peers, but also the community at large.

The court treatment portion of the program works with the following, as appropriate:

- Prosecutors
- Defense counsel
- Court personnel
- Other criminal justice representative

Program Philosophy

Team Wellness Center is dedicated to enhancing the well-being of individuals by providing an array of comprehensive behavioral and physical services in an environment that promotes quality of life, continuous improvement, and social awareness.

Program Goals

- Provide 24-hour overnight services to persons in the judicial system: awaiting court, jailed, arrested, incarcerated, early release, paroled, probation or released from department of corrections.
- Initiate integration of services to further stabilize the person's condition and prepare him/her for transfer to an alternative level of care.
- Enhance the dignity, personal choice and privacy of the person served.
- For persons with a history of alcohol or drugs: provide sober living techniques to increase the likelihood of sobriety and abstinence and to reduce potential relapse.

Specific Services Offered

Services offered included: Mental Health Treatment; Substance Use Treatment; Individual and Group Therapy; Peer Mentorship; Employment, Skill Building & Pre-Vocational Training; Adult Education / G.E.D. Classes; Dental Care; Primary Care Services; Housing Assistance; and Food & Accommodations (as available).

Components of the disease management program include:

- Population Identification: The above conditions and health behaviors are assessed during the intake process and flagged in the member's chart.
- Evidence-Based Practice Guidelines: The physicians, RN's, and member treatment teams are critical to educating members on an ongoing basis about how to better manage their conditions. TWC staff are educated on practice guidelines and utilize the "Paths to Improved Outcomes" manual to ensure Evidence-Based Care is provided to members with the targeted chronic conditions.
- Collaboration: The Paths to Improved Outcomes employ a collaborative and interdisciplinary approach to care, including care coordination with outside agencies.
- Self-Management Education: TWC recognizes that individuals who are better educated about how to manage and control their condition receive better care.
- Outcomes Measurement: The Chronic Conditions are monitored on a regular basis to ensure disease management interventions and approaches are effective.

Population Served

TWC serves persons at least 18 years of age, homeless with mental health and/or substance abuse issues.

Eligibility/Admissions Criteria

A written assessment is conducted for each person served that includes:

- Arrests
- Convictions
- Violations of parole and/or probation
- Prior incarcerations
- Pending cases
- Information on the person's participation in organizations or groups that encourage criminal behavior
- The relationship between the person's behavioral health and his or her criminal activity, including, as applicable:
  - Alcohol and other drug use
  - Mental illness
  - Post traumatic stress disorder
  - Family concerns
  - Violence
- Risk to self, other persons served, personnel and/or the community

Member must be accused or adjudicated, referred from within the criminal justice system who are experiencing behavioral health needs, including alcohol or other drug abuse or addiction, or psychiatric disabilities or disorders.

All members receiving services from TWC for behavioral health issues will be considered members of the Health Home. TWC receives referrals in a variety of ways, including MCPN referral, hospital referral, or self-referral. Members that decline to participate in the Health Home will be required to sign-off on the declination, and this will be noted in the member's chart. Members can decide to enroll in the Health Home at any time following the declination.

Eligibility screening and admission to TWC's RT/JD is determined by the following:

- Member is identified as eligible to be defaulted into DWMHA's Central Access Department
- Member is identified as being a part of a different contracted payer
- Member is covered under a contracted private insurance
- Referred by MPRI
- Referred by other Rehabilitation Facilities
- Referred by County Jail
- Referred by Department of Corrections
- Member is deemed medically stable or is under the care of a physician
- Member is deemed eligible to live at the address legally (i.e., proximity laws for sex offenders)
- Member is psychologically stable enough to participate in individual and/or group therapy (not in need of hospitalization to treat illness)
- Member is able to manage behavior in such a way as not to be of harm to themselves or others
- Member is in need of access to a comprehensive array of mental health, substance abuse or developmental disability services to meet their needs
- TWC also accepts self-referrals

Participation in the court treatment program is not denied solely on the basis of inability to pay fees, fines, or restitution.

Modalities of Treatment

Our treatment modalities are based on Evidence-Based Practices and research in the arena of Mental Health.

The most commonly utilized treatment modalities for case processing are:

- Cognitive Behavior Therapy (see expanded definition on Outpatient program)
- Brief Solution Focused Therapy
- Group Therapy

- Family Therapy
- Crisis Intervention/Stabilization
- Stages of Change/Motivational Interviewing
- Behavior Modification
- Relapse Prevention
- DBT
- Peer Support Specialists/Recovery Coaches

Primary care services that are provided internally follow best practices in medicine, as defined by the U.S. Preventive Services Task Force (USPSTF). Health Indicators are based on recommendations by the USPSTF and the National Council for Behavioral Health.

Adequate Services

A single entrance will be used for accessing all services. Primary care, behavioral health, and SUD services are provided seamlessly in the clinic. Upon admissions into the program, members will be assigned a Health Home Team. The Health Home Team consists of a therapist, a primary care coordinator, a back-up care coordinator, and a peer support specialist (see Program Description section on Staffing). The Health Home Team is responsible for performing intake and annual assessments with the member, assisting the member in articulating goals, developing a person-centered plan of care, and providing the member with necessary support, assistance, and referrals. Members will also be assigned to a psychiatrist and a primary care provider (unless an external PCP has already been assigned). Care Coordinators ensure coordination between the behavioral, primary care, and specialty providers, regardless of whether a member receives primary care services internally or externally.

Care Coordinators maintain contact with members at least monthly (more if determined by the IPOS) and will include the following:

- A review of the person-centered plan
- Optimizing of resources and opportunities through community linkages
- Assistance with developing or enhancing social support networks
- Assistance with accessing transportation services, as needed
- Assistance with accessing safe housing that is reflective of the abilities of the person served
- Assistance with accessing safe housing that is reflective of the preferences of the person served

The intensity of case management is based on the needs of the person served.

When multiple case management providers exist, linkage is made to:

- Ensure continuity of care
- Reduce duplication of services

Therapists and peer support specialists maintain contact with the member as determined by the IPOS, typically 1-4 times per month. Members receiving psychiatric medications will receive an initial psychiatric evaluation (as well as annually) and will be scheduled for follow-up with the psychiatrist on a monthly basis for a medication review. Some members may be scheduled more frequently with the psychiatrist if it is determined to be clinically necessary. Primary Care Providers will examine members at least annually (if receiving PCP services internally). Members with chronic health conditions will be monitored by a PCP at least quarterly, or more often if deemed clinically appropriate.

Members are typically discharged from the behavioral health home when they have met all of the goals outlined in their IPOS, or at their own discretion. TWC care coordinators will ensure a smooth transition into subsequent programming, primary care services, or follow-up care upon discharge.

Comprehensive Care Management

I. Communicating with other primary and specialty care providers: TWC asks all members to complete provide authorization/ROI to communicate with other providers. The care coordinators are responsible for ensuring that all communication between providers occurs and is documented. Types of information shared will include physical health assessments, medication updates and change, lab results, hospitalization status, and data related to current HEDIS measures. This information will be shared for both members who have a TWC PCP and members who do not.

II. Integrated IPOS: Following a psycho-social assessment, case management assessment, health assessment (and H&P if receiving primary care at TWC), and psychiatric evaluation, the care coordinator will assist members with constructing an IPOS, which outlines interdisciplinary member needs and goals. Interdisciplinary interventions will be included, which will assist member in meeting their goals, such as:
   a. Addressing issues specific to his or her individual needs
   b. Consistent with his or her cognitive and learning abilities
   c. Consistent with the program's philosophy of treatment
   d. Relapse prevention
   e. Potential contingency plans

III. Composition of Health Home Team:
   a. Member
   b. Therapist (LMSW, LLMSW, LLPC, or LPC)
   c. 2 care coordinators (LLBSW or LBSW) – 1 will be assigned as “primary”
   d. Peer Support Staff
   e. RN
   f. Psychiatric Provider (psychiatrist or NP)
   g. Primary Care Provider (optional)

IV. The program communicates the need for ongoing judicial interaction to each court treatment participant.

V. The court treatment program provides, or ensures the provision of the following outpatient services:
   a. Individual counseling/therapy
   b. Family counseling/therapy
   c. Group counseling/therapy
   d. Psycho-education
   e. Detoxification/withdrawal support
   f. Inpatient treatment
   g. Residential treatment
   h. Intensive outpatient treatment
   i. Case Management
   j. Provision of, or linkage to, skill development services needed to enable the person served to perform daily living activities, including, but not limited to:
      i. Budgeting
      ii. Meal planning
      iii. Personal hygiene
      iv. Housekeeping

VI. The treatment team works in a partnership with the judge to:
   a. Review treatment progress on an ongoing basis
   b. Respond to the progress and/or non-compliance of each person served

VII. The person served is provided with a description of the relationship between the criminal justice entity and the program, including:
   a. The extent and limitations of confidentiality and sanctions
   b. The possible implications of having a criminal justice member on the team

VIII. An ongoing assessment of the needs of the persons served to determine appropriateness of services directly provided or accessed

IX. Evidence of linkage with necessary and appropriate services, including, when applicable:
   a. Financial
   b. Medical or other healthcare
   c. Medication use
   d. Educational
   e. Employment
   f. Other community supports

Referral Source

Persons are referred to the RT/JD program by County Jails, Department of Corrections, Contracted Payers, TWC Case Holders, Therapist, Psychiatrist, Primary Care Physicians, Hospitals, Law Enforcement, self-referral and/or other CMH agencies.

Setting

TWC RT/JD program is provided in space that is dedicated for overnight accommodations with individual and shared bedrooms and bathrooms (gender specific). Participants will have access to clean bedding, laundry facilities, food and leisure activity; in close proximity to linkage with outpatient/health home services.

Staffing

Services are delivered by a team with specialized knowledge of the various theories of, and approaches to, criminal justice behavioral health services. Only a credentialed, qualified Mental Health Professional will provide treatment to children/families. Staff will be employed based on the following minimum criteria:

- Case Managers: Bachelor's Degree in Human Services related field (Licensure must be obtained LLBSW, LBSW, SST)
- Clinical Therapist: Licensed or Limited Licensed Master's Degree in Social Work, LLP, LLPC, MFT
- Nurse: Associate's Degree in Nursing (RN)
- Psychiatrist: MD, DO, or FNP and licensed to provide psychiatric services in the state of Michigan
- Peer Support: Certified Peer Support Specialists
- Primary Care Provider: MD, DO, PA, or FNP licensed to practice in the state of Michigan

Training

- Is provided to personnel prior to the delivery of services
- Includes regular interdisciplinary joint cross-training related to clinical and criminal justice issues
- Includes such topics as the requirements imposed on personnel from the criminal justice system who participate on the treatment team
- Safeguards that are available to personnel

Documentation

The following documents are general in nature and are in no way inclusive of all documents which may be located/required in an individual's Medical Record:

- Intake Paperwork
- Psychiatric Evaluation, Psychosocial Assessment, Nursing, and Case Management Assessments
- History and Physical
- Lethality Assessment
- IPOS
- Individual Progress Notes from each discipline
- Authorization to Release/Request Information
- Crisis Plan
- Medication consent
- Notice of Hearing Rights

Hours of Operation/Frequency

TWC's Overnight program provides Clinical Therapy, Case Management, Primary Care, Peer Support and other supportive services 7-days per-week, 8 p.m. - 8 a.m. Toll free number for all locations: (888) 813-8326

Location

Team Jefferson
11105 E. Jefferson
Detroit, Michigan 48202

Transition/Discharge Criteria

A member may be discharged from Outpatient Services for the following reasons:

- The member/guardian requests to be discharged
- Member has met all goals as written in the IPOS and new functional goals cannot be established. Member is able to function on his/her own, is community integrated and has established independence
- Member is not making additional functional gains or there has been a persistent regression in performance, which has a negative impact on the member's ability to meet goals established. Discharge will be administered due to lack of progress and inability to successfully complete individual member goals. A referral to a more appropriate TWC program or a program within the community will be made.
- Member has behavioral challenges that make treatment in their current level of care unsafe or ineffective. A referral to a more appropriate TWC program or a program within the community will be made.
- Member fails to comply with rules of the program
- Member is incarcerated again
- Member fails to respond to contact attempts (see discharge policy)

When the person served is referred to a different level of care in the community, the court treatment program establishes a process to consistently receive information regarding his or her status.

Payer/Funding Source

Funding is provided by Detroit Wayne Mental Health Authority (DWMHA), Michigan Department of Health and Human Services (MDHHS), and private insurances.

Fees

Fee For Service

Additional Information

All services provided by TWC abide by Person Centered Planning guidelines (see Person Centered Planning Policy)
All services provided by TWC abide by rules and regulations established for member rights (see Recipient Rights policy).
All members age 21 or under with Medicaid insurance shall be notified of the availability of EPSDT services and shall link the member and his or her family members to these services, when appropriate.
TWC will maintain an up to date Resource Manual that can be conveniently accessed and used by TWC staff.
All eligible members shall be offered case management, as well as an informed choice of case managers.
When applicable, frequent alcohol and other drug testing is used to monitor abstinence.

Outpatient services are provided to individuals enrolled in contracted payers or are private pay.