

**La Crosse County  
Human Services  
Comprehensive Community Services  
HFS 36 Updated Plan (3-08)**

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## **INTRODUCTION:**

La Crosse County Human Services has provided a comprehensive array of behavioral health services both through direct service and through contracting with a rich network of providers. The county was one of the first in the state to be certified to offer a community support program for the population with serious and persistent mental illness and also is certified for mobile crisis, outpatient mental health and AODA services. La Crosse County was certified in 2005 to include Comprehensive Community Services (CCS) in our continuum of services.

## **CCS PLAN -HFS 36.07**

### **Organizational Plan - HFS 36.07(1)**

Comprehensive Community Services (CCS) will be incorporated within the Clinical Services Section of the La Crosse County Human Services Department. (*See organizational charts - Appendix I*). The program will be closely coordinated with the county's CSP and Outpatient Programs for both Mental Health and AODA issues and also work in close collaboration with the county's Care Management Organization. The CCS benefit for children will closely be coordinated between the Family & Children's Section and the Clinical Section's of the Human Services Department, incorporating existing staff between these two sections.

CCS in La Crosse County is intended to provide one of the services in a comprehensive continuum of care model for behavior health (*see matrix - Appendix II*) SAMSHA. The program will be designed to provide a care management model for those with mental health issues not needing the intensity of a CSP approach to care management but needing more than simple outpatient services. The program is also designed to be a progressive model for leading participants to recovery for those who may be currently in CSP but not needing this program model in the future.

The Aging & Disability Resource Center of the county will work in collaboration with the Clinical Services Section to determine initial eligibility for the CCS benefit and assist interested consumers with application to the program.

CCS will build upon the county's commitment to participant recovery and participant empowerment principles. The "Core Values" for the CCS Program will include the following:

- Family or participant/member centered
- Participant involvement in planning individual recovery plans.
- Build on natural and community supports
- Strength-based
- Coordination and collaboration across systems.
- Multidisciplinary teaming
- Self-sufficiency
- Recovery/Reintegration
- Education and work focus
- Belief in growth,
- Outcome-oriented
- Integration of health outcomes

**Staff Functions - HFS 36.07(1)(a)**

**Administrator Function:** A supervisor from the Family and Children section will fulfill the duties of the CCS Administrator. The duties of this position in CCS will include the overall responsibility for CCS, including compliance with HFS36 and other applicable state and federal regulations; and developing and implementing policies and procedures.

**Service Director Function:** The Service Director role will be provided by staff from within Clinical Services. One individual will be responsible for day-to-day consultation with CCS staff, and be responsible to assure that quality services are provided. The other individual will oversee the authorization of services. Consistent communication will occur between these individuals to ensure that program values are maintained at all times. These individuals will also meet regularly with the Mental Health Professionals in order to empower them to assist in the day-to-day consultation of CCS staff.

**Mental Health Professional Function:** Mental Health Professionals will participate in the assessment process, recovery team, (if the participant chooses) service planning and discharge planning. This position will be responsible for the authorization of services. Mental Health Professionals will meet regularly with those individuals fulfilling the duties of CCS Service Director in order to become empowered to provide assistance with day-to-day consultation of CCS staff.

**Substance Abuse Professional:** When co-occurring substance use issues exist, a Clinical Services AODA Counselor, or qualified designee, will either be consulted or participate in the assessment process, recovery, team, service planning, and discharge planning.

**Service Facilitation Function:** The responsibilities of the "service facilitation function" will be assigned to a qualified staff member of both Clinical Services and Family and Children's Section who has a case management role or professional relationship to the participant. The CCS Supervisor and the unit supervisor of the staff member will agree on the designation of a staff member as the CCS service facilitator. When a staff member is fulfilling the CCS functions, the percentage of his/her time conducting those responsibilities will be allocated as CCS staff time. There will be side-by-side collaboration between the CCS Supervisor and the Family & Children's Supervisor to

delineate the multiple agency responsibilities.

The service facilitator role includes ensuring that the service plan and service delivery for each participant is integrated, coordinated and monitored, and is designed to support the participant in a manner that helps him/her to achieve the highest possible level of independent functioning. This position is also responsible for facilitating the assessment and service planning processes.

For the qualifications and staff functions of specific Health and Human Services staff members who will be assigned these duties in La Crosse County CCS, refer to the Staff listing Forms in *Appendix III*. Additional staff will be added to CCS to fulfill functions as more participants are admitted in the various phases.

### **Quality Improvement - HFS 36.08**

La Crosse County Clinical Services continues to work with consumers to explore how to improve our helping efforts. La Crosse County CCS will implement a Quality Improvement plan to evaluate how effectively the services are meeting participants' needs and to direct how changes may be implemented when participant's needs are not being met. This will occur after provisional certification and before the first year is over.

In 2005 La Crosse County Clinical Services formed a QA/QI committee that meets on a monthly basis. The committee is comprised of both staff and participants. This committee will make recommendations to the CCS program in exploring how to monitor and improve service efforts as part of its role to continually improve all Clinical Services programs. The committee collaborates with the Consumer Advisory Council on prioritizing where to focus efforts.

The CCS Quality Improvement plan will incorporate the following:

1. A consistent level of monitoring, and responding as needed to data collected through CCS Recovery Planning. CCS Recovery Plans will collect data on participant satisfaction with services, involvement in recovery planning, and progress toward desired outcomes. Participant satisfaction with assessments, service planning, service facilitation, and vendor services will also be collected. The confidentiality of persons providing opinions to CCS will be protected. All data will be summarized and reviewed with the CCS Coordinating Committee and CCS staff on a quarterly basis.
2. A yearly program survey of CCS staff will be implanted to gain their input on program strengths and to invite recommendations for improvement.
3. At least one Quality Improvement project will be implemented each year. It is likely that these projects will be designed and implemented with the assistance of the Clinical Services QA/QI committee. The Coulee Coalition for Children

of Differing Abilities and the Consumer Advisory Council will be informed or involved on all projects.

Quality Improvement Plan data and results will be shared with the CCS Coordinating committee and the Coulee Coalition for Children of Differing Abilities on a basis for discussion and planning.

**Coordination Committee - HFS 36.07(1)(c)**

Participants will be involved at all levels of La Crosse County CCS including program planning, design, and quality improvement. In February 2005, La Crosse County designated a CCS Coordinating Committee (*Appendix IV*). The composition of this group meets the specified ratio of no more than 1/3 county staff and at least 1/3 participant membership.

- Family and children membership for the CCS coordination committee will come through the Coulee Coalition for Children of Differing Abilities. This coalition currently has about 33% participant representation and will seek membership for CCS from members of this coalition when deemed necessary.

The committee will meet at least quarterly or more often as desired by group members. Written minutes of the meetings and a membership list will be maintained at La Crosse County Human Services.

The Coordination Committee members will receive orientation and training related to the role of the committee, understanding mental health and substance use issues, learning the benefits of psychosocial rehabilitation, special concerns of child, adult and elderly populations, and an overview of the systems that serve CCS participants. Orientation and training will be provided in the form of written information and in-service presentations at meetings.

The coordinating committee shall do all of the following:

- Serve in an advisory role to La Crosse County CCS.
- Review and make recommendations regarding the initial and any revised CCS plan required under s. HFS 36.07, the CCS quality improvement plan, personnel policies, and other policies, practices, or information that the committee deems relevant to determining the quality of the CCS program and protection of participant rights.
- Maintain written minutes of meeting and a membership list.
- Meet at least quarterly.

**Recruiting and Contracting With Providers - HFS 36.07(1)(d)**

La Crosse County will have an open network of options to meet the needs of CCS participants. This network will include both supports and services that are available via the CCS benefit as well as the persons own resources such as their MA card. CCS participants will be provided information about the identity, location(s), qualifications,

and availability of these supports and services on an ongoing basis. CCS administrative staff shall continuously monitor the extent to which La Crosse County maintains an adequate array and capacity of services to meet the needs of CCS participants.

La Crosse County Human Services has a well developed policy and procedure on purchasing and contracting with providers. This policy/procedure provides for a systematic approach for the purchase and contracting of goods and services while providing for fair and equitable treatment for all persons involved in public purchasing, maximizing the purchasing value of public funds, and providing the necessary safeguards for a public purchasing and contracting system.

**Updating and Revising the CCS Plan - HFS 36.07(1)(e)**

Amendments or revisions to the Comprehensive Community Services Plan will be made when there are substantive changes to the CCS Program including when services are changed or added to the service array and when policies and procedures of the program are added or revised, or when additional staff are assigned duties within CCS. The CCS Coordination Committee will review all amendments and revisions of the Comprehensive Community Services Plan. The feedback of the Coordination Committee will be documented and maintained with the updated plan.

**Recommendations of Coordinating Committee (and response) - HFS 36.07(2)**

**La Crosse County  
CCS Coordinating Committee Recommendations regarding CCS Plan  
Update  
(May 2008)**

*(Drafted based upon May 2008 CCS Coordinating Committee meeting notes)*

The CCS Coordinating Committee appreciates the opportunity to review changes made to La Crosse County's CCS Plan. Please see May meeting notes to determine members that were present for this discussion. We understand the following changes have been made:

Modifications:

1. Changed introduction language a bit to now focus on mainly CCS. References to Redesign and the CMO were removed.
2. ISP process no longer used to supplement Recovery Plan. All services provided and purchased by CCS are listed on the Recovery Plan. Use of the ISP is considered duplicating and confusing to consumers.
3. Changed nurses category from Psychiatric Medication Administration to Physical Health and Monitoring. Same role, but state split initial category into

two separate ones.

4. Removed Psychosocial Residential Supports category.
5. Removed references to ADRC doing MH/AODA Functional Screens.
6. Updated CCS internal staff list.
7. Updated CCS vendor list.
8. Removed ISP example.

We understand that we can access the full plan on the county website. At this time there is no positive or negative feedback as the changes seem to be very minor in scope. No recommendations are forwarded at this time. CCS Coordinating Committee members will view the full plan at their leisure and bring any concerns back to the full group.

### **CCS Administrative Response to Recommendations (May 2008)**

The CCS program continues to value the input of the CCS Coordinating Committee. Members are encouraged to view the full plan on the website and bring any topics of concern or interest back for discussion.

### **County System of Services - HFS 36.07(3)**

Families who have children with mental health and substance use issues and significant behavioral challenges due to a disability may be involved in receiving services through the Family and Children's Section. Children with Special Needs Unit I and II offer a continuum of services that are guided by the mission of "utilizing a family centered strength-based and culturally competent approach to work collaboratively with individuals, families and community to develop an integrated system of care that will empower those we serve to enhance their quality of life".

The family is viewed as the expert in the development of the plan of care. Effectively serving children with severe emotional disorders and behavioral challenges requires an integrated system of care. The challenge lies in understanding and accepting that, to be effective, agencies involved with children and their families are interdependent. No single agency can meet or respond to all family needs. The opportunity lies in gaining access to supportive services that might otherwise be overlooked, unavailable, or unrecognized.

Families and their children are offered a continuum of supports and services in order for the child to remain in their home or community or within the least restrictive environment that is clinically and educationally appropriate. These supports and services include three options. First, identifying what resources the family has. Second, informal and

community supports such as partner support and service coordination, religious community, summer programming, advocacy groups, support groups and tribal communities. Third, formal supports such as support and service coordination, therapist, psychiatrist, educator, vocational-rehabilitation specialist, mobile crisis services, respite, placement out of home and law enforcement are all a part of the comprehensive system of care.

La Crosse County has an extensive network of mental health and AODA providers within the Human Services Department, as well as the community.

**County System:**

Adults with mental health/AODA needs are primarily served in the Clinical Services Section of the Human Services Department. This includes: certified outpatient mental health and AODA programs; psychiatric services provided by two part-time physicians, two registered nurses providing coordination with physicians and medication management; two psychologists, a certified Community Support Programs serving approximately 80 participants; a certified Crisis Program which operates 24 hours each day; Adult Protective Services Unit; an Elder Abuse Interdisciplinary Team and a Targeted Case Management Unit. La Crosse County also operates a Care Management Organization, as a Family Care County, which has a Mental Health Specialty Unit that serves participants who have a mental health disorder in addition to a qualifying physical or developmental disability. In La Crosse County, most referrals for MH/AODA services are received in the Resource Center, which serves the single point-of-entry for Human Services Referrals.

**Adult Community Services:**

There are two major medical centers located in the city of La Crosse both of which provide inpatient and outpatient psychiatric care; mental health and AODA residential, outpatient and day treatment programs, as well as inpatient detoxification services. There are also currently three CBRF facilities specializing in mental health care and one CBRF which specializes in AODA stabilization. There are also three privately owned certified mental health clinics and four certified AODA clinics located in La Crosse County.

**Outreach HFS 36.07(3)(a)**

La Crosse County CCS in collaboration with the Resource Center of La Crosse County will conduct outreach activities in order to assist non-CCS programs and facilities to be aware of the concept of CCS and how to refer individuals.

The Resource Center meets with our Salvation Army once per month at their facility to discuss referrals. The Salvation Army can make a referral to the Resource Center at any time. There will be a mechanism established so the participant will be offered an opportunity to sign a release so there can be information shared with the Resource Center.

Specific referral sources that will be targeted for outreach will include but will not be limited to inpatient psychiatric or substance abuse treatment staff, discharge planners from general medical floors at the two major hospitals, participant care coordinators at the two major clinics, nursing homes, residential care centers and day treatment providers, Probation and Parole, the Justice Sanctions Program, the faith community, advocacy groups, as well as the community at large will be targeted for outreach efforts. A mental health professional from the Clinical Services staff regularly screens inmates from the county jail for mental health issues and makes appropriate linkages and referrals. Outreach can include formal presentations, TV and radio shows, mailings, payroll stuffers and informational literature mailed with other information sent out to the community. Outreach regarding this program will be included with other outreach activities of the Resource Center. A formalized program/power point will be developed so that staff from either the Resource Center or CCS can give consistent information and facts regarding CCS. Audio visual equipment already available in the Resource Center will be used.

The Resource Center will assist consumers to determine eligibility for admission to CCS or other mental health services offered by La Crosse County Clinical Services. If a consumer expresses interest in CCS and appears eligible the individual will be referred to a Clinical Services supervisor or designee for determination of the most available service, taking into consideration the participant's service preferences. At initial screening the Resource Center worker will look at all possible programs or services that may be beneficial to the participant including but not limited to; Family Care, Economic Support Benefit Programs, Social Security Disability Benefits/SSI or natural family and community supports.

The La Crosse County Clinical Services social worker designated with the responsibility for CCS Outreach will participate in discharge planning activities with psychiatric inpatient units to assist the participant in making a successful transition into CCS if appropriate. The Clinical Services supervisor will participate in discharge planning from other facilities named to ensure a successful transition. Individuals determined not eligible for CCS either by the Resource Center or the CCS supervisor will be referred to appropriate non-CCS programs. The Resource Center and the CCS staff will maintain excellent communication regarding role responsibilities as the participant accesses services.

Outreach to elders will occur in all areas as described; Terry McDougle of our AODA Clinical Services unit is our liaison with the detox units here in La Crosse. She will make direct referrals to the Clinical Services supervisor if the AODA participant is seen here at Clinical Services. If she interacts with a new AODA participant in the liaison responsibilities, an assessment and screen would be completed by the resource center and if eligible for CCS, would be referred. Any AODA unit staff can make a referral for CCS and the screening process would then begin.

Coulee Youth Center provides outreach AODA services in the community under contract with La Crosse County. If they should become concerned that someone needed CCS

services while seeing them in the community, they would contact the La Crosse County AODA case manager and they would then contact the Clinical Services supervisor for referral.

Outreach to families and children will occur through the Family and Children's Section at La Crosse County Human Services and its community partners. CCS will be integrated into the philosophy and practice of an integrated system of care which is utilized in Children with Special Needs Units I and II in the Family and Children Section.

The Family Resource Liaison, who is the systems change coordinator and a partner support and service coordinator for the Family and Children's Section, will assist with outreach activities. Presentations to groups on the integrated systems of care utilizing CCS to community partners and participants will occur. Specific referral sources will include but not limited to; families, relatives, friends, faith community, clinical settings, advocacy groups, therapists, psychiatrists, placement facilities, schools, CESA IV, vocational rehabilitation specialists, Economic Support and Resource Center at La Crosse County Human Services.

When a referral is made Family and Children's Intake will complete a "Children with Special Needs" referral form and it will be given to Children with Special Needs Unit I or II supervisor to determine the level of psychosocial rehabilitation services. The Family Resource Liaison will assist the supervisor to determine one of three options of service through the Family & Children's Single Point of Entry. The first option includes immediate linkage to supports and services in the community. The second option is short term support and service coordination which will assist families with linkage or transition out of formal support and services. The third option of service will be a referral back to the Children with Special Needs Unit I or II supervisor for formal support and service coordination. This third option may include entrance into CCS. An eligible participant may be admitted to CCS as a part of a mental health service domain. A support and service coordinator will be assigned to the family and child by the supervisor. In the event a child is eligible and a support and service coordinators have no openings on their caseload alternative services will be offered.

**HFS 36.07(3)(b)**

The La Crosse County CCS and Adult Protective Services staff will work in collaboration whenever a CCS participant is the subject of emergency protective placement, commitment, detention, protective services or elder abuse investigation. The participant's protective service needs, any court requirements and legal mandates will be incorporated into the CCS service plan. The adult protective services system will work side-by-side as a fully integrated services system for the participant.

**HFS 36.07(3)(c)**

Care coordination is essential to the effectiveness of CCS and other behavioral health services delivered by the county. Due to the county's involvement with Family Care, experience has been developed in defining collaborative working relationships between

multiple systems of care. When CCS services are provided in conjunction with other care coordination services, La Crosse County will work collaboratively with those service systems. When the care coordination is provided within any of our existing Human Services Department Section, i.e. Adult Protective Services, Child Protective Services, our Care Management Organization, etc., CCS staff will partner with existing teams or services to arrange a fully integrated service system. CCS administrative staff will collaborate with these other Human Services Sections to write MOU's that define roles and responsibilities. These MOU's will outline how the existing care coordination teams will work together for the participant's best interest.

For care coordination outside of our own Department, such as school systems, the CCS administrative staff will also pursue the development of MOU's to ensure coordination of services and systems. This process will maximize services through the provision of well defined roles and responsibilities coming about as the result of true partners for CCS participants and their desired outcomes via their participation in these systems.

**HFS 36.07(3)(d)**

When an individual is placed under Chapter 51 civil commitment, La Crosse County CCS will provide outreach and screening to determine if he/she is eligible to receive Comprehensive Community Services. When La Crosse County CCS is providing services to a civil commitment participant, the treatment requirements of the commitment will be incorporated into the CCS Service Plan. CCS will be responsible, in collaboration with our Court and Intervention Unit. For providing appropriate treatment plan services to the participant so that he/she can live in the least restrictive setting possible to ensure treatment and safety concerns.

**HFS 36.07(3)(e)**

CCS will establish contracts or MOU's with internal agency programs and outside services provider in order to define clear roles and responsibilities, ensure collaboration, and quality of service. Every contract and MOU will include agreements to incorporate CCS Service Plan goals, participate as necessary on teams, protect participant rights, and adopt the "Core Values". Likewise, contracts or MOU's will also include agreement to incorporate, court requirements and other legal mandates into CCS Service Plans, when applicable

**HFS 36.07(3)(f)**

The CCS will establish contracts with providers when a needed service is not available in the existing array of services. Contracts will include the provider's agreement to incorporate CCS Service Plan goals, participate as necessary on teams, protect participant rights, and adopt the program "Core Values".

If there is a service provider in the community available and willing to provide a service needed by a CCS consumer, a contract will be entered into the county. Our Fiscal

Department draws up the contract and renews them each year. La Crosse County CCS plans to utilize existing contracts whenever possible and establish new ones when necessary.

**Crisis Intervention Services HFS 36.07 (3) (g)**

La Crosse County Human Services has had a certified HFS 34 Emergency Mental Health Program since 2001. CCS participants will be offered the full array of crisis services that are currently provided to La Crosse County residents. These services include 24 hour telephone counseling, intervention and referral; mobile crisis intervention services; walk-in services providing face-to-face support; linkage and coordination services; stabilization services and hospitalization. Each participant's assessment and plan will include the development of a participant driven comprehensive crisis plan when indicated, which will identify strengths and needs related to potential crisis situations. When CCS Service Facilitators are unavailable, the mobile crisis responders will be contacted and will have access to the participant's crisis plan in order to resolve the crisis. Protocol dictates that the participant's case manager will be informed of all crisis contacts so that linkage and follow-up will be assured.

Children in CCS will receive mobile crisis services and child protection services when necessary. These services are available to children and their families 24 hours seven days a week. Each family and child in CCS will have an emergency response plan when needed for projected behavioral outburst which may include suicidal thoughts. This will be formulated with the entire integrated service team. Children's crisis policy and procedure dictates that when a child has three crisis emergency responses within a one year period of time an elaborate crisis plan will be done with the integrated services team and mobile crisis services. When it is determined that a child is in crisis or needing access to Child Protective Services and is a CCS participant, protocol will follow any established crisis system response planning within the Family and Children Section. Mobile crisis or Child Protective Services will secure communication with the support and service coordinator assigned to the family on any crisis or child welfare contact so that follow-up and linkage can be conducted.

**Implementation Plan:**

At this time CCS services are available to all eligible individuals that apply. We collect and compile all applications for CCS services and admit consumers who are eligible according to need, first and foremost, and then by date of application. For persons new to La Crosse County Human Services just applying for services, we will take the CCS application as appropriate and assess their need for immediate services. If our capacity in CCS does not allow for immediate admission, TCM or other appropriate services in the community will be sought out and the participant will be helped to receive those services until CCS may become available. We would give the participant an estimated time of admission when they apply and it is determined they are eligible for admission.

**Transitional Process for a Child to Adult Service Array:**

1. The Family and Children’s (FC) worker will assist the family in applying for a Disability Determination when a child is open to begin receiving services and supports. This will occur for children ages 3-17 years.
2. The FC Worker or parent will initiate the call to the Resource Center (RC) at 17 years 9 months. The Family and Children’s Worker may choose to contact the Comprehensive Community Services (CCS) Supervisor prior to this time frame (up to one year before the 18<sup>th</sup> birthday) for cases in which transition may be more involved.
3. When requested by FC Supervisor a FC social worker to provide background information to CCS supervisor to prepare for transition the following will be emailed by FC social worker to CCS Supervisor:
  - School Status-will graduate at age 18, stay in school, attend vocational programming or other direction of child’s education.
  - What are the needs of the individual, what is recommendation for support plan and what types of services will be essential to meet the individual’s needs.
  - Identify summer needs.
  - Have you referred for guardianship? This is to occur 6 months prior to transition.
  - Any other information that the social worker believes will aid the CCS to plan for the transition.
4. The CCS Supervisor or assigned CCS Worker may attend planned meetings for the individual related to transition.
5. The Aging & Disability Resource Center (ADRC) will assign a RC Worker to perform a functional screen and discuss Long Term Care Options counseling within 3 days.
6. The ADRC worker assigned can call the FC Worker once the process is started and will keep the FC Worker informed throughout the process.
7. The RC worker will notify the CCS Supervisor once initial screening has taken place for case assignment.
8. It is the RC Worker’s responsibility to explain to the parent/consumer that they must apply for financial assistance through Economic Support or social security.
9. The RC Worker will encourage the family to start the application process at Social Security. The application at Social Security can be started within the following timeframes:
  - \* SSI application can be started within the calendar month that the client turns 18.
  - \* If the client has already been receiving benefits under Social Security Disability for a deceased parent Social Security recommended making contact 3 months prior so that there isn’t any interruption in benefits. This is very important if the consumer is receiving benefits under student status.
  - \*The RC will not hold up the referral to Economic Support because the disability determination by Social Security hasn’t been made.
10. When appropriate the Family and Children’s worker will encourage the family to start the guardianship process six months before the person’s 18<sup>th</sup> birthday. The

- FC Worker will refer the family to the court and intervention unit. The outcome will be to have this completed by the consumer's 18<sup>th</sup> birthday.
11. The RC Worker will send the electronic screen and all notes to the CCS Supervisor for assignment.
  12. The CCS worker will contact the FC Worker to ensure a meeting is arranged so that supports and services will continue without interruption.
  13. The RC Worker will only stay involved at a minimal level once the electronic screen and all notes have been give to CCS Supervisor.

**PSR ARRAY OF SERVICES - HFS 36.07(4)**

The service array for La Crosse County CCS is set up to address the needs of consumers of all ages who are currently served within the program. It was also designed to address the needs of child participants who require support and service coordination to remain at home or community, who might otherwise not qualify for other mental health programming. Each child participant will benefit from an integrated system of care and may be transitioned out of formal services after 18 months. This is in contrast to children with mental health challenges who have long standing and long term needs which will be served through the children's long term support mental health waiver system.

The current array of psychosocial rehabilitation services is described below and listed in *Appendix V – CCS Service Array*. La Crosse County Human Services will add additional services to its service array based on an analysis of the needs of the CCS recipients receiving services.

**Comprehensive Assessment:**

Initial assessment, functional screen and assessment summary; completion of annual review of strengths, attributes and needs. Activities involved in the process used to identify the strengths, needs and desired outcomes of a consumer. Activities involved in evaluating progress toward desired outcomes.

The assessment service will ensure that a comprehensive strengths/needs assessment is completed with the participation of the participant, natural supports as identified by the participant, and involved additional service providers as appropriate and agreed upon by the participant.

A recovery team that includes the participant, his/her selected supports, and other service providers as appropriate, will be formed and will participate in the assessment. The participant has the choice to determine who is participating on the recovery team.

The assessment will be facilitated by the Service Facilitator and will include participation from the participant, recovery team, and mental health professional (*Please see Appendix VI Program Assessment Policy*). Additional professional consultation will be included as needed and appropriate, such as including consultation with a substance abuse professional, clinical therapist, clinical psychologist, psychiatrist or others. The process

will include all activities to prepare for completion of a service plan.

- Immediate crisis stabilization.
- Strengths, needs and culture discovery.
- Child and Family team formation, and facilitation.
- Comprehensive assessment and narrative.
- The team develops the Plan of Care.
- Assessment will be completed in 30 days.
- Address all assessment domains and criteria

All will be accomplished within 30 days of acceptance of application for admission to CCS.

### **Recovery Planning**

Services are determined through the development of an individualized recovery/service plan designed to provide for the highest level of independent functioning and quality of life possible and desired by the consumer.

The assigned service facilitator and designated mental health professional (both roles/responsibilities may be carried out by one individual) will facilitate the assessment and service planning process. *(Please see Appendix VII Program Service Planning Policy.)*

The recovery team that includes the participant, his/her selected supports, and other service providers as appropriate, will be will be involved in the creation of a Recovery Plan. The participant has the choice to determine who is participating on the recovery team. The Recovery Plan will be based upon the individualized assessment, team member input, and the expressed goals of the participant.

Service planning will be facilitated by the Service Facilitator and will include participation from the participant, recovery team, and mental health professional. Additional professional consultation will be included as needed and appropriate, such as including consultation with a substance abuse professional, clinical therapist, clinical psychologist, psychiatrist or others. The process will include all activities to complete a service plan.

- Immediate crisis stabilization.
- Strengths, needs and culture discovery.
- Child and Family team formation, and facilitation.
- Comprehensive assessment and narrative.
- The team develops the Plan of Care.
- Assessment will be completed in 30 days.
- Address all assessment domains and criteria

All will be accomplished within 30 days of acceptance of application for admission to CCS. The review process includes activities to review and update the service plan as the

needs of the participant change or at least every 6 months. The review activities include an assessment of the progress toward goals and participant satisfaction with services.

The mental health professional authorizing the CCS services will be a part of the recovery team in development of the service plan and will discuss all aspects of the plan with the team. If for some reason the consumer does not wish to have the mental health professional in their recovery team, the service facilitator/social worker assigned to the consumer will meet separately with the mental health professional and discuss the service plan. If disagreements arise, the CCS Service Director or Clinical Services Manager will settle any dispute about determination of need.

The CCS Recovery Plan will be signed by all active members of the consumer's Recovery Team. The minimum requirement will be signatures from the consumer and the service facilitator, and also by the mental health professional and/or Substance Abuse Professional. An internal authorization process will be utilized to ensure that only services authorized by the team are purchased from contracted vendors.

### **Service Facilitation**

All coordination, follow-up and monitoring activities that ensure the consumer receives assessment services, service planning, service delivery and supportive activities in an appropriate and timely manner. Includes assisting the consumer in self-advocacy. Progress will be tracked toward goals and consumer satisfaction with the services rendered.

Includes helping the consumer obtain necessary medical, dental, legal and financial services and living accommodations. Coordinating the provision of emergency services during crisis periods. This may be coordinating the actual provision or coordinating with the HFS 34 designated crisis intervention program.

Service facilitation will be provided to ensure the participant is linked with appropriate services and that those service providers collaborate to deliver a fully coordinated system of care for the participant. Various assigned Human Services staff members who meet the qualifications of a service facilitator will provide this service. Included in this category are activities that help participants and if the participant chooses, the participant's family, identify their needs and manage and gain access to necessary medical, social, rehabilitation, vocational, education and other services and provide support to participant in accessing those services.

Services facilitation services include responsibility for locating; managing, coordinating and monitoring all proposed CCS services, other services and informal community supports needed by the participant and his/her family.

### **Communication and Interpersonal Skills Training**

Specific skill training in communication, interpersonal skills, problem solving, conflict

resolution, assertiveness, and other specific needs identified within the consumer's functional assessment.

Individual or group interventions, including peer support, to increase social connections and meaning, and to improve communication skills and comfort in interpersonal relationships.

### **Community Skills Development and Enhancement**

Problem solving, support, training, assistance, and cuing related to functional living skills living to assist the consumer to gain and utilize skills related to personal hygiene, shopping, laundry, benefit education, household tasks, money management, how to access transportation, medication adherence, parenting, independent living problem solving, self-management, connection to community resources, social skill development, and other day to day requirements of living.

May be provided in a one-to-one or group intervention, including peer support. May include one-to-one therapeutic support to ensure that a consumer acquires the skills needed to attain independence.

### **Diagnostic Evaluations and Specialized Assessments**

Psychiatric evaluations and specialized assessments including the assessment process and summary to determine appropriate treatment and behavioral interventions, and the level of community support needed for an individual consumer. Examples to include trauma and sex offender assessment service.

### **Employment Related Skill Training**

Services that address the person's illness or symptom-related problems in order to secure and keep a job. Services to assist in gaining and utilizing skills necessary to undertake employment. May include:

- Initial employment and education assessment.
- Ongoing, on-site employment assessment/evaluation/feedback sessions to identify symptoms or behaviors and to develop interventions with the recipient and employer that affect work.
- Focus on work-related symptom management, anxiety reduction, and education about appropriate job-related behaviors.
- On-the-job or work-related crises. Does not include specific job seeking and placement activities.
- May include one-to-one therapeutic support, including peer support.
- Activities related to preparation for seeking employment including assistance in appropriate personal hygiene and grooming, clothing choices, anxiety reduction, arranging transportation, and other issues related to symptoms or behaviors that hinder securing employment.

Assistance in accessing or participating in educational and employment related services,

and coaching/cuing in order to minimize the effects of the consumer's disabilities.

### **Physical Health and Monitoring**

The goal is to assist the consumer in the administration of their medication in a manner designed to best fit their need and to help stabilize their illness while maintaining safety, and to promote progression to independence in self-medication.

Major activities may include:

- All activities related to the consumer's physical health conditions, management of side effects and symptoms related to the consumer's mental illness or prescribed medications and assistance in helping the consumer to develop his/her own monitoring abilities, including supportive activities. Monitoring of weight and vitals.

Medication monitoring can be very important in the stabilization of mental health. Clinical Services Nursing works closely with local pharmacies to provide systems tailored to individual needs. Each plan is set up on an individual basis to allow progression to independence as the participant is able. For services provided internally, we will work closely with CCS Participants and service facilitator to develop a plan that will ensure the necessary monitoring of medications. Teaching about medication management and the medications is an important part of helping the participant understand how to work with their care providers to control their symptoms. For more information on internal services in this area, see attachment of the medication section of the Clinical Services Policy (*Appendix VIII*) and Procedure handbook outlining the nursing services regarding medications.

### **Psychoeducation**

A method of working in partnership to impart current information about mental illness, to assist with coping skills for supporting recovery, and to encourage problem solving strategies for managing issues posed by mental illness. Family intervention geared toward coping strategies, support and problem solving skills to assist in fostering consumer's recovery. Activities must be performed for the direct benefit of the CCS consumer. Consultation to family members for treatment of their problems not related to the CCS consumer's is not part of this service. May include one-to-one therapeutic support, including peer support.

### **Psychotherapy**

Individual or group psychotherapy. Performed by a psychiatrist, psychologist, or master's level psychotherapist only (In HFS 36, it is staff listed #1 through #8.).

This service treats a personal, social, behavioral, cognitive and mental or alcohol or drug abuse disorder, usually provided in a natural setting or services office. Focus on recovery principles to promote independence in the community.

Group therapies to include improvement of social network, interpersonal skill training, psychotherapeutic topics, life stressors and mental health skills and dialectical behavior

treatment. Focus on recovery principles and independent living skills.

### **Recovery Education and Illness Management**

Recovery education and Illness management are a broad set of strategies that promote hope, healing and empowerment. These strategies are designed to help individuals manage their illness, reduce their susceptibility to the illness, cope effectively with symptoms, identify supports that are effective, and advocate for receiving those supports. Major activities may include:

- Individual skills/illness self-management training – focus on recovery training where outcome is to give the consumer self-assessment skills, and includes interventions such as modeling, role-playing, practice, homework, shaping and reinforcement. Community activities which focus on decreasing the symptoms of mental illness through various wellness activities. May include one-to-one therapeutic support, including peer support.
- Counseling – Oriented toward problem solving and supportive activities provided in individually and in groups for consumers and their families to engage in recovery-based activities at home and in the community. Teaching individuals how their thinking styles and beliefs influence their feelings, and helping them to evaluate and change thoughts the lead to depression, anxiety, and anger. Includes cognitive-behavioral strategies to reduce severity and distress of persistent symptoms and promote personal insight within a group dynamic
- Self-Advocacy and Rights Training – Educate consumers about their legal rights within the mental health system, housing, employment and benefits. Provide consumers with skills and tools to support their ability to self-advocate.
- Support to develop a crisis plan – includes identification of early warning signs of crisis and details about preferred supports.

### **CCS PROGRAM POLICIES AND PROCEDURES - HFS 36.07(5)**

**HFS 36.07(5)** (a) See existing Clinic policy

**HFS 36.07(5)** (b) See existing Clinic policy

**HFS 36.07(5)** (c) Timely exchange of information between the CCS and contracted agencies necessary for service coordination. It is the responsibility of the service coordinator/mental health professional to contact and document on a regular basis, those services that a participant is receiving. The frequency will be determined on the service plan and followed through with by the service coordinator and commented in the participant record. Should it become necessary by participant request or other circumstances to contact the contracted service provider on a more or less frequent basis, the service plan will be revised.

**HFS 36.07(5)** (d) Participant rights, see existing clinic policy

**HFS 36.07(5)** (e) Monitoring compliance to this chapter. It is the responsibility of the

CCS Service Director and Administrator to monitor compliance to this chapter. This will be accomplished by regular meetings with CCS Staff, monitoring of service plans and developing the QA mechanism.

**HFS 36.07(5)** (f) Receiving and making referrals. The receiving of referrals for CCS is outlined extensively on page 24, 25, and 26. The making of referrals to other services will first be the responsibility of the service coordinator and will require a release from the participant. At their request, the referral will be made to the desired service provider.

**HFS 36.07(5)** (g) It is the responsibility of the service facilitator to document in the participant's record that they have explained to the participant the services CCS has to offer, costs to the participant, grievance procedure, and the requirements for informed consent for medication and treatment.

**HFS 36.07(5)** (h) Cultural competence:

**Demographics:** La Crosse County's population is 108,148. The largest percentage of the population is white at 94.2%. The next largest group of person is Asian representing 3.2%. Black or African American person represent 0.9%. Person of Hispanic or Latino origin also represent 0.9% One percent of the population reported two or more races. American Indian represented 0.4%.

**Training and Staff:** All staff in the Comprehensive Community Services Program must exhibit cultural competency by exhibiting a set of behaviors, attitudes, practices and policies that are used everyday to work respectfully, effectively and responsibly in culturally diverse situations. The agency offers a variety of in-services each year spotlighting different ethnic groups and practices. CCS in collaboration with the Resource Center seeks training and has close agency connections with the Hmong community leaders in our community. We utilize Hmong interpreters on a regular contracted basis. Many individuals that are Hmong work in our agency. The Hmong community has offered training opportunities to increase cultural awareness. The Resource Center is an active member of the Hmong Mutual Assistance Association, any training that is offered will be attended by CCS staff. La Crosse County Human Services have a proven track record of servicing the entire community in a positive, culturally competent manner.

**Language:** La Crosse County Human Services has access to AT&T Language lines that give immediate access to phone interpreters in virtually any language. All staff have been trained on how to access this service. The La Crosse County Human Services Department maintains contracted county employees who can translate for person who are Hmong. The agency also employs person who speak Spanish fluently who can be asked to interpret. The agency also maintains a list of interpreters available in the community that can be used for Spanish, Hmong & Laotian, German, and Hearing Impaired. If there is a specific need, research would be completed to see if one of the two universities would have anyone on

staff to assist.

**Materials:** Some of the agency materials are available in Hmong. Many of the agency notices are available in Spanish. The Resource Center has access to state personnel for translation of materials as part of the contract between the County and State. La Crosse County Human Services Comprehensive Community Services

**HFS 36.07(5)** (i) Orientation policy included (Appendix IX)

**HFS 36.07(5)** (j) Outreach services. La Crosse County CCS in collaboration with the Resource Center of La Crosse County will conduct outreach activities order to potential CCS participants. CCS will seek referrals from potential sources such as inpatient psychiatric or substance abuse treatment facilities, law enforcement, La Crosse County Justice Sanctions, Probation and Parole, other departments within La Crosse County Human Services, family members, significant others, members of the general public and potential participants. The Resource Center will create and provide current and accurate information to the referral sources including pamphlets regarding services, detailed information on how to make a referral, along with referral forms and information on admission criteria and procedures. The information will also be made available at the Resource Center of La Crosse County's WEB site.

The CCS supervisor or their designee will provide specific consultation as needed to community agencies and service providers. This will be in conjunction with the screening process performed by the Resource Center of La Crosse County. The La Crosse County CCS Outreach Policy is included with this application. (*Please see Appendix X*) Also see Outreach section on page 12-13)

**Application and Screening Process - HFS 36.07(5)(k)** (application and screening included)

Any individual may apply for Comprehensive Community Services for him/herself or on behalf of another. Applications for service will be available in many locations, including the La Crosse County website. An individual may access CCS services in a number of ways:

## **Adult Mental Health System**

### **1. CCS Program Access via Resource Center**

La Crosse County has a "Single Point of Entry" for all participants that are "new" to the system. (*Appendix XII Narrative for Single Point of Entry*). Any individual interested in accessing services will begin to explore what is available at Human Services, and in the community with the assistance of Resource Center staff. If an individual is interested in Clinical Services programs a referral will be made to a supervisor of outpatient mental health programs.

The supervisor, or another designated Clinical Services staff, will meet with the participant to determine interest and need for programs offered. The MH/AODA Functional Screen data will be used to assist in determining eligibility and to determine if an individual requires more than outpatient counseling but less than the services provided by a community support program. The screen will also identify the existence of diagnosis of a mental disorder or a substance abuse disorder; and will indicate whether the participant has a functional impairment that interferes with or limits on or more major life activities that results in needs for services that are described as ongoing, comprehensive, and either high - intensity or low-intensity. An application for CCS services will be completed if an applicant is determined to need psychosocial rehabilitation services and is interested in, and eligible for, CCS services.

Services for consumers will be available for those persons who are in the process of determination. Our process provides for rapid service provision when necessary. After a person, for example, is in the resource center and determined eligible for CCS, the referral comes immediately to clinical services. Our Extended Intake Program Supervisor will receive the referral and assign a Social Worker. The consumer will then be assisted, as needed, to be enrolled into one of the available programs in Clinical Services (CSP, CCS, TCM or an intake to the outpatient clinic, mental health or AODA). This determination will be made based on consumer choice when at all possible and a clinical judgment. If there will be a lag in time from when someone is deemed appropriate and wants a CCS service, for example, then the Social Worker within the Extended Intake Program would continue to work with the consumer. Community resources at other agencies will also be discussed as options.

**2. Access to CCS for Participants of Current Clinical Services Programs**

La Crosse County Clinical Services participants will be notified of the CCS program. Interested participants will complete a MH/AODA Functional Screen with their current case manager. If an individual is interested in, and eligible for the CCS program an application for CCS services will be completed and submitted to the supervisor of outpatient mental health programs.

The MH/AODA Functional Screen data will be used to assist in determining eligibility and to determine if an individual requires more than outpatient counseling but less than the services provided by a community support program. The screen will also identify the existence of diagnosis of a mental disorder or a substance abuse disorder; and will indicate whether the participant has a functional impairment that interferes with or limits on or more major life activities that results in needs for services that are described as ongoing, comprehensive, and either high-intensity or low-intensity.

**Children’s Mental Health System**

**3. CCS Program Access via Family and Children’s Single Point of Entry**

Any individual or family member interested in accessing mental health services for those under age 17 will begin their exploration with the assistance of the Family and Children’s Single Point of Entry. An individual or family member seeking this service will be requested to contact Family and Children’s Intake at 608-785-5815 and complete a children with special needs referral form. Upon receipt of the referral the supervisor’s of Children With Special Needs Units I and II or designee will determine the child’s eligibility and need for psychosocial rehabilitation services.

The Children’s Long Term Support Functional Screen will be utilized as a tool to assist in decision making to determine eligibility and level of need for psychosocial rehabilitation services. The child must have a mental health diagnosis or a substance use disorder, has a functional symptoms in one area or functional impairment that interferes with or limits two or more major life activities that result in need for services that are described as ongoing, comprehensive, and high-intensity. The individual must also be receiving services from two or more of the following service systems; mental health, social services, child protective services, juvenile justice, special education, and substance abuse. An application for CCS services will be completed if an applicant is determined to need psychosocial rehabilitation services and is interested in, and eligible for, CCS services.

**4. Access to CCS for Participants of Current Children’s Mental Health Programs**

Participants will be notified of the new CCS program. Interested participants will complete a Children’s Long Term Support Functional Screen. If an individual is interested in, and eligible for the CCS program an application for CCS services will be completed.

The Functional Screen data will be used to assist in determining eligibility and if an individual requires more than outpatient counseling but less than the services provided by a Children’s Long Term Support Mental Health Waiver. The screen will also identify the existence of diagnosis of a mental disorder or a substance abuse disorder; and will indicate whether the participant has a functional impairment that interferes with or limits two or more major life activities that results in needs for services that are described as ongoing, comprehensive, and either high-intensity or low-intensity.

If CCS is determined to meet an adult or elder participant’s needs, but the program does not have the ability to begin services immediately, the individual will be referred to targeted case management in anticipation of availability of CCS. If the CCS program is able to begin services immediately, the individual

will be admitted to CCS, and the comprehensive assessment will be conducted.

The La Crosse County CCS Application for Services and Screening Policy (*Appendix XIII*) and Admission Criteria and Determination of Need Policy (*Appendix XIV*) outline how referrals to CCS will be screened and how eligibility will be determined.

**Recovery Team Development - HFS 36.07(5)(l)** (recovery team development and facilitation included)

Once an individual has been found eligible and admitted to the Comprehensive Community Services (CCS) program, a collaborative team (recovery team) will be formed. The process of forming the team will be initiated by asking the participant to identify who they would like this team to include. (The participant for children will include parent or legal guardian.) At a minimum, the recovery team will consist of the participant, a service facilitator and a mental health professional. As of now and at times, multiple roles and/or responsibilities within the recovery team may be carried out by the same person. For example, a service facilitator may also be the mental health professional. Additional members may be added due to participant request or with participant consent. Additional members could include other service providers, family members, natural supports, peer specialists, advocates, etc. The participant will decide who will be part of their recovery team. These teams may change over time according to what the participant wants.

If a participant has or is believed to have co-occurring issues such as substance use and/or abuse, the recovery team will consult with an individual who has qualifications of a substance abuse professional. The participant will have the choice of having a substance abuse professional on the recovery team. To maximize integrated service concepts, a person with dual qualifications may fill multiple roles. For example, an individual with mental health and substance abuse qualifications may fill the roles of substance abuse professional and mental health professional on the recovery team.

Participants will be equal participants on their teams and will be recognized as having expertise of their own. La Crosse County understands and believes that a person possesses great insight and knowledge regarding their illness and recovery. Personal experience will be acknowledged as well as educational/professional experience. Every effort will be made to reduce barriers to successful engagement and participation, including providing support and training that will enable participants to fully participate in CCS and in their recovery. La Crosse County understands and believes that successful engagement and participation is more likely to occur when participants are recognized as equal partners, treated with dignity and respect, have a voice and have ownership regarding their care and life.

The Service Facilitator will convene the team. Team members will have a clear understanding of and respect for each other's roles, limitations and strengths. The recovery team will participate in the assessment process and service planning. The role of

each team member will be guided by the nature of the team member's relationship to the participant and the scope of the team member's practice. Team members will provide information, evaluate input from various sources and make collaborative recommendations regarding outcomes, psychosocial rehabilitation services and supportive activities. This partnership will acknowledge the cultural beliefs and practices of the participant and will provide the best cultural competent services it can. If this is not occurring, the participant will be encouraged to bring additional members to the team who will be able to provide improved culturally competent services.

The La Crosse County CCS Recovery Team Policy (*Appendix XV*) describes the process for convening the team.

**Assessment Process - HFS 36.07(5)(m)**

The support and service coordinator assigned to conduct the assessment for a child will complete the assessment packet and give to a supervisor of Children with Special Needs Unit I or II. The supervisors of Children with Special Needs Units I or II or designee will complete a review of the assessment summary and sign off. The assessment processes and the review of the assessment summary will be completed within 30 days of receipt of an application for services.

**Service Planning Process - HFS 36.07(5)(n)**

A "CCS Recovery Plan" is the written plan of psychosocial services and supports to be provided or arranged for a participant. The service and support planning process will be explained to the participant and, if appropriate, a legal representative or family member.

The planning process will be facilitated by the assigned service facilitator in collaboration with the participant and recovery team. The development of services and supports is based on the individualized assessment, recovery team input, and the expressed goals of the participant. The service and support plan will maximize participant preference, address the needs and recovery goals identified in the assessment, and will be built upon a foundation of participant empowerment. For the Clinical Service Section the plan will define measurable outcomes and be completed within 30 days of the participant's application for services. Family and Children Section will complete the plan with measurable outcomes within 30 days.

The Service Plan will include:

- Identification of participant strengths and interests.
- Measurable goals and the type and frequency of data collection that will be used to measure progress toward desired outcomes.
- A description of the service facilitation activities that will be provided for the participant or on the participant's behalf;
- The psychosocial rehabilitation and treatment services to be provided or arranged

- for the participant including the schedules and frequency of services provided;
- The service providers and natural supports who are or will be responsible for providing the participant's treatment, rehabilitation, or support services, and the payment source for each;
- A Crisis/Wellness Recovery Plan when need is indicated.

The participant, a mental health or substance abuse professional, and the service facilitator will sign the completed service plan. All partial and completed Recovery Plans will be maintained in the Participant Treatment Record. Documentation of the Service Plan will be available to all members of the recovery team. The service facilitator will be responsible for obtaining appropriate authorizations to release information to the recovery team members.

The Service Plan will be reviewed and updated as the needs of the participant change or at least every 6 months. The review will include an assessment of the progress towards goals and participant satisfactions with services. The La Crosse County CCS policies on Service Planning (*Appendix VIII*) and Service Delivery (*Appendix XVI*) direct the service planning and delivery process.

**Service Coordination, Referrals, and Collaboration - HFS 36.07(5)(o)** (service coordination, referrals and collaboration included)

When multidisciplinary system involvement exists, there is especially a need for formalized coordination of services to ensure participant's needs are being addressed. La Crosse County CCS will develop and implement collaborative arrangements and interagency agreements to outline roles and responsibilities when working with participants who are involved in multiple services. Memorandums of Understanding (MOU's) will be developed with internal programs to the county working in coordination with CCS and MOU's or contracts will be developed with external agencies. The Service Coordination policy is included in *Appendix XVII*.

**Advocacy - HFS 36.07 (5) (p)**

Advocacy will provided to the participant by any member of their recovery team at the participants request. If a participant wishes to be referred for other advocacy, the service facilitator can refer them to PIE, Partners in Empowerment, ILR, Independent Living Resources or other advocacy groups as requested.

**Support and Mentoring for the Participant - HFS 36.07(5)(q)** (support and mentoring for the participant will be provided by CCS staff, recovery team members or arranged for in the service plan at the participants request.)

La Crosse County will provide support and mentoring for participants. Based upon participant request or in general, the service facilitator and the recovery team will support participants by providing education and training that will assist participants to develop skills and/or enhance current abilities in the areas of self-advocacy skills,

civil/participant rights and skills needed to exercise power, control and responsibility over their lives, their recovery and the services they receive. Education and training are not limited to what is listed above. In addition, La Crosse County will acknowledge and use peer support services as well as drop-in centers within the area for support and mentoring. Lastly, La Crosse County will assure that participants and legal guardians receive necessary information and assistance in advocating for their rights and service needs. Necessary information regarding participant and legal guardian rights will be given at the initial stage of service and as needed or by request. (*Staff Qualifications and Credentials Policy, Appendix XVIII and Comprehensive Program Community Services Staff Qualifications and Credentials Policy, Appendix XIX*)

Peer Specialists will be involved in program enrollment for consumers, and may also be employed by vendors to provide additional CCS services. A peer specialist, meaning a person who has mental health and/or AODA lived experience, has completed a wellness-recovery program and 70 hours of additional training. All training must be approved by La Crosse County. The additional 70 hours of training will include a curriculum of:

- I. Personal Development-Knowing Yourself (which covers)
  - recovery
  - the power of peer support
  - developing self-esteem and managing self-talk
  - community, culture and environment
  - meaning and purpose
  - emotional intelligence
  
- II. Turning Point-Preparing Yourself for Work (which covers)
  - telling your story
  - employment as a pathway to recovery
  - ethics and boundaries
  
- III. Skill Development (which covers)
  - communication skills
  - conflict resolution
  - understanding trauma
  - substance abuse
  - being with people in challenging situations
  - peer support in action, partnering with professionals.

This training curriculum is based from the peer employment training program by META Services, Inc. which is located in Phoenix, AZ. La Crosse County also acknowledges that additional training may be needed to support the position of peer specialist and training opportunities will be made available.

**HFS 36.07(5)(r)** (discharge planning and facilitation policy included Appendix XX)

**HFS 36.07(5)(s)** (monitoring and documentation; the service plan will outline the

monitoring required for each service contracted for. The service facilitator will document compliance to the service plan. Documentation will occur within 48 hours of the contact.) (*Appendix XXI*)