I. Policy

A. Integrated Community Based Services (ICBS) is a comprehensive approach to specialized service delivery for multi-system involved youth. ICBS provides oversight of a variety of services designed to intervene with supportive mental health services when youth are having problems coping in their environment: dealing with traumatic stressful events and/or changes; behavioral problems at home or school; and/or experiencing symptoms of mental illness. Services to children and youth are based on each individual child and family's specific needs, issues, strengths and goals, as assessed and identified in the plan. Services provided include psychiatric consultation, nursing services, group, family and individual therapy using evidence based practices, cognitive behavioral therapy, parent management training, and family support groups. Services are provided along a continuum of care within the Detroit Wayne Mental Health Authority (DWMHA) service system for children by Medicaid enrolled children's mental health service providers. ICBS Key Program Components include:

1. Comprehensive Evaluation
2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
3. Integrated Treatment Teams
4. Care Coordination Plan Management
5. Progress Monitoring
6. Community and Home Based Services
7. At Risk (Trauma) Screening
8. Service Category Classification
9. Emphasis on Home-Based Interventions and Services
10. This model of service delivery shall include structures that coordinate and support cross system efforts, including a continuum of supports and services across each system. Core elements of service delivery shall include: an integrated team approach, a shared caseload and flexible service delivery at various community locations with enhanced intensity, increased frequency, and shared responsibility among different organizations.

B. The value for CMO staff and CMH staff to work together and to coordinate the care for juvenile justice children who are SED and DD is important to successful engagement and positive outcomes. These youth and their families are more likely to have multiple psychosocial stressors that impact behavior and functioning in multiple life domains. ICBS Coordinators shall serve as a liaison to these two systems and their respective staff. ICBS Coordinators will additionally act as a liaison supporting CMO Case Managers, youth and families to receive well-coordinated services.

C. All WC-CFS enrolled youth designated as Seriously Emotionally Disturbed (SED)/Developmentally Disabled (DD) are expected to be enrolled with and receive services from a children's mental health provider, but youth and families retain the right to stay with or change a current provider and/or to decline to be enrolled with a Wayne County Children's Mental Health provider.

D. The JAC shall implement Integrated Community Based Services (ICBS) for Wayne County Children and Family Services (WC-CFS). The focus must be kept on intensive community-based services designed to maintain youth in their homes whenever possible. If placement becomes necessary, there must be attempts to place youth in therapeutic settings, not traditional correctional facilities. In addition to using a community-based treatment approach, the ICBS Coordinator must advocate for services that are tailored to specific outcomes for the youth, including achieving success in school, living with their families, avoiding delinquency, minimizing safety risks and enhancing overall well-being.

E. ICBS Coordinators are Master's level professionals employed by the JAC and deployed to each CMO agency. Using a Targeted Case Management service delivery model, the Coordinators will work collaboratively with Community Mental Health (CMH) professionals and Care Management Organization (CMO) Case Managers, identified youth that meet or may meet the CMH standards for SED/DD, their family members and other professionals, as necessary.

1. ICBS Coordinators shall be credentialed as Qualified Child Mental Health Professionals (QCMHP).

F. Each youth encountered by WC-CFS juvenile justice contractors shall be assessed by the JAC for eligibility for access to DWMHA children's mental health services. Those youth identified as SED or DD eligible for CMH services will be assigned to a Managed Care Provider Network (MCPN) or privately insured provider and an ICBS Coordinator.

G. Each JAC ICBS Coordinator will be responsible for ensuring access to CMH SED and DD services and for convening the Integrated Treatment Team to develop a Care Coordination Plan. The ICBS Coordinator will ensure that the CMO staff helps the youth's family identify a provider of choice within the CMH Preferred Provider Network or through the family's private insurance provider.

H. Each Care Coordination Plan shall be developed and completed by the ICBS Coordinator using a person centered planning process. The plan shall identify:

1. Amount, scope and duration of all services
2. Goals, objectives and measurable benchmarks (progress indicators) related to mental health treatment and outcomes, across all the systems of care in which the youth is involved;
3. Roles and responsibilities of all participants, including designated staff, the youth and family members.
4. Session lengths and locations, once identified by the provider, staff/agencies providing the services, and outline and define criteria for goal achievement, as per DWMHA criteria, standards and policies.

ICBS Coordinators shall monitor MH-WIN monthly for data reporting and monitoring to ensure services are in place.

Note: Privately insured youth cannot be verified as this is deemed confidential information by third party providers. For those youth privately insured, the CMO case management staff can use the authority of the Court Order to obtain verification of mental health services. The Care Coordination Plan is to only address mental health needs and is not a substitute for the CMO's Probation Supervision and Services Plan (PSSP), which is still required.

I. The CMO shall provide office, phone and desk space within their respective agencies for the ICBS Coordinators assigned to each agency.

J. A copy of the initial Juvenile Justice Early and Periodic Screening, Diagnostic and Treatment (EPSDT) shall be in the CMO and JAC case files for every SED/DD eligible youth, and for every adjudicated youth assigned to the CMO.

1. Pursuant to the JJSH, if a copy of the EPSDT has not been acquired by the JAC, during the assessment process, the CMO Case Manager shall ensure that one is completed on the youth and a copy is provided to the JAC within 30 days of assignment.

2. The EPSDT must be completed annually and placed into the CMO case record. The CMO Case Manager must provide a copy of the updated EPSTD to the ICBS Coordinator. Upon receipt from the CMO Case Manager, the ICBS Coordinator will ensure that the updated EPSTD is filed into the ICBS record

K. The ICBS Coordinator shall convene Integrated Treatment Team meetings for youth that meet criteria for SED or DD Community Mental Health Services via the JAC assessment. The Integrated Treatment Team shall be comprised of the youth and family members and CMH program staff, such as psychiatrists, psychologists, clinicians, Multisystemic Therapy (MST) and/or Wraparound facilitators, CMO staff and the ICBS

Coordinator. All parties attend, participate and discuss Care Coordination Plan successes and challenges, in the following circumstances:

1. Initial Community Placement, and every six (6) months thereafter until JJ Court wardship termination (face to face and/or by telephone or computer conference).

   - The Care Coordination Plan is reviewed, updated and/or modified, and signed at the initial and subsequent six month period review meetings. If updated/modified, the Care Coordination Plan shall indicate amount, scope and duration of all services.

2. Residential Transition/Reintegration

   The ICBS Coordinator shall convene Integrated Treatment Team meetings for juvenile justice youth transitioning from residential to community-based placement before a planned de-escalation, or immediately following a court ordered unexpected de-escalation from residential care.

L. The youth and family's progress toward individual treatment goals shall be monitored at various times throughout JJ and CMH enrollment:

1. During the Integrated Treatment Team meetings
2. During CMO meetings with families and youth
3. During supervision meetings between the individual therapist and a supervisor, as well as being addressed in Children's Programs staff meetings
4. All progress reviews must be recorded on JAIS within 6 business days of the event.

M. A quarterly CMH Progress Summary Report written by CMH providers shall be obtained and distributed by the ICBS Coordinator, for youth in the Children's CMH Programs. A copy of the CMH Progress Summary Report shall be provided to and discussed with the youth and family by the CMO Case Manager. The CMO Case Manager should integrate the CMH Progress Summary Report findings into Court Reports.

N. Progress toward identified goals will be documented in the JAIS database and on the ICBS Care Coordination Plan, to be reviewed and revised with the youth, family and other Integrated Treatment Team participants at each subsequently scheduled Treatment Team Meeting, as requested by the youth and/or family, and/or following a crisis. A review and re-assignment of roles and responsibilities in the Care Coordination Plan may be implemented at that time, as deemed relevant by the youth, family, and/or the Integrated Treatment Team participants including the CMH therapist.

O. To ensure that each youth is receiving all the services, assessments, treatment and evaluations necessary for successful progress toward their treatment goals, the ICBS Coordinator ensures communication with other participants of the Integrated Treatment Team on a regularly scheduled basis.

P. Newly assessed cases and re-openings are reviewed with the CMO team, supervisors, and the ICBS Coordinator when appropriate; including the cross disciplines of at minimum: social work, psychology and nursing to ensure the most appropriate and best quality of services are being provided. Reviews may be conducted by program supervisors and the provider's consulting psychiatrist. Case consultations are conducted on a regular basis with active and dynamic discussions that lead to rich learning experiences. A prescribing psychiatrist shall be available for case consultation, as needed.

Q. ICBS Coordinators shall work collaboratively with Supports Coordinators to ensure that youth who have a Developmental Disability (DD) have well-coordinated services that ensure their safety and developmental expectations.

R. The JAC shall include measures in the JAC QA Continuous Quality Improvement Plan, monthly, quarterly and JAC annual reports for both the monitoring and continuous improvement in quality of the program or processes described in this policy.

S. Each CMO shall designate a primary mental health services contact person to work with the ICBS Coordinator assigned to the CMO. Regular communication should occur between the CMO, CMH therapist and the ICBS Coordinator.

II. Definitions

A. Location of Services: All services shall be provided within the community unless office based services are clinically indicated. For youth transitioning from Mental Health or Developmental Disability out of home care to community, transition planning may occur at the residential provider within 30 to 45 days of a youth's plan to de-escalate to community based services.

B. Service Categories: CMH Children's Services providers shall be reimbursed by CMH based on two distinct service categories based on the following level of services received for children with the designation of Serious Emotional Disturbance or Developmental Disability:
1. Home based and/or Wraparound and/or MST
2. Two or more children's mental health services (not including assessment)

C. Target Population: Youth Who Are:
1. Age 6 to 21 years old (transition to adult services should be evaluated at age 17-19)
2. Medicaid Eligible and/or privately insured
3. Wayne County Resident
4. Disability Designation of SED and/or DD
5. Involved in Wayne County Juvenile Justice System

D. Eligibility Determination: Determination for eligibility will be made by the DWMHA Access Center based on the comprehensive Social History Assessment and JAC recommendations according to the ICBS Care Coordination Guidelines.

E. Points of Entry to SED/DD Mental Health services include:

1. Intake to Juvenile Justice via JAC Assessment
2. CMO Referral for SED/DD assessment
3. Discharge/de-escalation from Residential Care facilities

F. ICBS Service Coordinator:

ICBS Coordinators are Master's level professionals employed by the JAC and embedded in each CMO agency. Responsibilities include:

1. Maintain credentialing as Qualified Child Mental Health Professionals (QCMHP)
2. Act as the Liaison to CMO and CMH staff/systems, using the Targeted Case Management model of service delivery;
3. Maintain roster of adjudicated youth with a SED/DD;
4. Develop Care Coordination Plan for each identified youth in collaboration with the CMO;
5. Track and monitor progress;
6. Convene the Integrated Team participants for an initial plan and every six months once a youth is active in mental health treatment;
7. Coordinate the receipt and distribution of CMH Summary Reports as requested;
8. Ensure EPSDT completion and entry in the CMO and JAC files;
9. Review or update the At Risk (Trauma Screening) Checklist with the CMO quarterly;
10. Provide written summaries to the Case Manager for court reports, as requested (ICBS Coordinators are not expected to attend court hearings);
11. Follow up with other stakeholders (i.e. physicians, therapists, case-managers, families) on youth concerns and needs;
12. Assure the CMH provider is accessed for CMH for previously enrolled SED/DD youth to assessed treatment needs.
13. Identify and report access barriers and service array issues to JAC management for resolution.

G. Targeted Case Management: A set of related activities that includes the six (6) **Core Case Management functions,** which are the following:

1. **Assessment**: A written comprehensive evaluation completed by the ICBS Coordinator of a child and his or her family members' assets, deficits and needs. The assessment includes the following elements:

   a. **Physical health** (health problems or concerns, current diagnosis, medications, treatments, sensory impairments, nutritional status,

elimination problems),

b. **Activities of daily living** (mobility levels, personal care, household chores, personal business, amount of assistance required),

c. **Social/emotional status** (intellectual functioning, behavior problems or concerns, mental impairments, alcohol/drug abuse),

d. **Social relationships/support** (informal caregivers, e.g., family members, friends, volunteers, pets, formal service providers, significant issues in relationships or social environment),

e. **Physical environment** (safety and mobility in home, accessibility),

f. **In-depth resource analysis and planning** (coordination of insurance and veterans benefits, other sources of financial and in-kind assistance),

g. **Vocational/education status** (prognosis for employment educational/vocational needs, appropriateness/availability of education programs), and

h. **Legal status** (guardian relationships, involvement with the legal system).

2. **Individual Plan of Service/Person Centered Planning (IPOS/PCP) Development**: A personal individualized treatment plan addressing the needs of the adult or child and his or her family members. This treatment plan is developed through the person-centered planning process. The person-centered planning is a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves family members, friends, and professionals as the individual desires or requires.

3. **Linking/Coordination of Services**: Through negotiations and referrals, the ICBS Coordinator shall link the consumer and his or her family members to various community services/systems to meet the consumer and his or her family members' needs as documented on the IPOS/PCP.

4. **Monitoring of Services**: The ICBS Coordinator ascertains, on an ongoing basis, what services have been delivered and whether they appropriately meet the consumer and his or her family members' needs.

5. **Reassessment/Follow-up**: At least annually, the ICBS Coordinator shall

conduct an assessment of the consumer and his or her family members' needs. This assessment shall assess the consumer and his or her family members' progress toward treatment goals/objectives, the consumer and his or her family members' appropriateness for continued Case Management services, the consumer and his or her family members' satisfaction with services, and the consumer and his or her family members' desires regarding making adjustments to the IPOS/PCP.

6. **Advocacy**: Advocacy is acting on behalf of a client (individual, family or group) in order to access needed resources, services, or to influence policy change. Keeping in mind youth/family consent and involvement in the process. Additional end goals should be client empowerment and assertiveness taught through modeling. The ICBS Coordinator shall actively support and assist the consumer and his or her family members in gaining access to needed medical, social, educational, and vocational/rehabilitative services.

III. Procedure

A. CHOICES Enrollment for Right TRAC Juveniles

Youth referred by the Wayne County Prosecutor APA and Family Court to Right TRAC have a JIFF assessment administered by a JAC clinician. Youth that the JIFF and interview determine a therapy need can choose to be referred to JAC CHOICES. Based on JIFF findings, the JAC will determine the need for a more comprehensive assessment to determine SED/DD eligibility. At the JIFF assessment the youth and family may disclose the need for further evaluation. When the JAC comprehensive assessment confirms SED/DD, the case will be assigned to an ICBS Coordinator/CHOICES Targeted Case Manager. The JAC will facilitate a referral to the Wayne County Access Center. If chosen, JAC CHOICES will provide ongoing therapy and the CHOICES Targeted Case Manager will follow-up with the family to assess compliance with voluntary participation with a children's mental health provider and provide the data needed to the ICBS Supervisor. In these instances participation in services with the JAC will be voluntary and appropriate consents will be signed. These cases are not eligible for a CMO assignment.

B. Enrollment for Adjudicated Juveniles

1. Once an adjudicated youth comes to the attention of the JAC, the DWMHA information system database (MH-WIN) shall be reviewed by the Assessment Services Director to determine the current status of the youth in the mental health system.

   a. If the youth has a member identification number in MH-WIN, the JAC will proceed with the comprehensive assessment process.

b. If the youth has no identification number, the JAC will fax a copy of the Juvenile Agency Information System (JAIS) Intake Summary to the Wayne County Access Center to obtain a member identification number and then proceed with the comprehensive assessment process and upon receipt enter the ID number in to JAIS.

2. The JAC shall complete the comprehensive assessment process (including a CALOCUS and At Risk Trauma Assessment) of youth and family within 14 calendar days of case acceptance. Once assessed as SED/DD, the youth and caregiver/family will receive a CMH Children's Services Brochure which briefly outlines CMH services and an explanation of the children's SED or DD services.

3. The JAC shall submit an SED Eligibility Checklist to the Wayne County Access Center for review and processing of SED/DD status.

4. The Wayne County Access Center staff shall complete the CMH enrollment process within two business days of receiving the Juvenile Justice Enrollment information SED Eligibility Checklist, Court Order, Enrollment Application and notification of CMH Provider if applicable).

5. Upon notification that the Wayne County Access Center has authorized a youth's SED/DD eligibility, the JAC documents this updated status in the JAIS database and via the Enrollment and Provider Assignment Confirmation. If no notification is received from the Access Center, the JAC will proceed in accordance with the WC-CFS policy, while still pursuing Access Center for resolution.

   a. When an adjudicated youth appears SED/DD eligible, the JAC informs CMO of the youth SED/DD status by JAIS Case Note within 14 days of enrollment and documents SED/DD eligibility using the Notification of Automatic Referral to CMH form in the JAC Assessment Packet.

   b. When a youth is a newly determined SED/DD eligible youth, the JAC shall provide information to the family about its "choice" of a MCPN and CMH provider.

      i. The parent/legal guardian must complete and sign the enrollment application indicating the MCPN and service provider preference. Original signed documents must be provided to or faxed to the JAC Director of Assessment Services who will place a copy in the youth's file and forward a copy to the Wayne County Access Center.
      ii. The JAC shall, at the time of assessment, or the CMO worker may, after receipt of Assessment Packet, reference the CMH Children's Services Guidebook to assist the family in choosing a MCPN and Provider.
      iii. Within five (5) business days of receipt of the JAC Comprehensive Assessment Packet, the CMO will notify the JAC of the family's choice of provider using the Enrollment and Confirmation Assignment Report. The Wayne County Access Center must be notified within five (5) business days

of a family's choice of provider within the CMH PPN or the JAC, unless the youth is already active with a provider.

iv. Wayne County Access Center staff shall enroll a youth in the MCPN and provider of the family's choice as indicated and documented by the JAC staff. The family may request to change providers and/or an MCPN assignment at any time.

v. If the Wayne County Access Center is not notified within five business days of a family's MCPN and provider preference, the enrollment will be processed as a "random assignment" to an MCPN. Upon JAC notification of MCPN assignment, the JAC will then notify the ICBS Coordinator, who will ensure that the assigned CMO Case Manager assists the family in identifying a CMH provider within that network (within 5 business days).

vi. MCPNs are notified daily of new enrollees. Once a provider is chosen, Wayne County Access Center staff will send a written enrollment notification to the CMH Provider.

6. The ICBS Coordinator will ensure that the CMO staff has coordinated with the parent to contact CMH provider within five (5) business days of the notification of MCPN enrollment.

7. The CMO Case Manager will make the CMH intake appointment in conjunction with youth and parent/caregiver's schedule. During the CMH provider intake, the parent/caregiver must be available for questions, and the available services and processes must be explained to the family. If applicable, the Case Manager will ensure transportation to and be present for this appointment.

8. All CMH Children's Services providers for juvenile justice youth must have at least two designees authorized for JAIS access for review of the JAC Social History Assessment and supplemental documentation prior to scheduled appointments.

9. The CMO Case Manager shall provide a copy of the JAC Social History Report narrative and the JAC Psychological Evaluation Report to the CMH Provider at least three days before the scheduled intake appointment. The ICBS Coordinator will work with the CMO Case Manager to assure that the process and coordination between CMH, the youth/family and the CMO is timely and effective.

10. The CMH provider shall schedule an intake appointment within 14 days of the initial telephone call from a family requesting service.

11. The ICBS Coordinator shall audit JAIS case notes regularly to ensure all efforts are documented prior to the JAC Integrated Treatment Team Meetings.

12. The ICBS Supervisor will conduct regular utilization reviews of JAIS case notes to ensure compliance with this policy and procedure and to report concerns to the

CMO Case Manager and supervisor as well as to the CMH providers, as appropriate.

C. Case Coordination Between CMH and CMO Staff

1. Case coordination shall occur in the following manner:

   a. The ICBS Coordinator's primary responsibility is to ensure that SED/DD youth have access to and receive necessary mental health services, not to duplicate the work of the CMO Case Managers. The ICBS Coordinators will assist with any barriers to mental health treatment access or receipt of necessary services. Any concerns about mental health treatment that require administrative involvement must be brought to the attention of the ICBS Coordinator and /or the ICBS Supervisor by the CMO. The Coordinators will address these issues with WC-CFS and the DWMHA contact person. The CMO Case Manager is responsible for development of the Initial and Updated Probation Supervision and Services Plans and overall coordination of services and ongoing collaboration with the CMH provider.
   b. The CMH provider staff and /or JAC staff will obtain a Universal Release of Information document, allowing both entities to share verbal and written information for the purpose of integrated treatment planning. The Authorization for Release of Information document shall be maintained in both the CMO and CMH case files, and be specific to the exchange of CMH information.
   c. The CMH provider staff and CMO staff shall share client documentation, specifically Initial and Updated Probation Plans, the Person Centered Plan of Service, and Wraparound Plans of Care. This documentation will be maintained in each agency's client case record.
   d. The CMH provider staff and CMO staff will participate in the interdisciplinary treatment planning meetings such as: Integrated Treatment Team, Person Centered Planning, Wraparound Child and Family Team meetings, etc.
   e. The CMH provider staff and CMO staff will notify each other of case related meetings in a timely fashion (within two weeks); i.e. court hearings, child and family team meetings, treatment team meetings.
   f. The Integrated Treatment Team (CMH Provider staff, JAC ICBS staff, youth and family and CMO staff) will communicate as needed (face to face and/or phone) regarding treatment status/progress and at a minimum: Every six months for Case Consultation, Plan of Care updates after any transitions and subsequent to Court hearings.
   g. The CMH provider staff and CMO staff will work in partnership with the family to plan for services/resources, terminations, Wraparound/Service extensions, changes to services, continuing care plans, etc.
   h. The CMH provider staff and CMO staff will document case coordination activities in their respective client records.

2. The CMH provider has information that is critical to assisting the CMO staff in assessing risk and coordinating the care of the youth. The CMH provides services

focused on the mental health functioning of the child and/or family and may be requested to share information regarding treatment and medication with the Court, DHS and System of Care Services. The CMH staff shall adhere to the following standards:

a. CMH providers are not expected to routinely attend court hearings. They may occasionally be requested to attend when deemed clinically necessary or as ordered by the Court,
b. Provide requested input into the CMO Court Report,
c. Notify the CMO staff of any changes in the client's level of care/services and attendance.

3. The CMO is ultimately responsible for the health and welfare of the youth while s/he is under the jurisdiction of the Wayne County Third Circuit Court as an adjudicated juvenile. The CMO staff should make every effort to coordinate with other professionals including the Department of Human Services for Dual Wards and/or the Court as appropriate, working with the youth and family related to education, community mental health, and/or community resources.

4. The ICBS Coordinator acts as the liaison and shall work in collaboration with CMO Case Managers/Supervisors and CMH staff to ensure the following requirements are met:

   a. The ICBS Coordinator shall refer Probation Level 2 youth who are potentially eligible as SED or DD to the JAC for CMH services at least **30** days prior to de-escalation from the residential treatment provider (reintegration from residential placement) in order to ensure continuity of care in receipt of mental health services. If a youth was already enrolled in an MCPN at time of placement, the ICBS Coordinator will proceed with accessing the identified CMH provider for SED or DD outpatient services and consult with the JAC Director of Assessment Services if assistance is needed.

   b. The ICBS Coordinator will ensure that the CMH provider is notified of upcoming court hearings, as well as request participation as deemed necessary.

   c. CMH provider is notified of court outcomes relative to treatment or removal from community within 48 hours of receipt of the court hearing outcome.

   d. Referrals for CMH services are made to the JAC 30 days prior to discharge from a residential treatment facility, or within five business days of an unexpected discharge from out of home care, thus ensuring continuity of care*. See Section III.B5-10 for CMH access procedure.*

      Note: When a youth is prescribed psychotropic medication at discharge from residential placement, detention or a hospital, the CMO must ensure youth has at least a two week supply of the prescribed medication and a prescription refill for

the current medication upon discharge from the residential provider. This ensures no lapse in medication/treatment occurs during the transition process to a community-based psychiatrist.

D. Outcomes Data Analysis

1. Semi-annual reports from ICBS will be provided to WC-CFS for the following Items:
   a. Number of youth eligible for SED and DD services for defined period of time.
   b. Number of youth eligible in the community and data analysis regarding status of attending the first CMH appointment as scheduled by CMO with comments regarding concerns and missed appointments.
   c. Number of youth/families refusing CMH services, including the name of youth and CMO.
   d. Data analysis regarding meetings scheduled and those unable to be held. The report format should include:
      - Name of youth
      - CMO
      - Date
      - Initial Plan or Six Month Review
      - Attendees
      - Reason for why meeting unable to be held, if applicable

   e. Number of transition meetings needed and number of transition meetings held with CMO for SED/DD youth de-escalating from residential care for timely engagement in CMH services.
   f. Significant issues not noted above.

IV. Exhibits

None

V. References

A. Detroit-Wayne Mental Health Authority (DWMHA) Policies

B. Michigan Compiled Laws, Mental Health Code Act 258 of 1974: Sec. 330.1206, Sec. 330.1208.

C. DWMHA “Integrated Community Based Services for Adjudicated Youth: Care Coordination Guidelines”