

In a **system of care**, mental health, education, child welfare, juvenile justice, and other agencies work together to ensure that children with mental, emotional, and behavioral problems and their families have access to the services and supports they need to succeed.

**Community-based programs that are available
to serve youth who live at home are:**



Skill Building

Care Coordination

**Home & Community
Based Services Waiver**

Single Point Of Access

Single Point of Access for Children & Adolescents is Monroe County's entry point to care for our community's highest needs/highest risk children and youth

SPOA is for children and youth with mental health concerns whose needs extend beyond outpatient therapy and/or medication management.

All programs are voluntary for the family and the youth.

What is SPOA?

**For a youth to be eligible
for community based
programs, he/she must
meet the following
general requirements**



The Youth Must ...

Eligibility



Be a Monroe County resident



Be between the ages of 5 and 18



Have a current mental health diagnosis



Have significant difficulty in daily life that is related to their diagnosis



Have a significant risk of psychiatric hospitalization or out of home placement



Be returning from out of home placement

CFT & Care Coordination



Step 1

The care coordinator will meet with the whole family. During the initial meeting, the care coordinator learns about the youth and their family, their strengths, interests, talents, and who and what is important to them. Any safety concerns will be addressed at this time.



Step 2

A team will be built with the youth and family. Examples of team member include: parents/guardians, behavioral specialist, family supports, health care providers, community resource providers, mentors, teachers and faith leaders.



Step 3

Once the CFT meetings begin, the family will pick areas in their life that they feel they need to work on. With the support of the team, ideas of how these areas can be improved will be generated.

as a Process

Step 4

As the youth and family's Plan of Care is developed, their strengths and supports will be used to help meet the challenges and foster the changes the family intends to make.

Step 5

The plan is reviewed and updated based on improvements and/or life changes, as the youth and family develop new strategies and are better able to manage their challenges.

Step 6

Once goals and objectives have been achieved, the family will be ready to graduate out of care coordination.

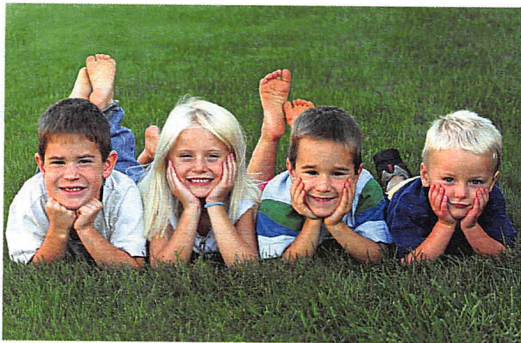
Care Coordination

Villa of Hope's Case Management Program consists of Intensive (ICM) and Supportive (SCM) Case Management. The Program uses the CFT process to develop a team of natural and formal supports around the family. In order to create a proactive plan to meet a family's needs, you can expect a minimum of twice monthly visits for SCM and four times a month for ICM. Typical areas of focus include developing healthy coping mechanisms, positive family interactions, appropriate social and communication skills and tools for academic success. In most cases, the program lasts 9-12 months. The goal is that youth and families leave the program with new skills, a sense of empowerment and hope for the future.

Skill Building

Skill Builders work with youth, families, therapists, and other providers to identify short-term goals for specific skill development related to a child's mental health challenges. Skill Building is provided in a youth's home, community, and/or school, depending on the youth's individual needs, and Skill Builders work flexible hours (including early morning, evenings, and weekends), meeting with youth and families at times that work best for them. In general, Skill Building is provided for 4-6 months; the number of hours varies depending on each individual's needs and goals.

Home and Community Based Services (HCBS) Waiver



An intensive program that provides a variety of services and supports for youth who are at significant risk for long-term hospitalization or residential placement and their families. These supports are designed to meet the youth's individualized needs in order for him/her to remain at home. An Individual Care Coordinator meets with the youth and family a minimum of six times a month and uses the CFT process to identify needs and to develop goals. Services that may be accessed to support the youth's plan are: skill-building, respite, intensive in-home, family support and crisis response.

Who Can Refer?

Anyone can make a referral*, but the most common referral sources are:

- Therapist
- Psychiatrist
- Pediatrician
- Hospital & Crisis Services
- FACT
- Other professionals working with your family

* As a parent or guardian you are able to self-refer. However, it is recommended that you work with your child's mental health provider to complete the referral.

What Documents do I Need?

Along with the **Universal SPOA referral form**, paperwork from the child's therapist, psychiatrist, psychiatric nurse practitioner or pediatrician that includes your child's current diagnosis, the date of that diagnosis, and a psychosocial assessment. Any additional information you are able to provide about the child's mental health challenges will be beneficial.



What are the Responsibilities of the Referral Source?

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|---|--|
| ◆ Fully educate family and youth on services being offered | ◆ Inform families when the referral has been submitted |
| ◆ Accurately complete and submit the referral form in a timely manner, including all required information | ◆ Provide updates as needed to SPOA Coordinator |

How Do I Submit a Referral?

Send the appropriate
documentation to:



SPOA Program Manager
1099 Jay St. Bldg. J
Rochester, NY 14611

Or email to:
childspoa@monroecounty.gov

Referral Forms can be obtained by
calling (585) 753-6104 or
(585) 753-2680

Who Can I Call with Questions About this Process?

You can call (585) 753-2650 and ask to
speak with either the Child & Adolescent
SPOA Facilitator or Program Manager.

What Happens After I Submit a Referral?

1. The family will receive a letter letting them know the referral has been received.
2. Packet is reviewed for eligibility.
3. Referral source will be contacted with any questions or missing requirements.
4. Admission to programs is on a revolving basis and there is often a waitlist. During this time staff will contact the family periodically to check in.
5. When an opening is available the child's information will be provided to the program and a representative will contact the family directly to arrange the first meeting.
6. As a parent or youth you have the right to withdraw the referral at any time.
7. If you are dissatisfied with the referral process or determination made you can contact Barb Mitchell, Children's Behavioral Health Manager at 753-2909.

Referral Process

Frequently Used Terms:

CAPHS: Child and Adolescent Partial Hospitalization Services

CFT: Child and Family Team

FACT: Family Access and Connection Team

HCBS: Home and Community Based Services Waiver

HFA: Hillside Family of Agencies

ICC: Individualized Care Coordinator

ICM: Intensive Case Management

LOC: Level of Care

LGU: Local Government Unit

MCOMH: Monroe County Office of Mental Health

MHA: Mental Health Association of Rochester

NOD: Notice of Decision

OMH: Office of Mental Health

OPWDD: Office of Persons with Developmental Disabilities

SCM: Supportive Case Management

SED: Serious Emotional Disturbance

SOC: System of Care

SPOA: Single Point of Access

VOH: Villa of Hope

YFP: Youth and Family Partnership

Important Resources:

Mental Health Association:	mharochester.org	(585)325-3145
Hillside Family of Agencies:	hillside.com	(585)265-7500
Villa of Hope:	villaofohope.org	(585)865-1550
MCOMH:	http://www2.monroecounty.gov/mh-index.php	(585)753-6047

Community Behavioral Health Services: http://www.monroecounty.gov/health_providers

Approximate wait times for outpatient treatment: http://www.monroecounty.gov/health_providers/search/times

Monroe County System of Care: http://www2.monroecounty.gov/mh-childrens_soc