II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

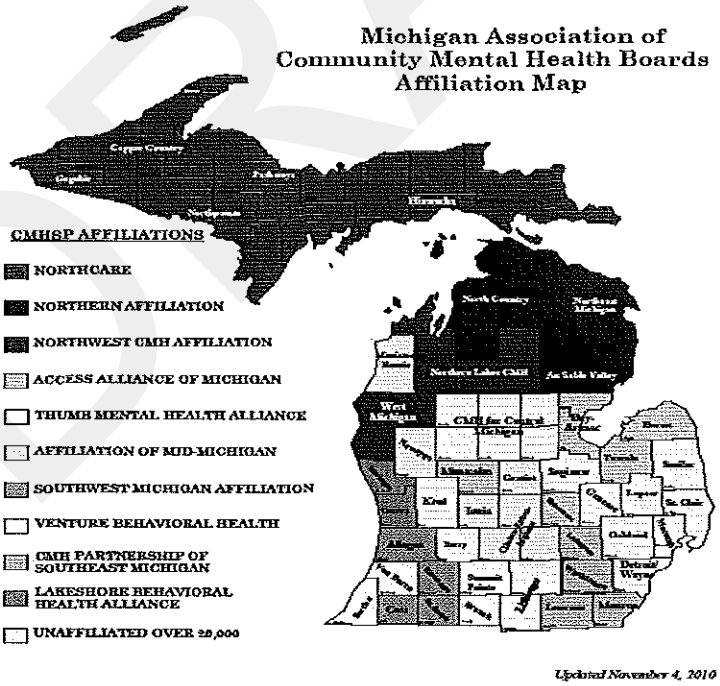
Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

Footnotes:

OVERVIEW

In Michigan, behavioral health prevention, early identification, treatment, and recovery support systems are the primary responsibility of the State's mental health and substance abuse services authorities, collectively known as the Behavioral Health and Developmental Disabilities Administration (BHDDA), and located within the Michigan Department of Community Health (MDCH). MDCH, one of the largest of the 18 departments in Michigan's State government, is responsible for health policy and management of the State's publicly-funded health service systems. At least 2 million Michigan residents will likely receive services in 2014 that are provided with total or partial support from MDCH. The department was created in 1996 by consolidating the Department of Public Health (now the Public Health Administration), the Department of Mental Health (now BHDDA), and the Medical Services Administration (MSA-the state's Medicaid agency). The Office of Drug Control Policy (currently the Bureau of Substance Abuse and Addiction Services) and the Office of Services to the Aging were later consolidated within MDCH.

At the time of this writing, MDCH has contracts with 18 Prepaid Inpatient Health Plans (PIHPs), which are comprised of single or multiple Community Mental Health Services Programs (CMHSPs), for Medicaid services to children with serious emotional disturbance (SED), adults with serious mental illness (SMI), and children and adults with developmental disabilities. Each region is required to have a comprehensive array of services that allows for maximizing choice and control on the part of individuals in need of service. Individual plans of service are developed using a person-centered planning process for adults and a person-centered/family-centered process for children.



The State of Michigan is in the process of undergoing a structural reorganization in its public behavioral health service sector, to accomplish both greater administrative efficiencies and more complete integration in the delivery of mental health and substance use disorder treatment services. The passage of 2012 legislation (the Poleski Bills) calls for the full integration of Michigan's Mental Health and

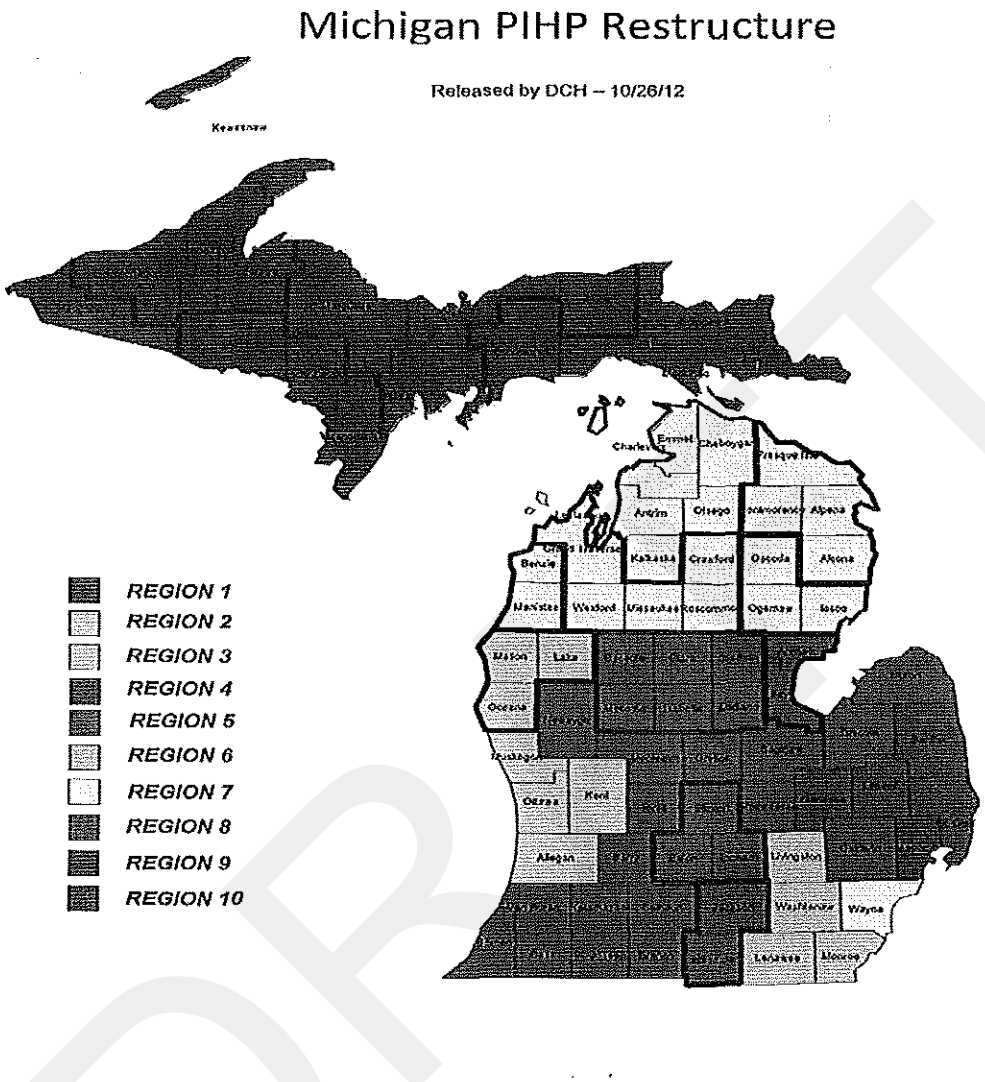
Substance Abuse Service Authorities, to replace the historically established arrangement of 18 regional mental health affiliations (PIHPs) and 16 separate regional substance abuse affiliations (SA Coordinating Agencies). The statewide provider network will move from the current 18 regional CMH affiliates (or PIHPs), to 10 such regional entities, each of which will also serve as both the mental health and substance abuse authority for their respective region. Whereas MDCH currently contracts with 46 CMHSPs for delivery of non-Medicaid funded services (including federal mental health block grant), under the new arrangement Michigan's Department of Community Health will instead contract with these 10 enhanced PIHPs/CAs.

Although ongoing health reform efforts (including Medicaid expansion decisions) will likely change the landscape as we move into 2014-15, the public mental health service delivery system currently contains a small outpatient mental health benefit (20 visits) within the Medicaid Health Plans, which are presently contracted with MDCH through the Medical Services Administration to provide health and dental care to Medicaid beneficiaries. There is also a small fee-for-service mental health benefit for Medicaid beneficiaries (up to 10 visits) with a physician or psychiatrist. The array of Medicaid mental health specialty services and supports provided through PIHPs under Michigan's 1915b/c capitated managed care waiver includes: Applied Behavioral Services, Assertive Community Treatment, Assessments, Case Management, Child Therapy, Clubhouse Rehabilitation Programs, Crisis Interventions, Crisis Residential Services, Family Therapy, Health Services, Home-Based Services, Individual/Group Therapy, Intensive Crisis Stabilization Services, Medication Administration, Medication Review, Nursing Facility Mental Health Monitoring, Occupational Therapy, Personal Care in Specialized Settings, Physical Therapy, Speech, Hearing and Language, Substance Abuse, Treatment Planning, Transportation, Partial Hospitalization, and Inpatient Psychiatric Hospitalization. The specialty services and supports known as "b.3" services which are included in the MDCH contract include: Community Inclusion and Integration Services, Family Support and Training (including Parent-to-Parent Support), Respite Care, Housing Assistance, Peer-Delivered or -Operated Support Services, Prevention and Consultation Services (e.g. School Success Program, Childcare Expulsion Prevention Program, Infant Mental Health, Family Skills Training) and Wraparound Services. Additionally, in July of 2011, some of the services included as "b.3" for individuals over the age of 21 are now included in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program covered by Medicaid for individuals under 21 only. These include: Community Living Supports, Family Training (e.g. Parent Education, Programs for children of parents with mental illness) Peer-Directed and -Operated Support Services, Prevention-Services Direct Model, Skill Building Assistance, Supported Employment, Supports Coordination, and Wraparound Services.

MDCH has a number of mechanisms in place to provide leadership in the coordination of mental health services within the broader system. The PIHP contracts currently describe the PIHPs' responsibilities and deliverables, and will continue to do so under the reorganized system. These contracts place a heavy emphasis on customer service, uniform data collection and encounter data reporting, fiscal management, quality assessment, and utilization. Each PIHP is currently required to have agreements in place with Medicaid Health Plans, Substance Abuse Coordinating Agencies (CAs), and other human services agencies that serve people in the mental health system, and in Michigan's upcoming reorganized system, even fuller assurances of integrated and coordinated care will be required.

BSAAS has historically coordinated substance abuse and addiction treatment, prevention, and recovery services through sixteen CAs. These sub-state entities are responsible for administering the provision of services within their jurisdictions, which have included single or multiple counties, with each of Michigan's 83 counties included in a regional CA catchment area. CAs are incorporated in various administrative entities, including local health departments, community mental health service agencies, county commissions and freestanding non-profit agencies appointed by county commissions. Michigan currently contracts directly with each of the CAs to coordinate and purchase substance abuse services for the public in their region.

BSAAS has historically required that the regional CAs make available to the public outpatient services (including intensive outpatient), residential services, medication-assisted treatment, case management, early intervention, peer recovery and recovery support, and integrated treatment for co-occurring mental health and substance use disorders. As a part of the service requirements that will be supported, BSAAS has been expanding and improving integrated treatment for persons with co-occurring mental health and substance use disorders. This has been a focus of improvement over the last several years, occurring in partnership with the public mental health system. This process has been impacted at the state level through the statewide Practice Improvement Steering Committee and its Co-occurring Change Agent Leaders work group, comprised of state mental health and substance abuse staff, CA and PIHP representatives, stakeholders from local agencies and persons in recovery. Again, as already indicated above, by 2014 the State of Michigan will be re-structuring such that the Substance Abuse Coordinating Agency function will be integrated, geographically and administratively, within each of what are expected to be 10 enhanced PIHP/CA entities, serving as their respective region's integrated mental health and substance use treatment authorities (see "Michigan PIHP Restructure" map below).



Prospective 2014-15 Restructure/Integration of Michigan's Behavioral Health System

The Public Health Administration (PHA) within MDCH is responsible for behavioral health promotion and early intervention activities and other activities which complement the behavioral health services offered by BHDDA. The PHA is also responsible for statewide suicide prevention planning and activities, maternal, infant and early childhood programs that include behavioral health screenings and referrals, tobacco use prevention and treatment programs, fetal alcohol syndrome prevention programs, the coordinated school health program, chronic disease prevention and management programs and health integration activities.

BUREAU OF SUBSTANCE ABUSE AND ADDICTION SERVICES

The Michigan Department of Community Health (MDCH) is one of 16 departments of state government, responsible for health policy and management of the states publicly funded health service systems. The Michigan Public Health Code, Public Act 368 of 1978 (as amended) Sections 6201 and 6203, establishes the state substance abuse authority (SSA) and its duties. The Bureau of Substance Abuse and Addiction Services (BSAAS), within the MDCH Behavioral Health and Developmental Disabilities Administration, functions as the Michigan SSA. BSAAS' duties include the administration and coordination of public funds such as Substance Abuse Prevention and Treatment (SAPT) Block Grant for the prevention and treatment of substance abuse and gambling addictions.

BSAAS allocates SAPT Block Grant funding through 16 regional Coordinating Agencies (CAs), whose responsibilities include planning, administering, funding and maintaining the provision of substance abuse treatment and prevention services for 83 counties in Michigan. All CAs have Prevention Coordinators (PCs), who receive input from and empower local communities in their response to substance abuse prevention needs.

In Fiscal Year (FY) 2010, BSAAS embarked on a recovery oriented system of care (ROSC) transformational change initiative. This initiative changes the values and philosophy of the existing substance use disorder (SUD) delivery system from an acute crisis orientation to a long term stable recovery orientation. Michigan's ROSC definition was adopted on September 20, 2010 as follows: *Michigan's recovery oriented system of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The opportunities established through collaboration, partnership and a broad array of services promote life enhancing recovery and wellness for individuals, families and communities.*

BSAAS subscribes to the belief that ROSC is not a program; it is a philosophical construct by which a behavioral health system (SUD and mental health) shapes its perspective. Michigan's SUD system includes the full continuum of services including recovery support, peer based recovery support, community based services, professional based services (treatment), and prevention services that are client centered and directed to meet the needs of individuals, families and communities. The overarching goal for Michigan's ROSC effort is to promote community wellness. Within a ROSC, SUD service entities, as well as their collaborators and partners, cooperatively provide a flexible and fluid array of services in which individuals can move.

CAs develop annual action plans for their region within this type of system of care and this type of service array. Systemically, the infrastructure includes the use of a data-driven planning process, expands the use of evidenced-based programs, develops epidemiological profiles and logic models, and increases the capacity to address mental, emotional and behavioral conditions to support and improve the quality of life for citizens of Michigan.

Prevention programming is intended to reduce the consequences of SUDs in communities by preventing or delaying the onset of use, and reducing the progression of SUDs in individuals. Prevention is an ordered set of steps along a continuum that promotes individual, family and community health; prevents mental and behavioral disorders; supports resilience and recovery; and reinforces treatment principles to prevent relapse. The Michigan ROSC Implementation Plan goal four: *To enhance our collective ability to support the health, wellness, and resilience of all individuals by developing prevention prepared communities,* comprises the umbrella under which prevention services are conducted. This goal underscores the value of prevention prepared communities (PPCs) as the cornerstones of a ROSC. CAs are expected to sustain a strategic planning framework (SPF) process and a service delivery system that will show evidence of working toward community-level change. A role

for prevention services directed toward individual behavior change remains for specific high-risk selective and indicated populations.

CAs are expected to employ the six SAMHSA Center for Substance Abuse Prevention (CSAP) strategies to engage individuals and the community to effect population-based change. This multi-component and strategic approach should cover all age groups including support for children, senior citizens, all socio-economic classes, diverse cultures, minority and under-served populations, service men and women, gender-specific and targeted high-risk groups. As part of the BSAAS strategic plan, the following has been identified as prevention priorities through 2013.

1. Reduce childhood and underage drinking.
2. Reduce prescription and over-the-counter drug abuse/misuse.
3. Reduce youth access to tobacco (Synar and Synar-related activity).
4. Address a local priority identified based on epidemiological evidence.

Annually CAs prepare a *Prevention Services Planning Chart* to elicit a logical sequence of information from consequences, through planned outcomes, provider involvement, and training needs and must show evidence of a data-guided planning process indicative of the collection and analysis of baseline data to validate the selection of consequences for each priority. It must also indicate the evidence-based programs and strategies to be selected to prevent substance use and SUDs; promote mental health; and reduce obesity and infant mortality.

Early Identification

Treatment is intended to assist those individuals identified as having a substance abuse or dependence diagnosis. Each regional CA utilizes an Access Management System (AMS) that acts as a gatekeeper of sorts to publicly funded services in their region. Through the AMS, individuals and their families are screened and referred to services at the appropriate level of care, and the provider of their choice. Just as the SSA maintains contracts with the regional CAs, the CAs maintain contracts with their provider panel for publicly funded services to ensure that policies and procedures are followed and a baseline for services is maintained statewide. As indicated, there is a baseline expectation for service provision statewide, however, services above the baseline vary by region and are frequently based on the identified needs of the region's population. Each region is required to maintain and adhere to a cultural competency plan that includes population demographics, hiring expectations and practices at the CA and provider level based on the demographics of the regional population, practices that are in place to ensure appropriate cultural training for staff and culturally appropriate resources for the individuals accessing services. The service delivery system is the same for adults and adolescents, and an adolescent or parent would contact the AMS to initiate services for the adolescent.

Recovery Support Systems are a network of supports put into place to assist an individual in maintaining their recovery or sobriety. These supports can be in the form of, but not limited to, peer mentors, recovery coaches, aftercare programming, employment assistance, housing assistance, educational counseling, supportive housing and a commitment to supporting an individual throughout their recovery journey. Recovery supports are organized at the regional level, and vary by CA. Michigan has developed a Recovery Coach Technical Advisory for the SUD field and identified the Connecticut Connection for Addiction Recovery curriculum for those interested in becoming recovery coaches. Regional CA representatives and representatives from the recovery community were important contributors to this process. Training opportunities were offered regionally in FY 2011 and 2012.

Michigan addresses needs of the following specific populations for persons with or at risk of having substance use and/or mental health disorders:

Persons who are intravenous drug users (IDUs): All individuals who are intravenous drug users are considered a priority population in Michigan, with pregnant women who are IDU's being admitted first to treatment. Individuals who are IDUs are offered both drug free and medication-assisted treatment (MAT) by the AMS. Many choose MAT, and this can result in sometimes lengthy wait times, depending on what is available in their region, how far they can travel, and their financial situation. Those placed on the waiting list for MAT are offered interim services, as well as services at a lower level of care to keep them engaged while they wait for the opportunity to attend the service of their choice.

Adolescents with substance abuse and/or mental health problems: The majority of adolescent SUD programs in Michigan are considered co-occurring capable programs, as the population trends show that the majority of adolescents with an SUD also have a mental health concern. There are several residential programs in the state that offer services to the adolescent population, as well as numerous outpatient treatment centers.

Children and youth who are at risk for mental, emotional and behavioral disorders, including but not limited to addiction, conduct disorder and depression: This population is not served through the SUD treatment system, but can access prevention and mental health services.

Women who are pregnant and have a substance use and/or mental disorder: Pregnant women, as a priority population, have immediate access to SUD treatment services. Many programs that offer SUD services to pregnant women are also considered to be co-occurring capable and can address most mental health needs. If a pregnant woman is not able to participate in treatment services immediately, she is offered interim services and connected with the regional women's treatment coordinator for follow up.

Parents with substance use and/or mental disorders who have dependent children: There is one residential program in Michigan that is able to accommodate an entire family (parents and children) in SUD treatment. Several other residential programs are able to accommodate women and their children, and at the outpatient level, ancillary services such as child care are offered both to mothers and fathers who are primary caregivers. If parents are at risk of losing their children and involved with the child welfare system, they are a priority population in Michigan and are able to access SUD treatment services immediately.

Military personnel (active, guard, reserve and veteran) and their families: Military personnel without other resources are able to access the publicly funded system as needed. To date, there are no specially focused programs to meet their needs, but regions are working to train clinical staff in the needs of the military population and the challenges they face. As often as possible, we encourage those military personnel with benefits to access services through the Veteran's Administration.

American Indians/Alaska Natives: There are twelve federally recognized tribes in Michigan. Each tribe provides substance abuse services to the tribal citizens residing in their specified tribal service area. The array of services provided by each tribe is variable, ranging from limited outpatient services to a more comprehensive array of prevention and treatment services. The Indian Health Services does provide limited resources to Michigan tribes for substance abuse services through PL 93-638 contracts and compacts. However, many tribal citizens reside outside the tribal service areas in urban communities. For these citizens, the American Indian Health and Family Services provides outpatient treatment and prevention services to the Detroit American Indian community and the Grand Rapids community receives limited services from the Grand Rapids office of the Nottawaseppi Huron Band of the Potawatomi.

Citizens of Michigan tribes experience health disparities unlike any other population in Michigan with higher rates of substance use disorders amongst youth, chronic alcohol and drug use, suicide rates, as well as depression and PTSD. Tribal citizens face unique challenges in their efforts to access effective substance abuse services. These challenges include; limitations on the array of services available from tribes and tribal organizations, limitations on the availability of non-tribal culturally competent services, limited access to funding, over-reliance on grant funding, and geographic barriers.

Services for persons with or at risk of contracting communicable diseases are addressed in the following manner:

Individuals with tuberculosis (TB): All persons receiving SUD services who are infected with mycobacteria TB must be referred for appropriate medical evaluation and treatment. CAs are responsible for ensuring that the agency to which the client is referred has the capacity to provide these medical services or to make the services available. In addition, all clients entering residential treatment and residential detoxification must be tested for TB upon admission. With respect to clients who exhibit symptoms of active TB, policies and procedures must be in place to avoid the potential spread of the disease. These policies and procedures must be consistent with the Centers for Disease Control guidelines and/or communicable disease best practice.

Persons with or at risk for HIV/AIDS and who are in treatment for substance abuse: Each CA must assure staff knowledge and skills in the provider network are adequate and appropriate for addressing communicable disease related issues in the client population. To assist in meeting this requirement, BSAAS, in conjunction with other partners in MDCH, has developed a web-based Level I training curriculum. In addition, CAs are required to assure that all SUD clients entering treatment have been appropriately screened for risk of HIV/AIDS, STD/Is, TB and hepatitis, and that they are provided basic information about risk. For those clients with high risk behaviors, additional information about the resources available and referral to testing and treatment must be made available.

Although not required, targeted services are also provided for the following populations:

- Individuals with mental and/or substance use disorders who are homeless or involved in the criminal or juvenile justice systems
- Individuals with mental; and/or substance use disorders who live in rural areas
- Underserved racial and ethnic minority and LGBTQ populations
- Persons with disabilities
- Community populations for environmental prevention activities, including policy changing activities, and behavior change activities to change community, school, family and business norms through laws, policy and guidelines and enforcement
- Community settings for universal, selective and indicated prevention interventions, including hard-to-reach communities and "late" adopters of prevention strategies

CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (SED)

The organization of Michigan's system of care (SOC) for children with SED includes many state and local agencies, advocacy groups, family members, and local providers of services. State agencies in Michigan are organized in such a way that each agency may provide multiple services. For example, the Michigan Department of Community Health (MDCH) is responsible for health and mental health services, some housing services, substance abuse services, medical and dental services, and Medicaid and Children's Special Health Care Services (Title V). The Michigan Department of Human Services (MDHS) is responsible for foster care, children's protective services, delinquency services and some housing assistance services. The Family Division of County Circuit Courts is responsible for juvenile justice services. The Michigan Department of Education (MDE) is responsible for educational services and the implementation of Parts B and C of the Individuals with Disabilities Education Act. Employment services and housing services are provided by the Department of Labor and Economic Growth (DLEG) and the Michigan State Housing Development Authority (MSHDA).

As indicated earlier in this document, recent legislation passed in Michigan is requiring that each CA be incorporated into an existing PIHP to formally integrate mental health and substance use disorder services statewide by January 1, 2013. Many CAs have already merged into the PIHP system, however some have not. This transition is currently underway and will impact the way service providers are structured into FY14-15 and provide for the development of a formally integrated behavioral health service network statewide. Some PIHPs have placed a specific focus on training on COD for children and these include Oakland and Central Michigan. Oakland County PIHP has held training in Motivational Interviewing in order to increase engagement of families in PMTO, as well as addressing the mental health and substance use issues of adolescents and family members. CMH for Central Michigan also includes a specific COD focus on children/adolescents to assist with meeting goals around their substance use. Several other PIHPs use Multi-Systemic Therapy (MST) as a strategy for addressing co-occurring disorders. There continues to be a need for additional cross-agency cooperation between mental health and substance abuse services with regard to serving youth with co-occurring disorders. The integration of the CAs into the public mental health system statewide may contribute to additional solutions in this area as well.

There has been increased interagency collaboration in the state which has contributed to a more comprehensive SOC for children with SED that will continue into FY14-15. In responding to Request for Proposals (RFP) for the children's portion of the federal mental health block grant for the past five years, CMHSPs were asked to take the lead with their community stakeholders including the other agencies (child welfare, juvenile justice, education, etc.) and family members to plan the SOC for children with SED and propose projects in their RFP submissions that would fill identified gaps in the local SOC. Many of these projects will continue into FY14-15. However, many barriers remain in the development of a statewide comprehensive SOC and access to mental health services for children who need them. Human service agencies recognize that they need to continue to explore ways to reduce the duplication of services, especially case management and the provision of services through the use of the wraparound process and family-driven and youth-guided practice, to maximize the use of funds.

Historically in Michigan, efforts have been made to move children into communities from more restrictive out-of-home placement, while still providing beneficial and helpful treatment interventions. This movement has continued and will continue to be supported with mental health block grant funding. The development and implementation of intensive community-based services has been crucial to moving children into the least restrictive environment without compromising treatment effectiveness. A major part of Michigan's transformation plan has been the incorporation of family-driven and youth-guided practice, which has led to increased consumer choice and treatment interventions that are

designed as the child and family desires. MDCH has previously supplied SAMHSA, in the FY12-13 Mental Health Block Grant Application, with a copy of the Family-Driven and Youth-Guided Policy and Practice Guideline document that is an attachment to all PIHP/CMHSP contracts with MDCH that requires providers to utilize a family-driven youth-guided approach to services provided in the public mental health system.

MDCH has been a leader in increasing collaboration with other state agencies, local communities, and families. MDCH participates in many interagency groups and emphasizes collaboration for children's services. Through these groups, the SOC has improved through the elimination of duplicative efforts and new projects being planned with joint efforts in development, implementation, and evaluation of services. More work is being planned to further improve the SOC, increase parent leadership development, and increase and maintain youth involvement on interagency committees. FY14-15 appears to bring additional opportunities for collaborative efforts in the areas of juvenile justice, screening, identification and treatment of social/emotional/mental health issues in home and community-based environments, Mental Health First Aid training for schools, law enforcement and other child serving entities, services to transition-aged youth and public/private collaboration to address the needs of children with SED (and often times SED along with a developmental disability and/or cognitive impairment) who repeatedly cycle through residential and psychiatric placements.

Michigan has achieved some success in creating the foundation for a statewide SOC for children with SED. All public mental health providers in Michigan utilize a standard definition of SED and uniform access standards, as outlined in an attachment to the MDCH contract with the PIHPs and with the CMHSPs. Standardized, validated and reliable outcome measures, the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 1989)[1] for youth ages 7-17 and its counterpart for children ages 3-7 the Preschool Early Childhood Functional Assessment (PECFAS) (Hodges, 1994a)[2] are used to assess treatment effectiveness for all children served in the public mental health system. MDCH is supporting with block grant funds the statewide implementation of two evidence-based practices Parent Management Training-Oregon Model (PMTO) (Bank, Rains, & Forgatch, 2004; Forgatch, 1994)[3] and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (Cohen, Mannarino, Deblinger, 2006)[4]. And in fiscal year 2009, the SOC planning process was formally incorporated into the public mental health system through the Program Policy Guidelines (PPGs) through which MDCH requires CMHSPs to provide an assessment of their local SOC and how they plan to move forward to improve outcomes for children with SED and their families and children with developmental disabilities and their families. MDCH is working individually with PIHPs to provide technical assistance regarding progressing to more comprehensive SOCs. CMHSPs were also required to utilize a SOC planning process to prepare their applications for funding through the children's portion of the mental health block grant and/or in implementing the 1915(c) Waiver for children with SED (SEDW). MDCH has been particularly interested in increasing access to specialty mental health services and supports for Medicaid eligible children/youth with SED in child welfare (i.e., abuse/neglect, foster care and/or adopted children/youth) and juvenile justice. Also at the community level, interagency administrative groups serve to assure interagency planning and coordination. Of these various local committees, the most pivotal group is the Community Collaborative. All of Michigan's 83 counties are served by a single county or multi-county Community Collaborative which functions to oversee the planning and development of children's services. The local collaborative bodies are comprised of local public agency directors (public health,

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[1] *Hodges, K. (1989). Child and Adolescent Functional Assessment Scale. Ypsilanti: Eastern Michigan University.*

[2] *Hodges K. The Preschool and Early Childhood Functional Assessment Scale. Ypsilanti, MI: Eastern Michigan University, Department of Psychology; 1994a.*

[3] *Bank, N., Rains, L., & Forgatch, M. S. (2004). A course in the basic PMTO model: Workshops 1-3. Unpublished manuscript. Eugene: Oregon Social Learning Center.; Forgatch, M. S. (1994). Parenting through change: A training manual. Eugene: Oregon Social Learning Center.*

[4] *Cohen, J., Mannarino, A., Deblinger, E. (2006) Treating Trauma and Traumatic Grief in Children and Adolescents, London and New York: The Guilford Press.*

community mental health, child welfare, juvenile justice and substance abuse agencies), family court judges, prosecutors, families and sometimes a youth, private agencies and community representatives.

Key components of SOC (family-driven and youth-guided, cross system funding for services for child welfare foster care children with SED, etc.) have been the focus of interagency planning at the state level for many years, and great strides have been made in the past two years. As a result of participation in the February 2009 National Federation of Families for Children's Mental Health's Policy Academy on Transforming Children's Mental Health through Family-Driven Strategies and continuing work by that team, an official MDCH policy on Family-Driven and Youth–Guided Practice is utilized by PIHP/ CMHSP providers to operationalize the concepts of family-driven and youth-guided service provision. A statewide Parent Support Partner training curriculum was developed in a partnership between the family organization and MDCH, and training began in 2010 and will continue in FY14-15. The child welfare and judicial systems have also begun including family-driven and youth-guided concepts in their routine operations.

Another key component of SOC that has been addressed recently is cross-system funding. MDCH and MDHS have committed to a collaborative partnership which has expanded the SEDW DHS pilot to 36 counties, including current and former SAMHSA SOC grantee sites in Michigan. The waiver sites provide comprehensive mental health services, including wraparound, to children in MDHS foster care. This initiative provided the impetus for further collaboration between MDCH and MDHS to provide services to additional children in the child welfare system who may not meet the criteria for the SEDW but who still require specialized mental health services. MDHS provides the state match to Medicaid for both these projects in order to increase access to mental health services through CMHSPs/PIHPs for children in MDHS foster care and child protective services levels 1 and 2. Also, an MDCH block grant funded SEDW Access position, located at the local MDHS office, was offered to participating SEDW sites to provide mental health screening, assessment and liaison functions to facilitate children being identified and enrolled in appropriate mental health services. This partnership has been integral in assisting MDHS in responding to the consent decree that was the result of the Dwayne B. v. Granholm (2006) lawsuit (that requires, among other things, MDHS to provide improved screening and access to mental health services for children in foster care) and will continue to assist in the response to the revised consent decree Dwayne B. v. Snyder (2011) as well as to sustain a stronger SOC for children in the child welfare system in Michigan.

MDCH and MDHS have also worked closely with present and former SAMHSA SOC grantee sites (in Kent County, Saginaw County, Southwest Detroit, Ingham and Kalamazoo counties) to provide leadership in collaborative efforts to develop SOC in their communities and impact state level efforts. MDCH and MDHS staff have regular meetings with sites to discuss strategies, progress, outcomes and sustaining the gains made during the grant period. The lessons learned by these sites provide a wealth of knowledge about what has been successful and what has been challenging in implementing SOC at a local level. A partnership between past and present federal SOC sites with participation and sponsorship from relevant state departments along with the Association for Children's Mental Health (ACMH - the National Federation of Families for Children's Mental Health State Chapter) has resulted in an annual state SOC Conference, which gives child-serving staff and families from all over the state access to information to help move SOC forward. Participants from graduated and current federal SOC sites participated in the Policy Academy on Transforming Children's Mental Health through Family-Driven Strategies and the Parent Support Partner training was first piloted in past and present SAMHSA SOC grantee sites before it was offered statewide. Also, it was through MDHS staff experience as a principal investigator for one of the SAMHSA SOC grantee sites that support for and commitment to SOC was solidified. Finally, youth leadership has expanded based on many of the youth that have come from the federal SOC site communities.

ADULTS WITH SERIOUS MENTAL ILLNESS (SMI)

As early as 2001, the National Institute of Medicine's report brief entitled, Crossing the Quality Chasm – A New Health System for the 21st Century highlighted the finding that, *"Scientific knowledge about best care is not applied systematically or expeditiously to clinical practice. It now takes an average of 17 years for new knowledge generated by randomized controlled trails to be incorporated into practice, and even then application is highly uneven. The committee therefore recommends that the Department of Health and Human Services establish a comprehensive program aimed at making scientific evidence more useful and more accessible to clinicians and patients."*[5]

Additional calls for systems transformation came in 2003 with the President's New Freedom Commission on Mental Health report, in 2004 with the State of Michigan's Mental Health Commission final report, and in 2006 with another National Institute of Medicine report on Improving the Quality of Care for Mental and Substance-Use Conditions. As recently as 2009, Proctor et al noted that, *"One of the most critical issues in mental health services research is the gap between what is known about effective treatment and what is provided to and experienced by consumers in routine care in community practice settings."*[6]

In response to these findings and calls for action, a concerted effort has been underway by SAMHSA to provide the information and tools necessary for States to know about, to develop, and to implement any number of evidence-based practices that have been shown to improve the well-being and recovery of service recipients facing various mental and emotional health challenges. From the development of various toolkits (made available to provider systems at no-cost), to the ongoing availability of information about newly developed practices with demonstrable bases of evidence on its National Registry of Evidence-based Programs and Practices (http://www.nrepp.samhsa.gov/), SAMHSA has equipped the field with foundational knowledge and effective models with which to improve the quality of services for recipients of our care.

Assisted by available block grant resources, Michigan has continued to make strides in improving our system of care to include the availability and delivery of many of these recommended practices. Among the strengths demonstrated across our State, efforts have continued to progress in the development and implementation of a range of SAMHSA-endorsed evidence-based practices (EBPs) and cross-cutting initiatives across our CMH provider system, including block grant-supported projects targeting the following adult service practice areas. As many of these practices are only partially implemented and/or are encountering sustainability challenges, they also continue to represent ongoing needs for the coming FY14-15 grant cycle:

Assertive Community Treatment

The 90+ community-based Michigan Assertive Community Treatment (ACT) teams engage and work with adults who experience the most severe and troubling symptoms of serious mental illness. Firmly embedded in the public mental health system and a Medicaid covered service, ACT uses proactive engagement to provide continuous, rapid, flexible, twenty-four hour a day, seven days a week, three hundred and sixty-five days a year treatment. Although there is a well-established 20 year history of ACT, assuring the necessary skills and information in workforce development and support of this very high intensity evidence-based practice remains a priority. An ACT specific training is required annually.

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[5] *Institute of Medicine: Committee on Quality of Health Care in America (2001). Crossing the Quality Chasm: A New Health System for the 21st Century, Washington, D.C.: National Academy Press.*

[6] *Proctor, E., Landsverk, J., Aarons, G., Chambers, D., Glisson, C., & Mittman, B. (2009). Implementation research in mental health services: An emerging science with conceptual, methodological and training challenges. Admin. Policy Mental Health 36: 24-34.*

ACT-specific training is required by Medicaid, and the Quality Management Site Review Team emphasizes adherence to Medicaid. A quality improvement tool, the Field Guide to ACT was created, adopted and is used today to support ACT teamwork addressing Medicaid, the sponsoring organization, in consumer relations and satisfaction and outcomes.

As the fixed point of responsibility, the ACT team consists of multi-disciplinary mental health professionals that most often include a peer. Responsible for working with ACT consumers to develop the person-centered treatment plan and for supporting consumers in all aspects of community living, ACT assists consumers to live in the most independent setting possible, while supporting goals focused toward recovery. Consumers receiving ACT services in Michigan typically have needs that have not been effectively addressed by traditional, less intensive services. Additionally, ACT consumers have been asked to participate in the 44 item MHSIP Survey.

Fully integrated into the public mental health system, ACT interfaces with many of Michigan State's other supported evidence-based practices such as IDDT and FPE. ACT is represented on the Practice Improvement Steering Committee; the ACT subcommittee has been disbanded and is poised to reconvene when policy and practice issues arise. ACT is one of the evidence-based practices in the www.improvingmipractices.org website and, as such, has a variety of resources and information available to ACT team members, the public, consumers, administrators, and families.

Data from service usage from Boilerplate Section 404 Report from FY 11 indicates that 5,257 consumers participated in ACT. ACT consumers have been gradually decreasing as agencies look more closely at needed levels of care. Across the state, ACT represents 7.01% of the CMHSP budgets. Agencies costs range from a low of .02% to 26.45%.

In FY 11, ACT consumers across the State were chosen to participate in the MHSIP survey. Average responses follow: 91% for Appropriateness of Care; 88% for both Access and General Satisfaction; 82% for participation in Treatment Planning; 75% for Outcomes; 74% for Functioning; and 71% for Social Connectedness.

Family Psychoeducation

Family Psychoeducation (FPE) in Michigan is provided through the PIHPs, CMHSPs, and contract agencies for partnering with consumers and families to support recovery. FPE is comprised of three phases: 1) joining sessions, where practitioners and families begin to form a practitioner, consumer-family alliance and learn about the individual families experiences related to mental illness; 2) a structured one day workshop that focuses on the biological causes of mental illness as well as individual needs of families; and 3) multi-family groups focus on a structured problem-solving approach over time, creating a safe environment to experiment, communicate, cope, grow and practice new social skills.

Representation on the Practice Improvement Steering committee (PISC) is consistent. FPE has a strong subcommittee, the Steering Committee, made of dedicated and skilled staff from throughout the state.

Over time a significant structure to support FPE has been achieved. A part-time State Coordinator works with MDCH and the Steering Committee to plan and implement the Facilitator, Advanced Facilitator and Trainer/Regional Supervisor training. A FPE Sustainability document has been created. Bimonthly Learning Collaboratives focusing on FPE staffs current needs and challenges. Learning Collaboratives are well-attended and have lively participation. In effort to maintain high fidelity, technical assistance/fidelity reviews are offered to PIHPs annually. There are 15 active supervisors/trainers spread regionally to provide regular supervision throughout the State.

Basic research was completed with Medicaid data from 10/1/09 to 9/30/11. Consumers participating in multi-family problem solving groups were evaluated to determine whether participation in FPE decreases the use of higher intensity mental health services [Crisis Intervention (CI), Crisis Residential (CR), and Inpatient (IP)] measured nine months before FPE and measured nine months after FPE. Those receiving less than ten units of multi-family groups nine months before FPE and nine months after FPE were measured. The findings are as follows: less than 10 units of multi-family groups showed small decreases in CR -7.0%, IP -22.9% and a significant decrease in CI -46.4%. Also measured were those receiving ten or more units of multi-family groups nine months before FPE and nine months after FPE. Consumers participating in more than ten units of multi-family groups showed significant decreases in CI -58.6%, CR -62.9%, IP -78.4%. It is important to note that many FPE participants had no CI, CR, IP before, during, or after FPE. This is an area rich for research but, meanwhile, it looks like FPE can greatly reduce the use of expensive services.

Data is from the "Point-in-Time Survey" Family Psychoeducation, November 2012, Initial Report, University of Michigan, Mary Ruffolo. Surveys were completed within a two week period by 146 Consumers and 121 Families about their family members. Acceptance, respect, help, hope, and dealing better with daily problems averaged 87% for families and 70% for consumers. 53% of families observed an improvement in physical health. 92% of consumers indicated taking medications on a regular basis. Categories included daily problems, control of life, dealing with crisis, getting along better with family, better social in social situations, taking care of needs, handling things when awry, regular medications, crisis help from natural supports, no police contact or hospitalizations during the past three months averaged 69% improvement.

Co-occurring Disorders (COD): Integrated Dual Disorders Treatment (IDDT)

MDCH activities for the implementation and sustainability of evidence-based and best practices for addressing co-occurring behavioral health and substance use disorders include:

- Michigan Fidelity Assessment Support Team (MIFAST):
  - Integrated Dual Disorder Treatment (IDDT) readiness assessment, onsite fidelity reviews, and follow-up technical assistance;
  - Dual Disorder Capability in Mental Health Treatment (DDCMHT) onsite reviews and follow-up technical assistance.
- Co-occurring Change Agent Leadership (CoCAL);
  - Monthly meetings of this subcommittee of Michigan's statewide Practice Improvement Steering Committee.

The MIFAST group reviews programs for the purpose of assisting them in developing and sustaining IDDT teams that practice with a high level of fidelity. MIFAST does this by conducting a technical assistance conference to help agencies develop an implementation plan for IDDT, followed by an onsite visit to determine the degree to which the agency has achieved implementation by fidelity scoring of the 26 scorecard elements, and subsequent provision of technical assistance to aid in the improvement of areas that are shown to need further development. The MIFAST team has added the DDCMHT site review process to its menu of assistive activities. The MIFAST team underwent formal training through SAMSHA in order to provide system wide review of "dual disorder" treatment capabilities across all programs at the outpatient level of care. In 2012, eleven agencies requested DDCMHT site-reviews of their outpatient treatment programs. Each site was provided with a scoring report and a work plan with suggested activities for enhancing supports and services in each area reviewed.

The 2013 plan for MIFAST IDDT is to ascertain the number of IDDT teams practicing across the State of Michigan; determine the number of IDDT teams who have had four or more IDDT site Reviews since 2006; determine the number of protocols that consistently score above a 4 and organize site reviews to

target areas that score below 3.1; provide both review and technical assistance for areas below 3.1 in site reviews and follow-up; initiate site reviews for IDDT teams who have not yet participated or have had <3 reviews; conduct DDCMHT site reviews for all outpatient level of care programs; conduct MIFAST inter-rater reliability enhancement training for veteran and new reviewer team members; and recruit and induct additional peer support specialists or persons with lived experience onto the review team as consultants to MIFAST and as part of the site review process.

The CoCAL has goals and objectives for the continuance of implementation, sustainability and improvement of the standards of practice for integrated treatment. The CoCAL currently has four defined work groups organized around its goals: 1) COD Workforce Development; 2) COD Outcomes Work Group; 3) MIFAST Activities; and 4) Systems Integration & Funding. The COD Workforce Development activities include planning the annual statewide Co-occurring Conference, and additional staff training and development.

The annual Co-occurring Conference is intended to bring together staff from administrative and practice levels and provide them with the best examples of co-occurring mission, vision, policy and practice initiatives, as well training on evidence based practices developed and adapted for co-occurring treatment. The conference planning group meets to review submissions from presenters who wish to participate in this conference. Reviews are conducted to determine if presentations meet the goals of the conference for integrated treatment, evidence-based and meet standards for strength-based and recovery characteristics. Plenary speakers are also reviewed and chosen based on their ability to meet the goals of the conference.

Motivational Interviewing

Motivational Interviewing (MI) is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal. MI represents a philosophy as well as a set of skills for effectively engaging and assisting Michigan's behavioral health system's service recipients facing one or more areas of difficult behavior change about which they may be ambivalent.

Goals for 2014-15 and beyond with regard to Motivational Interviewing include:

- Expanding the Motivational Interviewing internal trainer project by using trainers developed through a state-funded initiative to strengthen Supervisor Skills for observing, coaching and enhancing Motivational Interviewing skills with the people they supervise.
- Final development and placement of web-based Motivational Interviewing training modules on the Improving MI Practices (www.improvingmipractices.org) website, to be made available to the frontline workforce of Michigan's public behavioral health system.
- Placement of the Video Assessment of Simulated Encounters (VASE-R) on the Improving MI Practices (www.improvingmipractices.org) website so that Michigan's behavioral health workforce members can have access to an assessment tool that is easy to use and that can give them a reliable assessment of the degree to which training has enhanced their understanding and application of the Motivational Interviewing philosophy and skills.

Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. It has become the evidence-based treatment of choice for serving individuals with Borderline Personality Disorder, a population that when untreated/undertreated tends to drive up emergency service/crisis service and psychiatric hospitalization costs.

- With approximately 50 DBT teams delivering services across Michigan's public behavioral health system, each existing PIHP regions feature one or more available DBT team providing this evidence-based treatment to service recipients with Borderline Personality Disorder.
- Ongoing core and refresher training continues to be provided annually to Michigan's public behavioral health workforce, along with evaluation of the effectiveness of the current training approach, leading to ongoing redesign for FY14-15 to increase cost-effectiveness and sustainability. An extensive practice knowledge exam has been developed and is currently being beta-tested, for eventual roll-out to all DBT practitioners in Michigan's public sector behavioral health service system, to better gauge the level of core knowledge and skills, and to inform future training and support for performance quality. This DBT practice knowledge exam will be made available in an online format via the Improving MI Practices (www.improvingmipractices.org) website, with test results immediately available to MDCH for aggregation and analysis, for the purposes of supporting high-quality service delivery, and to help inform needed training moving forward.
- Statewide efforts to improve and expand the quality and availability of DBT services is being guided by a newly convened DBT Subcommittee, led by experienced practitioners from within Michigan's behavioral health service network, which advances the products of its work to the MDCH-advising Practices Improvement Steering Committee.
- One pilot FY12-13 project involves tracking consumer-level outcomes utilizing the BSL-23 (23-item Borderline Symptom Checklist) to collect changes in symptoms over time, with practitioners inputting this outcome data into a secure, web-based application for subsequent aggregation and analysis.
- Needs moving forward include supporting ongoing effective service quality, with better outcome tracking and analysis to substantiate progress and cost/benefit value.

Supported Employment (SE)

The focus has been and needs to continue to be the increased access to employment enhancing services for those who may not otherwise utilize these programs. SE program numbers have increased by 18%--much of that is due to the fact that adults with mental illness are able to access services in locations where there were not services previously offered. Five new SE programs were started in the last fiscal year—offering access to services primarily in rural areas of the state. SE should be seen as a means to re-enter the community for many instead of the few—education for case managers and other referrers was started and needs to continue by way of initial training on the subject as well as on-going refresher courses.

Partnerships with Vocational Rehabilitation (VR) (including Michigan Rehabilitation Services and the Bureau of Services for Blind Persons) continue to be enhanced. Work has been done on a joint document that describes the role of mental health and of VR in the development of work opportunities for individuals with disabilities across the state. Stronger partnerships continue to develop in regions across the state to promote joint funding for individuals who are co-recipients of service. There is a more focused effort to train staff from VR and from mental health on working jointly toward employment for people with mental illness and/or co-occurring disorders.

Effective service quality is enhanced by the fidelity efforts across the state. 15 projects received comprehensive reviews, resulting in quality improvement plans that will enable programs to work toward more effective and efficient programs. Quality improvement has focused primarily on preference development, individualized job development and executive buy-in—all leading to sustainability for SE. To determine cost/benefit, MDCH is piloting a data collection and analysis project with five of the largest PIHPs—the outcomes of which will lead us to the development of a data collection process for the state that will be able to give us information which is the most important in the

development of sustainable and effective programs.

Much work has gone into "cleaning up" the data that MDCH receives and aggregates from locals. During the past fiscal year, definitions of different levels of employment were streamlined. Analysis has been done to determine reporting methodology that would give the department data that is easier to report, aggregate, and analyze in a timely fashion so the department can guide the field. This new method of reporting is being piloted this fiscal year with five large PIHPs. The intent will be to learn and adjust during this pilot and roll out the new tracking method to the field by October 2013.

MI Benefits Information Network Training is key to developing a state-wide multi-agency/partner training and support network using braided funding to best assure a long-term, sustainable benefits planning information structure across Michigan. With loss of Social Security grant funding to employ a network of well-trained benefits planners, a new and better Michigan specific training model is very needed to assist individuals with mental illness in making well-informed choices about employment. Approximately 90 individuals will attend this training in FY 2013. Joint planning meetings have started to determine possible certification of attendees, quality assurance of analyses completed, monthly support topics, and on-line training events.

MDCH continues to offer SE 101 training and will be developing the web-based training equivalent. Skills training to practitioners, new practitioners and case managers continue to be provided. Several areas of Michigan remain where SE is not available as well as communities where the services are only open to few consumers of service. Efforts will continue to influence access to services via direct attention to non-participating locals, increased technical assistance to small programs and maximizing partnerships with VR.

Legislation (Senate Bill 564) to amend Freedom to Work should provide opportunities to persons with mental illness because they are commonly the individuals with larger SSDI checks and face Medicaid with a Deductible (spend-down). Now individuals may make an informed choice about working or increasing their work, paying a premium if earnings exceed a given amount, and retain needed Medicaid coverage. It is projected that about 3,300 additional individuals will attain Medicaid eligibility through this legislation. Growing efforts to advance Employment First in Michigan through an executive order or legislation will focus on changing "expectations" of individuals, families, agencies, organizations and employers to expect that all individuals can and should be employed. This commonly grows out of services for persons with developmental disabilities but efforts in MI clearly intend to include people with mental illness.

Older Adults

Older adults are eligible for the same service array as younger adults within the public behavioral health system. Dementia, as a primary diagnosis MAY be covered under the current Public Mental Health Code but usually is not. In FY 11 about 8,500 older adults received public behavioral health services which are less than 5% of the total number of adults served. Note: Citizens aged 65 and older make up nearly 14% of Michigan's population according to the 2010 Census, with a projected 36% increase 2010 to 2020. It is expected that there will be twice as many persons aged 65+ in 2030 as 2000, making up 20% of the population by 2030. Approximately another 800 people had both a Developmental Disability and a mental illness and some 3,256 received behavioral health services in a nursing facility. One population specific grant, "The Mental Health and Aging Project" has multiple activities among the Inter-Tribal Council, but all focus block grant funding on Native Elders.

MDCH has partnered with universities such as Eastern Michigan University's Alzheimer's disease and Education Program, and colleges like Lansing Community College, Mental Health and Aging Project (MHAP), to provide a variety of seminars and workshops related to both mental illness and dementia.

An annual Mental Health and Aging Conference and regional seminars focus on the mental health needs of elders. Other partnerships include collaborative work with the Michigan Assisted Living Association, providing materials, curriculum, and training on dementia care to staff of facilities whose residents include over half persons with dementia. Department staff wrote "Concepts and Elements of Dementia in Person-Centered Training" for the Michigan Alliance of Person-Centered Communities, which is a coalition of organizations working in long-term care. An online general education course has been developed for both the geriatric workforce as well as the general workforce.

Recently, MDCH began working with the Geriatric Education Center of Michigan (GECM) and the Center for Rural Health. Providing behavioral health information through the monthly teleconference "grand rounds" has reached new audiences: 50 locations with multiple attendees in primary care, primarily in the Upper Peninsula and upper-lower rural areas, plus presentations on behavioral health for older adults at regional GECM sites. MDCH staff re-wrote two educational modules on "Caring for Caregivers: Basics" and "Caring for Caregivers of Persons with Dementia" for primary care continuing education. Collaboration with GECM has extended to their "Alzheimer's Disease and Related Disorders Supplemental Training Grant," with enhancements to curriculum and relevant case studies (e.g., cases of persons with physical and mental health issues and accompanying dementia), and expansion of training participation to mental health professionals, which builds on MDCH's focus on Integrated Health. Upcoming efforts include writing educational modules on co-occurring mental illness and substance abuse for the audience of primary care professionals.

MDCH directs the "Nursing Home Training on Dementia Care" which is in its third year of a grant from CMS' Civil Monetary Penalty funding. Dementia Educators develop staff skills in dementia care in 20 selected nursing homes in Michigan, and act as consultants and mentors to co-train facility staff for sustainability. They teach non-pharmacological approaches and interventions to reduce and prevent distressed and challenging behaviors by residents with diagnosed dementia, with an anticipated outcome of reduced discharges to hospitalization because of behaviors. This work now coincides with a 2012 national CMS initiative to reduce use of psychotropic drugs for nursing home residents with dementia.

Involvement in the Michigan Dementia Coalition, a grassroots collaboration of representatives of universities, community agencies, and state government units continues. Department staff led the Respite Care Award Program in 2012, with written press releases and connection with professional organizations for inclusion in professional conferences to promote awareness of respite care for persons with dementia and to share innovative and exemplary practices. The article, "Best Practices in Respite Care" was written and disseminated.

As adjunct members of NASMHPD Older Persons Division, Department staff share state programming information. In 2012 staff participated in a presentation on Depression in Older Adults SAMHSA toolkit at its annual conference in Mississippi. Staff also presented a session on Wraparound for Persons with Dementia project.

Clubhouse

Currently there are 44 Clubhouses that serve over 4,500 consumers in the state. The International Center for Clubhouse Development (ICCD) model programs have been recognized as an evidenced-based practice by the Substance Abuse and Mental Health Services Administration (SAMHSA) since March 2011. Employment outcomes for Clubhouses played a significant role in SAMSHA's decision. Two of the three journal articles used to make the finding focused on employment. Both articles were studies of employment outcomes at a Clubhouse certified by the ICCD.

Accredited Clubhouses follow specific guidelines for employment systems within the clubhouse, and they were able to objectively demonstrate strong effectiveness for this model. Therefore, the ICCD

standards on employment should be seen as the most effective method known to secure an array of employment opportunities for clubhouse members. For this reason, fidelity to the ICCD clubhouse standards is strongly encouraged.

Jail Diversion

Diverting justice involved persons from incarceration is a top strategic priority in Michigan. Jail Diversion programs operate in each Community Mental Health Services Program (CMHSP) and Prepaid Inpatient Health Plan (PIHP). While diversion programs and services vary by size and location, they all have the same goal in common. Diverting individuals who have a serious mental illness, including those with co-occurring substance use disorder, or who have a developmental disability and have contact with the criminal justice system around misdemeanor or non-violent felony offences is the goal. Screening and assessment for mental health intervention are provided to determine whether appropriate services can be offered in the community as an alternative to serving jail time. Law enforcement and the judiciary make the final determinations. In prior fiscal years', the Mental Health Block Grant supported post-booking diversion activities in Genesee and Kalamazoo counties through mental health court programs. Both programs funded peer support specialists and reported the effectiveness of integrating such supports into all aspects of mental health programming. In Kalamazoo, peer support specialists provided assistance to new participants and also facilitate wellness recovery groups to current participants and graduates. In Genesee, peer support specialists assisted new participants with post-booking services including transportation as well as providing expertise in joint training efforts with local law enforcement and CMH staff.

FY12 data reported by the CMHSPs and PIHPs indicates that the number of pre-booking diversion incidents with adults having mental illness totaled 2,721 (up from 2,608 in FY11). The number of pre-booking diversion incidents with those having developmental disabilities totaled 36, and the number of pre-booking incidents with those having a co-occurring SUD (a newly tracked category beginning in FY11) totaled 602. The number of post-booking incidents of adults with mental illness totaled 872, the number of post-booking diversion incidents with those with developmental disabilities totaled 141, and the number of post-booking diversion incidents with those with co-occurring SUD totaled 1,722. MDCH is available to provide technical assistance and consultation via national, regional and local resources, identifying training opportunities and to keep CMHSPs/PIHPs in touch with each other to offer individual and specific assistance when requested or as needed. A new jail diversion workgroup was started in February 2012 with the goal of further reducing incarceration rates of those with a mental illness.

Mental Health Courts

Beginning in FY09, appropriations for both the State Court Administrator's Office (SCAO) and MDCH included funding for implementation of a pilot mental health court program. MDCH funds supported treatment costs and Judiciary funds supported court operations. Boilerplate for each agency (FY09 section 459 of the MDCH appropriations) requires collaboration and joint development of guidelines for the operation and evaluation of these pilot courts. Correspondingly, in collaboration with the SCAO, a joint application was issued, applicant proposals reviewed and nine pilot mental health court programs project sites were approved and funded for FY09 implementation. This collaboration continues.

When state general fund appropriations for these pilot projects were reduced in FY09 and eliminated in FY10, funding to continue these projects was made available through Byrne/JAG American Recovery and Reinvestment Act of 2009 federal grant funds which supported the pilot projects through FY 2012. Funded mental health courts are operational in Wayne, Oakland, Berrien, Livingston, Jackson, St. Clair, Grand Traverse and Genesee counties. In FY 13 approximately 2 million was appropriated to the State

Court Administrative Office to continue the funded pilot projects as well as to fund a new mental health court in Saginaw County.

MDCH contracted with Dr. Sheryl Kubiak and her team from Michigan State University (MSU) to conduct an outcome evaluation of the eight pilot programs located in Wayne, Oakland, Berrien, Livingston, Jackson, St. Clair, Grand Traverse and Genesee counties spanning 2009-2011. The evaluation examined multiple data sources to analyze both mental health court processes and outcomes. The following is an overview of the results contained in the report.

- Participant characteristics at admission: 678 individuals admitted into the mental health courts prior to 12/31/2011. Average age of admission was 35 years of age; two-thirds were male and 67% Caucasian. Majority were unemployed at admission (91%) and 20% were homeless. 40% admitted with a primary diagnosis of bipolar disorder, 29% schizophrenic/ psychotic or delusional disorders (21%) 12% other such as developmental or personality disorders.

- Average length of stay was 276 days of those admitted; of 450 discharged 43% successfully completed. Successful completions were typically older (avg. 39 years) and had misdemeanant/civil offenses. Younger participants combined with a felony offense were predictive of a lower chance of successfully completing.

- 406 (60%) of the 678 admitted into mental health court screened positive for a current substance abuse problem. Of the 406, 185 (46%) did not receive any formal substance treatment in the year prior to mental health court.

- 70% of participants received substance abuse treatment within CMH at some point in time (pre, during, post mental health court) SUD service utilization generally increased during mental health court participation but declined post mental health court with 28% of those discharged receiving a SUD treatment service after mental health court.

- Prior to mental health court, 81% spent an average of 39 days in jail. During mental health court, 54% spent an average of 24 days in jail. Of the 450 discharged 149 participants were jailed post mental health court averaging 23 days in jail.

- Recidivism data: During Mental Health Court (MHC): 55 (8%) were charged with a new offense and 46 convicted. Of the 46, 10 were convicted of a felony offense.

- Post-MHC: 44 (6.5%) participants were charged with a new offense. Examining both during and post mental health court periods: as of 12/31/2011, 14% of participants had been charged and convicted of a new offense since admission into mental health court. Of 93 convicted, 30 were convicted of a felony offense.

Drug Treatment Courts

Drug treatment courts represent an enhancement of community supervision by closely supervising drug offenders in the community, placing and retaining drug offenders in treatment programs, providing treatment and related services to offenders who have not received such services in the past. The benefits of drug treatment courts include generating cost savings when offenders' reliance on the service delivery system is ultimately or eventually reduced and especially when drug courts reduce jail and prison utilization. They have been found to substantially reduce drug use and recidivism while offenders are in the program. Drug courts have evolved over time and now include several models to serve specific subsets of the offender population. These models include adult drug treatment courts, driving while intoxicated courts, family dependency treatment courts, juvenile drug courts, tribal courts and more

recently Veterans courts. Although they share the same therapeutic jurisprudence model, each drug court model has program-specific components designed to meet the needs of its target population. These programs have offered a solution to the problem of jail overcrowding, as well as to the problem of drug and alcohol-related crime.

Michigan has led the way in drug treatment court implementation. In June 1992, the first woman's drug treatment court in the nation was established in Kalamazoo County targeting felony offenders. The program was very successful and other courts sought to establish drug court programs as well. Due to continued success and increasing levels of dedicated federal and state funds, drug courts grew rapidly over the next ten years. Currently, 105 drug courts are operating, not including 11 veterans courts of which 4 are in the planning stages.

Prisoner Re-entry

Based on a model developed by the National Institute of Corrections, Michigan's Re-entry program was implemented in 2005 over eight pilot sights; the state sought to reduce recidivism rates among those returning to state correctional facilities. Initially a two-phased program that addressed "Going Home and "Staying Home", the program expanded in 2009 to include the "Getting Ready" phase and in preparation, trained over 3,500 employees. The first phase begins two months prior to release on parole where they are transferred to a facility in close proximity to the community of where they will be residing. Prisoners meet with community transition teams where needs such as housing, substance use, mental health issues are assessed and addressed. The second phase continues the work from the first phase but prioritizes employment and provides linkages and support with the local Michigan Works program. The third phase continues support services in attaining housing, employment, behavioral health services and any other tools necessary for parolees to succeed as they transition into their community.

A three-year follow-up study through 2011 of those released in 2008 (most recent cohort to complete 3 year follow up period) found that those in the re-entry program were thirty-eight percent less likely to return to prison. Additionally, the overall revocation rate for 2011-174 per 1,000 is the lowest rate since 1987. (Michigan Prisoner Reentry, A Success Story MDOC 2012)

Recovery-Oriented Care / Recovery Support Services

Recovery-based services and supports remain a strong foundation of publicly funded behavioral health programs in the state. As part of Michigan's Certified Peer Support Specialist (CPSS) initiative, approximately 1,200 individuals have been trained and certified in the state. Individuals work in a variety of areas including supports coordination, psychosocial rehabilitation programs, access centers, drug and mental health courts, crisis settings, drop-in centers, employment, housing outreach, jail diversion, Assertive Community Treatment, and a variety of other evidence based practices. Michigan was the second state in the country to receive approval from CMS for Medicaid reimbursement of peer services. A strong relationship with the Veterans Administration has led to over 65 Veterans receiving certification working at community mental health programs, provider agencies and VA centers.

Currently a Transformation Transfer Initiative (TTI) grant is being implemented that employs CPSS at FQHCs in two locations of the state. The grant has demonstrated successful outcomes in improving peer led whole health and wellness initiatives. Ongoing continuing education trainings for peer specialists are provided including Wellness Recovery Action Planning (WRAP), emotional CPR, Chronic Disease Self-Management Program, smoking cessation, motivational interviewing, Whole Health Action Management (WHAM), trauma informed care, housing outreach, and development and implementation of support groups. Training is focused on a train the trainer model and developing recovery cultures and practices statewide.

The Michigan Recovery Council established in 2005 continues to provide leadership in strengthening a recovery based system of care. The Council developed and implemented a recovery train-the-trainer curriculum called Making Recovery Real to educate local communities, families, agencies and interested others in recovery. The Council provides information to local and regional areas of a diverse membership with the majority of individuals being persons with lived experience in public mental health services and supports.

Integrated Physical & Behavioral Health initiatives

- Ongoing efforts are underway to better integrate mental health and substance use disorder treatment services with physical health services, in a variety of settings including Federally Qualified Health Clinics (FQHCs), in traditional primary care clinics, and in CMH and other traditional mental health care settings.
- A statewide Integrated Health Learning Community has been established, in partnership with the Michigan Association of Community Mental Health Boards and with ramp-up assistance from National Council consultants. Technical assistance and training will be made available through this Learning Community, as well as enhanced communication between Michigan communities as they strive to advance integration initiatives in their respective regions.
- Needs moving forward include continuing to learn and apply lessons from pilot projects and initiative implementation to inform ongoing efforts to be optimally positioned to develop and utilize various health home models and accountable care approaches in concert with ongoing healthcare reform.

Trauma-specific and Trauma-informed Services

- Increasing recognition of the high prevalence of historical trauma among many adult services populations, with support for developing and implementing Seeking Safety and Trauma Recovery and Empowerment Model services as part of Co-occurring Disorders treatment, as well as addressing trauma within the context of advanced Dialectical Behavior Therapy for borderline personality disorder with progressive exposure approaches. Additional attention is being given to moving systems of care to becoming more trauma-informed, with assistance from Community Connections consultants, and through the use of their Trauma-informed Self-Assessment framework.
- A newly established Trauma Subcommittee has been convened to advance statewide development and implementation of trauma-informed and trauma-specific services. Efforts of this subcommittee (which reports up to the Practice Improvement Steering Committee) included facilitating statewide training to our behavioral health workforce, and conducting a statewide needs-assessment survey to help inform training plans moving forward.
- Needs include building and supporting ongoing effective service quality, with outcome tracking and analysis to substantiate progress and cost/benefit value.

Additional block grant-funded resources have been utilized in statewide efforts to counteract stigma, and to advance cultural competency, both initiatives which have helped to address some of the unique needs of diverse racial, ethnic and sexual gender minorities.

Unique local challenges also exist across Michigan, including the specialized needs of the homeless populations that are significant in many of the State's urban areas, as well as the challenges posed by rural areas in the State where the lack of greater population density makes it difficult to deliver services that would require high staffing levels and/or significant staff-provided transportation needs for regular service participation to occur.

Michigan's economic difficulties of the past few years have also continued to pose financial challenges, in the form of decreased levels of available General Fund resources with which to provide adult services to those needful recipients that are not covered by Medicaid or other health insurances. The needs of service recipients have also been exacerbated by the associated increase in the stressors of poverty and unemployment. Block grant resources have played a critical role in supporting the development, implementation, sustainability, and delivery of effective mental health services to Michigan recipients that otherwise would suffer from the lack of other available funding. As of the time of this writing, Michigan had yet to decide about our state's Medicaid expansion as part of national health reform efforts. Estimates project that if/as Medicaid expands, up to 500,000 new service recipients may become eligible for Medicaid-covered services, with a significant percentage of those needing behavioral health intervention. Although additionally available Medicaid funding would be a welcome resource, issues of capacity, available workforce level and competency, and service population shifting from Block Grant and General Fund to Medicaid fund sources will all pose transitional challenges as Michigan moves into the 2014-15 grant cycle.

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

ADULTS AND CHILDREN WITH SUBSTANCE USE DISORDERS

Implemented as part of the Strategic Prevention Framework/State Incentive Grant (SPF/SIG), Michigan continues to maintain a functioning epidemiological workgroup. The SEOW is a standing workgroup under the auspices of the Recovery Oriented System of Care (ROSC) Transformation Steering Committee (TSC). The chairperson of the SEOW (or his/her designee) attends TSC meetings to not only provide input into the overall ROSC efforts from a SEOW perspective, but also to be available as a resource to the TSC if data needs are identified. Recommendations from the SEOW will be made to the TSC, which in turn will make recommendations to BSAAS for ultimate decisions. The project director for the SEOW is a BSAAS staff member, as are the SEOW epidemiologist and the SEOW liaison.

The mission of the SEOW is to expand, enhance, and integrate the substance use disorder needs assessment, and develop the capacity to address mental, emotional and behavioral conditions to support and improve upon the quality of life for citizens of Michigan. Guiding principles that direct the work of the Michigan SEOW include utilizing a public health approach which encompasses improving health through a focus on population-based measures; the use of a strategic planning framework including assessment of need, capacity building, planning, implementation, and evaluation, in order to position Michigan with prevention prepared communities; align SUD and mental health service provisions; and implement a ROSC. The combined SUD and mental health indicator tracking system to support MDCH's efforts of integration of behavioral health and policy development is also one of the SEOW Guiding Principles. In addition, the SEOW uses a collaborative process, building on existing partnerships, as well as developing new relationships, at the state, regional, local and community level at all stages of its work in order to address the unique issues of Michigan, celebrating the diversity of our state.

The primary activities of the SEOW for FY 2014-2015 will be to: 1) expand the scope of the SEOW to include treatment and recovery (not just prevention) and to include mental health disorder prevention and treatment, as well as mental health promotion; 2) continue to gather new data as it becomes available, particularly around prescription and over-the-counter drug abuse; 3) analyze data being gathered, and serve as a resource for both the state and local Community Epidemiology Workgroups (CEWs); 4) continue work on establishing a web-based central data repository for Michigan that can be easily accessed and updated; and 5) evaluate and prioritize continued data gaps, and develop plans for filling these gaps.

The SEOW is chaired by the Prevention Coordinator of the Clinton Eaton Ingham-Community Mental Health Authority/Coordinating Agency. Membership on the SEOW includes representatives of various state-level departments including Michigan Department of Education, Michigan State Police, and various divisions and administrations within MDCH including epidemiology, local health services, mental health, and SUD treatment. In addition, CAs, community coalitions, and the Michigan Primary Care Association are represented on the SEOW. As of January 31, 2013, the following are SEOW members:

Member Name	Organization	Workgroup Affiliation
Elizabeth Agius	Wayne State University	Member/Evaluator
Dr. Lorri Cameron	MDCH, Division of Environmental Health	Member
Rebecca Cienki	Michigan Primary Care Association	Member
Lisa Coleman	Genesee County Community Mental Health	Member
Katy Gonzales	MDCH, Lifecourse Epidemiology & Genomics Division	Member
Jon Gonzalez	MDCH, Office of Local Health Services	Member
Denise Herbert	Network 180	Member
Joel Hoepfner	Michigan Association of Substance Abuse Coordinating Agencies (MASACA) Representative	Member/Chairperson
Charlotte Kilvington	Michigan State Police	Member
Kim Kovalchick	Michigan Department of Education	Member
Mary Ludtke	MDCH, Mental Health	Member
Dr. Corinne Miller	MDCH, Bureau of Epidemiology	Member
Dr. Su Min Oh	MDCH/BSAAS (Prevention)	Member/SEOW Epidemiologist/Staff Liaison
Larry Scott	MDCH/BSAAS (Prevention)	Member/SEOW Project Director
Angela Smith-Butterwick	MDCH/BSAAS (Treatment)	Member
Felix Sharpe	MDCH/BSAAS	Member
Brenda Stoneburner	MDCH/BSAAS (Prevention)	Member
Jeff Wieferich	MDCH/BSAAS (Treatment)	Member
Brittany Beard	Michigan Primary Care Association	Alternate Member

The following represent data sources used by the SEOW:

- National Survey on Drug Use and Health (NSDUH)
- Drug Abuse Warning Network (DAWN)
- State Epidemiological Data System (SEDS)
- Child Adolescent Functioning Assessment Scale (CAFAS)
- Michigan Behavioral Risk Factor Surveillance System (BRFSS)
- Treatment Episode Data Set (TEDS)
- Michigan Automated Prescription Monitoring System (MAPS)
- Michigan In-Patient Database (MIDB)
- Michigan Youth Risk Behavior Survey (YRBS)
- Michigan Profile for Healthy Youth (MiPHY)
- Michigan Traffic Crash Facts

- Fatality Analysis Reporting System (FARS)
- Liquor Licenses
- Uniform Crime Reports
- Michigan Death Certificates
- Pregnancy Risk Assessment and Monitoring System (PRAMS)

The recent state epidemiological profile provided by SEOW describes Michigan residents' consumption patterns, intervening variables, and substance abuse consequences, as well as mental health well-being based on state and federal data sources.

The findings for Michigan youth include:

- Between 2004 and 2010, alcohol-related traffic crashes involved at least one driver, aged 16-20, who had been drinking, caused an annual average of 173 deaths and serious injuries.
- In 2010, underage alcohol use cost Michigan taxpayers $2.1 billion dollars.
- In 2010, 3,993 youth, 12-20 years-of-age, were admitted for alcohol involved treatment in Michigan, accounting for 10.8% of all alcohol involved treatment admissions in the state.
- In 2011, 40 percent of Michigan 9 through 12thth grade students had tried smoking and 14% of students smoked cigarettes on one or more of the past 30 days.
    - In 2011, 16% of Michigan youth reported having seriously considered suicide and 8% students reported having attempted suicide one or more times.

The findings for Michigan's general/adult population include:

- Of all 2010 traffic crash fatalities, 30.4% involved at least one alcohol-impaired operator, bicyclist, or pedestrian.
- Between 2004 and 2010, alcohol-related traffic crashes involving at least one driver, 16-25 years-of-age, who had been drinking, caused an average of 470 deaths and incapacitating injuries.
- During 2008-2010, an estimated 5.4% of individuals over the age of 18 years old are heavy drinkers and 16.6% of them were binge drinkers.
- In 2011, prescription drugs totaled 5,581 treatment episodes with the highest rates in adults 21-54 years-of-age.
- Between 2003 and 2010, the biggest increase in the number of legitimate prescriptions was noted as Opioid antagonists (Suboxone).
- In 2010, Michigan's age-adjusted suicide rate was 12.5 per 100,000 population, with the rate of death for males, four times higher than for females.
- Between 2008-2009, young adults 18-25 years-of-age in Michigan, had higher rates of a major depressive episode and psychological distress, compared to adults 26 years-of-age.

Primary indicators used in assessing community needs include: nonmedical use of pain relievers, level of past 30 day use of alcohol and binge drinking among youth aged 12 to 20, alcohol involved death and serious injuries, past year psychological distress, past year major depressive episode, and age adjusted suicide rates.

As a result of this work, unmet service needs and critical gaps have been identified as follows:

- Reducing childhood and underage drinking
- Reducing prescription drug and over-the-counter (RxOTC) misuse and abuse

- Reducing youth access to tobacco
- Reducing suicide
- Greater collaboration between primary care and prevention providers, including coalitions.
- Greater collaboration between Tribal entities in the collection of data relevant to the severity, incidence, prevalence and trends related to substance use and mental health disorders.
- Training and technical assistance in implementing evidence-based practices effective in reducing childhood and underage drinking, youth access to tobacco, prescription and over-the-counter drug misuse and abuse, and suicide.

CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

According to 2012 US Census figures, Michigan is the 8th most populous state in the United States with an estimated population of 9,883,360, with approximately 2,295,812 of those residents being children, ages 0-17 (per most recently available 2011 Census figures). Prevalence data supplied by the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2011 National Outcome Measures Prevalence Report suggests 7-13% of the 1,214,930 children from ages 9 to 17 in Michigan could be identified as having a serious emotional disturbance (SED). That means anywhere from 85,045 to 157,941 children ages 9 to17 might have been eligible for services in the public mental health system in 2011 alone. However, data reported in the fiscal year 2011 Finger Tip Report compiled by the Michigan Department of Community Health (MDCH) indicates 39,748 children (ages 0 through 17) with SED were served in the public mental health system. Improvement in identifying and engaging children who may be in need of mental health services in Michigan is needed. According to the Michigan Department of Human Services (MDHS) Fiscal Year 2010 data, 13,098 children were residing in out-of-home foster care and juvenile justice placements which cost $164,123,227.31 that year. According to the Michigan Department of Education (MDE) the statewide high school drop out rate in fiscal year 2011 was 11% despite a concerted effort by education to reduce youth leaving school before graduation. According to Human Rights Watch, as of 2012, Michigan remains second in the nation for the number of juveniles (358) serving a life sentence without parole. Data reported on the National Center for Children in Poverty website (http://nccp.org/publications/pub_687.html#26) indicates nationally that up to 44% of youth with mental health problems drop-out of school; up to 50% of children in the child welfare system have mental health problems; and 67 to 70% of youth in the juvenile justice system have a diagnosable mental health disorder. Finally, 75 to 80% of children and youth with mental health problems do not receive needed services nationwide. When considering this national data, it is clear that a significant percentage of the children and youth represented in the Michigan education, child welfare and juvenile justice statistics have SED and are not receiving needed services. A collaborative approach to addressing the needs of these children/youth and families is needed to achieve better outcomes for the children/families involved.

Michigan's fiscal climate has shown some improvement in the last two years. According to the State of Michigan's "Mi Dashboard" (http://www.michigan.gov/midashboard/0,1607,7-256-58012---,00.html) the unemployment rate in Michigan was 8.9% in December 2012 which was better than December 2011 but remained 1.1% above the national average of 7.8% for that same time. Also, the number of children living in poverty in Michigan has risen from 23% in 2010 to 25% in 2011. According to information provided by SAMHSA in the 2011 National Outcome

Measures Prevalence Report, Michigan dropped to 37th in the national poverty ranking which remains in the high poverty tier. Data reported in the MDHS' Green Book Report of Key Statistics, November 2012 edition, indicates that 1,920,155 Michigan residents were eligible for Medicaid in that month and of those eligible residents, 744,467 were families and 82,335 were other children. Also, according to the Annie E. Casey Foundation Kids Count Data Center, the 25% of the children (ages 0-18) in Michigan living below the federal poverty level in 2011, remained above the national average of 23% for that same time period. In addition, Medicaid births in Michigan are now approximately 50% of all births. Additional data from the National Center for Children in Poverty website indicates that 21% of low-income children and youth, ages 6 through 17, have mental health problems. It is prime time in Michigan for partnerships to be forged to attempt to meet the needs of Michigan's children and families collaboratively on a larger scale and a statewide SOC is an effective way to achieve this.

The recent dire fiscal climate in Michigan resulted in fewer resources for all child-serving systems, but it also helped to create an environment where MDCH and MDHS were open to collaborating and matching funds which resulted in the SEDW pilot project. The project has helped MDHS to realize that the expertise of the mental health system may assist them in their vision. It also has helped the mental health system develop a sense of responsibility for children that are in the child welfare system. There are opportunities to improve fiscal efficiencies and to re-direct dollars from ineffective, costly out-of-home models into effective community-based models inherent in this partnership. The MDCH/MDHS SEDW Pilot Preliminary Evaluation Report from February of 2011 demonstrated fiscal saving and better outcomes for children and families which has acted as a catalyst for other collaborative projects.

However, there are additional barriers to a statewide SOC that MDCH has been trying to address for several years. These needs include the following:

- lack of a comprehensive assessment of disparities in mental health outcomes for children of color and the impact of poverty on health and mental health;
- inconsistent access to comprehensive and meaningful mental health evaluations and risk assessments for children and youth involved in all systems;
- differing levels of awareness and education regarding identifying and treating trauma and other mental health conditions as they appear in children served in all systems;
- unequal access to community-based treatment alternatives that all systems can access and trust so that decisions are not made out of fear or a lack of options,
- ensuring youth and family voice and choice at every level in numbers significant enough to not only represent their status as youth and family members but to achieve cultural and linguistic competence in the development and implementation of the SOC;
- sparse availability of treatment for co-occurring disorders in children/youth;
- lack of a unified vision and message regarding SOC across the state and inconsistent commitment from system partners.

These issues are themes that have repeatedly arisen in discussions with system partners, family and youth. MDCH believes that there are many reasons that these needs have not been fully addressed at this point after so many years of SOC work in the state, but two main reasons appear to be that the SOC has historically been viewed as a mental health initiative that can either be imposed upon or opted out of by other systems instead of a statewide initiative to better

serve the children with SED in every system. There is a need to unify the approach and encourage all partners to recognize their vital role in the statewide SOC and understand the benefits to them for their involvement because the mental health system cannot do this alone. Secondly, Michigan has never developed an effective way to expand and/or connect the pockets of excellence that exist across the state into a statewide SOC. There have been great collaborations in certain areas that have demonstrated incredible outcomes and benefits for the communities involved, but that has never been translated into a formal statewide initiative. Michigan has and plans to continue to use children's mental health block grant funds, in addition to other resources, to provide the means to build upon strengths in Michigan and to continue to address need areas with the long-term outcome being a viable and sustainable statewide SOC for children/youth with SED and their families.

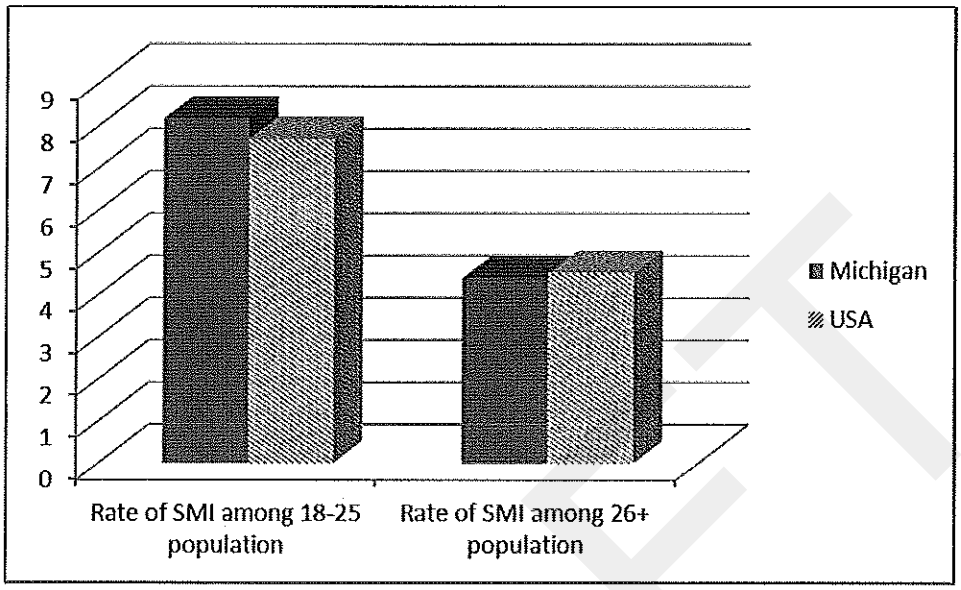
ADULTS WITH SERIOUS MENTAL ILLNESS (SMI)

Of Michigan's estimated population of 9,883,360 reported in the 2012 US Census, 76% are over the age of 18, an adult population estimate of 7,576,157. Per the 2011 data set provided by the National Survey on Drug Use and Health (NSDUH) and revised in March of 2012, 4.99% of American adults (approximately 15.6 million) were estimated to have SMI. Michigan's total number of civilian adults with SMI as calculated in 2011 by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute's State Data Infrastructure Coordinating Center (NRI/SDICC) was estimated at 409,112 for a prevalence rate of 5.4%. Applying the NRI/SDICC low/high prevalence rate range of 3.7-7.1% to the 2012 state adult population total would predict Michigan's adult SMI population to be between 280,318 and 537,907. Another source of prevalence data is the National Survey on Drug Use and Health, which estimates that 4.95% of Michigan's adult population have serious mental illness, with the confidence interval range between 4.28% and 5.72%, and predictive of a Michigan's adult SMI population between 324,260 and 433,356.

Per FY11 data reported by Michigan's public mental health care system, only 144,668 adults were provided with Community Mental Health services, suggesting a significant gap between the prevalence of serious mental illness in Michigan's adult population and the penetration of public sector mental health services, as it is unlikely that the differential can be fully accounted for by the cohort of SMI adults served in the private-sector, or via other systems. Clearly, improvement in identifying, engaging, and serving adults who may be in need of public sector mental health services in Michigan is needed. This gap between prevalence and service penetration continues to support the global need for greater availability of and access to care for Michigan's adult SMI population, needs that block grant resources can assist in meeting.

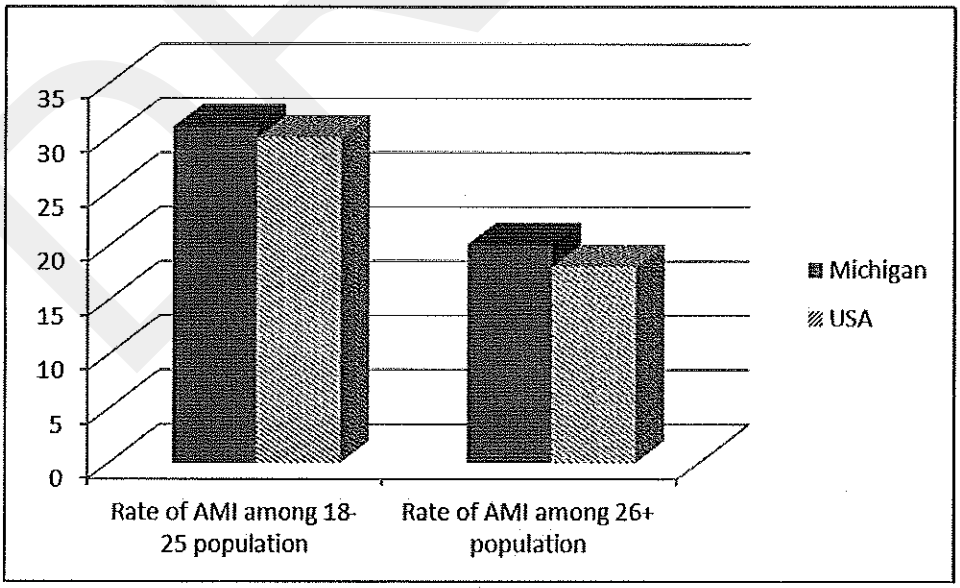
Additional indicators of the need for mental health services include Michigan's data on the incidence rates of suicide, Serious Mental Illness, and Any Mental Illness. According to data provided by the SEOW, Michigan's 2010 age-adjusted suicide rate was 12.5 per 100,000 individuals, up from the 2009 rate of 11.3 per 100,000. The rate of suicidal deaths for Michigan males was found to be four times higher than for Michigan females. According to 2010-11 NSDUH findings of the prevalence of a Serious Mental Illness (SMI) within the prior year, Michigan's young adults in the 18-25 age range showed higher rates (8.17%) than the national average (7.69%) in 2010-11. Michigan's adults aged 26 and older were found to have lower

incidence rates of Serious Mental Illness within the prior year (4.4%) when compared to the national average (4.52%).



Michigan's Rates of Serious Mental Illness among Adults, 2010-11

According to 2010-11 NSDUH findings of the prevalence of Any Mental Illness (AMI) within the prior year, Michigan's young adults in the 18-25 age range showed higher rates (30.98%) than the national average (29.95%) in 2010-11. Michigan's adults aged 26 and older were also found to have higher incidence rates of Any Mental Illness within the prior year (20.14%) when compared to the national average (18.08%).



Michigan's Rates of Any Mental Illness among Adults, 2010-11

The State's unique economic and unemployment stressors are believed to be contributing factors to the higher rates of mental illness and suicidality reported across Michigan's adult populations. The persistence of many of these stressors over a period of years has had a cumulative effect not only in the increase of situationally influenced depression, but also in the lack of greater General Fund resources with which to better meet these needs. The assistance of block grant funding plays a critical role in supporting Michigan in this regard.

Data supplied by SAMHSA's 2011 Mental Health National Outcome Measures report appears to indicate that Michigan continues to lag behind the reported national average in each of the following areas of adult evidence-based practice (EBP) delivery:

- Medications Management
- Illness Self-management
- Dual Diagnosis Treatment
- Family Psychoeducation
- Supported Housing

This may serve as one indicator of needful additional service development and implementation, and/or improvement in service reporting processes moving forward. For example, it is acknowledged that significant progress has been made in the development of a Medications Algorithm to guide the prescription practices of psychotropic medications, as a pilot project funded by Flinn Foundation grant resources. In the provider clinics that have adopted this or similar tools, positive outcomes are being reported, yet since this has not yet been adopted/implemented on a statewide basis, no standardized data has been available to include in SAMHSA's Mental Health NOMs report. In somewhat similar fashion, although a formal Illness Self-management practice (like the SAMHSA-endorsed Illness Management and Recovery model) has not been uniformly adopted in Michigan, illness self-management concepts and practices have been and are being adopted in a non-standardized fashion in various areas of the State, but not in a manner that is conducive to uniform reporting. Although there currently exists the means to accurately capture the delivery of the IDDT-level of intensive Dual Diagnosis Treatment services, Michigan still has room to grow in working out improved identification, delivery, and capture of Dual Diagnosis Treatment services at lower levels of intensity. To this end, the use of the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) has been piloted in Michigan as a framework for capturing and supporting the continued development and implementation of Dual Diagnosis Treatment services across the entire continuum of service type and intensity of need.

Michigan's Mental Health Code requires that an annual needs assessment be conducted with every CMH service provider across the State. This input is solicited through various means, including local Town Hall meetings, surveys of service recipients, board members, staff, and community members. Primary themes of the most recent findings of this process (FY11) are represented below, organized by Block Grant Application categories, as another indicator of reported service need for adult service recipients.

HEALTHCARE HOMES/INTEGRATED BEHAVIORAL AND PHYSICAL HEALTH

- Fuller integration of mental health & substance abuse services with physical health care service provision;
- Better coordination and collaboration with primary care service providers;

OUTPATIENT SERVICES

- More and better treatment services for individuals with co-occurring mental health and substance use disorders;
- Housing and supported living resources and services, services to the homeless;
- Supported employment / competitive employment / employment supports;
- Services to the increasing older adult population;
- Trauma-informed and trauma-specific service development and implementation.

RECOVERY SUPPORT SERVICES

- Greater development of Peer Support Service availability;
- Better training and supervision for staff providing peer-delivered services, including knowledge/competencies pertinent to both mental health and substance abuse recovery;

SYSTEMS IMPROVEMENT

- Transformation toward a more recovery-oriented system of care;
- Fuller integration of co-occurring mental health and addictions services;
- Services for populations lacking Medicaid coverage;
- Better jail diversion and/or coordination with the criminal justice system, including the expansion of mental health court programs.

Additionally, statewide meetings with multiple stakeholders (Executive and Clinical leadership, front-line Staff and Supervisors, Service Recipients) have resulted in discussions about how best to advance effective, cross-cutting practice competencies within a scarce-resource environment. Survey data from the regional PIHP-level Clinical Directors and chairs of each region's Improving Practice Leadership team has indicated the following areas of perceived need for equipping staff to better serve adult populations across the State of Michigan moving forward.

- Integrated Treatment for Co-occurring mental health and substance use disorders
- Motivational Interviewing / Enhancement
- Cognitive Behavioral Therapy, including DBT
- Trauma-informed and Trauma-specific Services

These and other inputs are what have informed Michigan's strategic planning process for how to best advance the optimally effective use of limited resources to better serve the needs of our State's adult SMI population, reflected below and in the sections that follow. The role of block grant funding to assist in advancing many of the involved initiatives will be critical to Michigan's efforts to continue to move in the direction of more effective, recovery-supporting service development and delivery.

BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES ADMINISTRATION STRATEGIC PLAN GOALS

1. **Individuals served by the Behavioral Health and Developmental Disability (BH&DD) Service System receive appropriate general health care services that effectively identify, treat and reduce co-morbidities (1 and 2; 1a and 2d)**
    a. Integrate Behavioral Health and General Health services to assure easy, effective and timely access.
    Objectives:
        1. Develop plan for integration of health care services
        2. Include primary prevention of health problems; such as obesity, diabetes, cardiovascular disease, chronic obstructive pulmonary disease (COPD), hypertension, substance use disorders, and promotion of health as explicit activities
        3. Develop plan for viable Health Home models for persons with chronic and co-morbid conditions (or tendencies toward same)
        4. Promote evidence-based protocols for assessment of adverse health effects of psychotropic medications as routine part of psychiatric visits.

    b. Integrate services for persons with substance use disorders (SUD) with services for persons with serious mental illness (SMI) in order to improve efficiency, care and access
    Objectives:
        1. Develop plan for the administrative integration of SUD and CMH service systems in order to reduce the number of distinct administrations in a cost-effective manner
        2. Improve co-occurring treatment capacities across the system

2. **Stakeholders (individuals who receive services, their families, other allies, and persons with a significant interest in the BH & DD Service System) are involved in policy development and decision-making at the local, regional (i.e., affiliation) and state levels (2 and 4)**
    Objectives:
    a. Increase/improve stakeholder involvement at all levels in order to more appropriately address their concerns, with special consideration given to the concerns expressed by persons served and their families
    b. Promote Peer Support Specialists, Peer Mentors, Parent Support Partners, and Peer Recovery Coaches as active participants in planning, implementation and monitoring/evaluation of services and supports at the state and local levels

3. **There is improvement in performance of the local BH&DD Service Systems (CMHSPs & CAs) in helping persons served achieve positive outcomes (2)**
    a. Treatment outcomes for each population improve
    Objectives:
        1. Establish measures for key outcomes

2. Promote and support the expansion and continuation of evidence-based and promising practices

b. Quality of Life for each population is improved

Objectives:

1. Increase number of people who are employed competitively
2. Improve general health status
3. Increase number of persons living in home-like settings
4. Reduce homelessness
5. Decrease rates of arrest and correctional supervision

c. Develop systems that provide continuing prevention services which promote individual, family and community health

Objectives:

1. Reduce youth access to tobacco products
2. Reduce prescription and over-the-counter drug abuse
3. Reduce underage drinking

d. BHDDA helps ensure system accountability regarding performance improvement

Objectives:

1. Implement performance contracting with PIHPs, CMHSPs, and CAs
2. Publish information regarding system performance for review by people receiving services, stakeholders, and the public

4. **Individuals receiving BH&DD Services are assured that the system will protect their health, safety and welfare (2)**

Objectives:

a. Reduce use of restraint and seclusion in LPUs and ERs and other community settings that encounter individuals with acute behavioral distress
b. Reduce use of physical management interventions with individuals served in licensed residential settings
c. BHDDA and PIHPs monitor services and supports for individuals in total care (or close to it) with evidenced high vulnerability to injury and harm
d. Provide targeted support to communities with high risk of SUD and emerging SUD threats

5. **The BH&DD system is administratively efficient and effective in the delivery of services and supports (3)**

Objectives:

a. PIHPs consolidate administrative functions within affiliations to reduce costs and/or improve the consistency of policies and services
b. PIHPs and CMHSPs reduce redundancies in reporting, training and oversight requirements in their contracting with providers

c. Disparities in access, type and intensity of services across the system are minimized
d. BHDDA reduces redundancies in reporting and oversight requirements of CMHSPs, PIHPs, and CAs
e. BHDDA provides the leadership to local BH&DD Service Systems, as well as BHDDA Central Office, in achieving positive results regarding administrative efficiency and effectiveness

6. **The provision of care (services/supports) throughout the BH&DD Service System is one that supports the culture of gentleness, resiliency, recovery, and full integration into community life (2)**

Objectives:

a. Services and supports for individuals with mental illness are based on a foundation of recovery
b. SUD services and supports are offered within a recovery-oriented system of care
c. A system of care is in place for children with serious emotional disturbances and children with developmental disabilities
d. All persons served are supported to integrate into the mainstream of community life
e. Services and supports for individuals with developmental disabilities, adults with serious mental illness and children with serious emotional disturbance are provided within in a culture of gentleness
f. The workforce understands and can implement the mission and goals of the BH&DD Service System
g. The workforce is able to provide culturally competent services

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: System of Care for Children/Youth with Serious Emotional Disturbance (SED) and Their Families

Priority Type: MHS

Population (s): SED

Goal of the priority area:

Treatment outcomes for children/youth with SED and their families continue to improve through participation in a statewide SOC.

Strategies to attain the goal:

- Develop a structure to expand the availability and access to a statewide comprehensive SOC for children/youth and their families that includes improved treatment outcomes, using block grant funding in addition to other resources.

- Engage system partners and stakeholders in the process of developing as statewide SOC.

- Utilize block grant funding to support system improvement activities such as statewide PMTO and Trauma Informed Initiative for children with SED, state supported training and technical assistance in targeted areas such as co-occurring treatment, wraparound, home-based services, early childhood screening and assessment, family-driven and youth-guided service provision and peer-to peer parent and youth support activities.

- Utilize block grant funding to support projects identified by CMHSPs to fill gaps in their local systems of care for services that improve outcomes for children/youth with SED and their families.

- Utilize data to inform policy and program decision making and improvements.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Statewide total CAFAS scores from intake to discharge for children/youth with SED served in the public mental health system will go down in FY14 and again in FY15 from a baseline

average obtained from FY10 data.

Baseline Measurement: FY10 baseline: 56.5% of children assessed with the CAFAS statewide demonstrated at least a 20 point (statistically significant) reduction in their overall CAFAS score from intake to discharge.

First-year target/outcome measurement: FY14 target: 58.0%

Second-year target/outcome measurement: FY15 target: 58.25%

Data Source:

John Carlson, PhD and the Michigan Level of Functioning Project

Description of Data:

Statewide aggregate CAFAS data

Data issues/caveats that affect outcome measures::

Data must be sent to Dr. Carlson from Multi-Health Systems, Inc. who collects and stores data from the online CAFAS system. There have been delays in obtaining data from Multi-Health Systems, Inc. which are being addressed.

Indicator #: 2

Indicator: The number of children/youth with SED served in the public mental health system that receive wraparound services will increase in FY14 and again in FY15 from a baseline of number served in FY10.

Baseline Measurement: FY10 baseline: 1,332 children served by Wraparound

First-year target/outcome measurement: FY14 target: 1,350 children

Second-year target/outcome measurement: FY15 target: 1,400 children

Data Source:

MDCH Division of Quality Management and Planning

Description of Data:

State encounter data

Data issues/caveats that affect outcome measures::

Data reporting is not complete at time of application, estimates are used.

Indicator #: 3

Indicator: The number of children/youth with SED served in the public mental health system that receive PMTO will increase in FY14 and again in FY15 from a baseline of number served in FY10.

Baseline Measurement: FY10 baseline: 263 children served by PMTO

First-year target/outcome measurement: FY14 target: 320 children

Second-year target/outcome measurement: FY15 target: 330 children

Data Source:

MDCH Division of Quality Management and Planning

Description of Data:

State encounter data

Data issues/caveats that affect outcome measures::

Data reporting is not complete at time of application, estimates are used.

Indicator #: 4

Indicator: The number of children/youth with SED served in the public mental health system that receive Trauma-Focused Cognitive Behavior Therapy will increase in FY14 and again in FY15 from a baseline of number served in FY10.

Baseline Measurement: FY10 baseline: 283 children served by PMTO

First-year target/outcome FY14 target: 467 children

measurement:

Second-year target/outcome measurement: FY15 target: 475 children

Data Source:

MDCH Division of Quality Management and Planning

Description of Data:

State encounter data

Data issues/caveats that affect outcome measures::

Data reporting is not complete at time of application, estimates are used.

Indicator #: 5

Indicator: The number of certified Parent Support Partners trained to work in the public mental health will increase in FY14 and again in FY15 from a baseline of number trained in FY10.

Baseline Measurement: FY10 baseline: 0 Parent Support Partners certified

First-year target/outcome measurement: FY14 target: 55 Parents

Second-year target/outcome measurement: FY15 target: 65 Parents

Data Source:

Michigan Parent Support Partner Training Project

Description of Data:

Count of trained parent support partners

Data issues/caveats that affect outcome measures::

None

Priority #: 2

Priority Area: Enhanced Partnerships for Children/Youth with Serious Emotional Disturbance (SED) and Their Families

Priority Type: MHS

Population (s): SED

Goal of the priority area:

Enhanced partnerships exist to serve children/youth with SED and their families, including traditionally underserved populations, using block grant funds and other resources, that reduce duplication of efforts.

Strategies to attain the goal:

- Expand the SEDW

- Continue to support DHS access positions in SEDW sites.

- Continue to support juvenile justice projects and foster the relationship between MDCH and MDHS and the State Court Administrative Office to encourage more collaborative work.

- Continue to pursue and support integrated physical health and behavioral health initiatives for children and youth with SED and their families.

- Begin training and support initiative for youth with SED and co-occurring substance use disorders (SUD).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of children enrolled in the SED Waiver (SEDW) will increase in FY14 and again in FY15 from FY11baseline.

Baseline Measurement: FY11 baseline: 265 children served by the SED Waiver

First-year target/outcome measurement: FY14 target: 400 children

Second-year target/outcome measurement: FY15 target: 450 children

Data Source:

SEDW online data management system

Description of Data:

Count of kids on the SEDW

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: The number of youth involved in the juvenile justice system who received necessary public mental health services will increase in FY14 and again in FY15 from FY11 baseline.

Baseline Measurement: FY11 baseline: 1,572 youth served

First-year target/outcome measurement: FY14 target: 1,650 youth

Second-year target/outcome measurement: FY15 target: 1,700 youth

Data Source:

MDCH Division of Quality Management and Planning

Description of Data:

State encounter data

Data issues/caveats that affect outcome measures::

Data reporting is not complete at time of application, estimates are used.

Indicator #: 3

Indicator: The number of children served in integrated physical and mental health projects will increase in FY14 and again in FY15 from FY12 baseline.

Baseline Measurement: FY12 baseline: 662 children served by integrated physical and mental health projects

First-year target/outcome measurement: FY14 target: 700 children

Second-year target/outcome measurement: FY15 target: 750 children

Data Source:

Project LAUNCH, SKIPP Project and any additional integrated project data

Description of Data:

Count of children served

Data issues/caveats that affect outcome measures::

None

Indicator #: 4

Indicator: A baseline of youth receiving co-occurring services will be obtained in FY14 and the number served will increase in FY15.

Baseline Measurement: FY14 baseline: To be determined

First-year target/outcome measurement: FY14 target: To be determined

Second-year target/outcome measurement: FY15 target: To be determined

Data Source:

MDCH Division of Quality Management and Planning

Description of Data:

State encounter data

Data issues/caveats that affect outcome measures::

Data reporting is not complete at time of application, estimates are used.

Priority #: 3

Priority Area: Integration of Behavioral Health and Primary Care Service Delivery to Mental Health Service Recipients

Priority Type: MHS

Population (s): SMI

Goal of the priority area:

To link a greater number of individuals with SMI to coordinated and/or integrated primary care services to improve duration and quality of life.

Strategies to attain the goal:

- Continue to support regional PIHP health home projects with Block Grant resources, to increase the number of SMI individuals receiving primary care services.

- Continue to support statewide Integrated Health Learning Community as a venue for sharing information, resources, training, and trial-and-error learning gains.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of adults receiving services from integrated/coordinated physical and mental health projects will increase in FY14 and again in FY15 from FY12 baseline.

Baseline Measurement: FY12 baseline: 821 adults receiving services from integrated/coordinated physical and mental health projects

First-year target/outcome measurement: FY14 target: 900 adults

Second-year target/outcome measurement: FY15 target: 975 adults

Data Source:

PIHP Integrated Health Block Grant project reports, and any additional integrated project data, up to and including Learning Community survey data.

Description of Data:

Count of adults served through the PIHP block grant projects.

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: The number of CMHSP and/or Primary Care provider staff receiving training in integrated behavioral and primary health care delivery will increase in FY14, and again in FY15 from FY12 baseline.

Baseline Measurement: FY12 baseline: 0 staff receiving training

First-year target/outcome measurement: FY14 target: 90 staff

Second-year target/outcome measurement: FY15 target: 110 staff

Data Source:

PIHP Integrated Health Block Grant project reports, and any additional integrated project data, up to and including Learning Community survey data.

Description of Data:

Staff registrations from Learning Community sessions; quarterly narrative report data from the PIHPs.

Data issues/caveats that affect outcome measures::

None

Priority #: 4

Priority Area: Provide integrated treatment to adult SMI service recipients with co-occurring mental health and substance use disorders.

Priority Type: MHS

Population SMI

(s):

Goal of the priority area:

To improve the penetration of integrated co-occurring mental health and substances use disorder treatment services within the adult CMHSP provider network.

Strategies to attain the goal:

- Continue to provide training to the CMHSP workforce on co-occurring disorders treatment knowledge and skills, including motivational interviewing, and other IDDT &/or DDCMHT framework domains areas.

- Continue to provide IDDT and/or DDCMHT program site reviews, and subsequent associated technical assistance/coaching input for advancing service development and implementation.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of IDDT, DDCMHT, and/or DDCAT program site reviews will increase in FY14 and again in FY15 from FY12 baseline.

Baseline Measurement: FY12 baseline: 18 program site reviews

First-year target/outcome measurement: FY14 target: 20

Second-year target/outcome measurement: FY15 target: 22

Data Source:

MIFAST data from MDCH Specialist on number of IDDT, DDCMHT, and/or DDCAT program site reviews conducted.

Description of Data:

Number of IDDT, DDCMHT, and/or DDCAT reviews conducted.

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: The number of adult CMH service recipients receiving treatment services for co-occurring mental health and substance use disorders will increase in FY14 and again in FY15 from FY12 baseline.

Baseline Measurement: FY12 baseline: 15,711 adults receiving services

First-year target/outcome measurement: FY14 target: 16,497 adults

Second-year target/outcome measurement: FY15 target: 17,322 adults

Data Source:

MDCH Data warehouse encounter data for services modified with HH or HH&TG modifiers.

Description of Data:

Count of adults receiving co-occurring services.

Data issues/caveats that affect outcome measures::

Data reporting is not complete at time of application, estimates are used.

Priority #: 5

Priority Area: Indicated behavioral health service delivery to justice-involved consumers.

Priority Type: MHS

Population (s): SMI

Goal of the priority area:

Reduce the number of SMI adults in jail/prison who could benefit from full engagement in outpatient behavioral health services.

Strategies to attain the goal:

- Leverage Governor Snyder's proposed increase in state funding for specialty courts including mental health courts of $2.1 million (FY13) levels and an additional $2 million in FY14/15 to increase pre-booking and post-booking diversion, including expansion of Mental Health Court Programs, in partnership with the State Court Administrative Office.

- Provide support to projects to implement a process to improve screening and assessment for behavioral health issues and assist projects to provide greater access to such services.

- Provide training to workforce members involved with mental health court programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of mental health court programs will increase in FY14 and again in FY15 from FY12 baseline.

Baseline Measurement: FY12 baseline: 8 State-subsidized mental health court programs + 4 locally funded

First-year target/outcome measurement: FY14 baseline: 9 State-supported + 5 locally funded

Second-year target/outcome measurement: FY15 baseline: 11 State-supported + 6 locally funded

Data Source:

Data from MDCH Specialist and mandated project reporting.

Description of Data:

Count of mental health court programs from project reporting.

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: The number of Adults with mental illness receiving behavioral health services through a mental health court program will increase in FY14 and again in FY15 from FY12 baseline.

Baseline Measurement: FY12 baseline: 530 adults receiving services through a mental health court program

First-year target/outcome measurement: FY14 target: 610 adults

Second-year target/outcome measurement: FY15 target: 700 adults

Data Source:

Data from MDCH Specialist and mandated project reporting/Michigan State University Statewide Mental Health Court Evaluation.

Description of Data:

The number of adults receiving behavioral health services through a mental health court program.

Data issues/caveats that affect outcome measures::

None

Indicator #: 3

Indicator: Increase knowledge base of mental health diagnosis, developmental disabilities, and/or co -occurring disorders of specialty court/mental health court teams. Collaborate with other state agencies (SCAO) to provide targeted training to courts/teams.

Baseline Measurement: FY12 baseline: 0 workforce members representing courts/teams will receive training

First-year target/outcome measurement: FY14 target: 60 workforce members

Second-year target/outcome measurement: FY15 target: 80 workforce members

Data Source:

SCAO conference attendance record; MSU Statewide Mental Health Court Evaluation.

Description of Data:

Count of training specialty court/mental health court team participants.

Data issues/caveats that affect outcome measures::

None

Priority #: 6

Priority Area: Promote Healthy Births

Priority Type: SAT

Population (s): PWWDC

Goal of the priority area:

Reduce infant mortality in the target population and increase the incidence of healthy, drug and alcohol free births.

Strategies to attain the goal:

- Increase outreach to pregnant women to increase the population's access to treatment.

- Provide extended case management to pregnant women to provide support after the treatment episode in order to promote a healthy birth.

- Promote recovery support services to extend engagement and support retention.

- Build capacity to provide trauma-informed care.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of reported drug free births

Baseline Measurement: FY12 Baseline: 200 drug free births reported by programs serving PWWDC

First-year target/outcome measurement: FY14 Target: 205 drug free births

Second-year target/outcome measurement: FY15 Target: 210 drug free births

Data Source:

Women's Specialty Services Report

Description of Data:

Raw count of women who enter treatment pregnant or become pregnant while in treatment and have a subsequent substance free birth, based on the results of meconium testing.

Data issues/caveats that affect outcome measures::

This measure must be tracked by hand and, if a woman leaves treatment unexpectedly, a program may never know if she has a healthy birth. MDCH has worked diligently to ensure numbers are reported accurately, and continue to encourage case management and recovery supports for pregnant women as they exit formal treatment.

Priority #: 7

Priority Area: Reduce IVDU wait times

Priority Type: SAT

Population (s): IVDUs

Goal of the priority area:

Reduce the percentage of individuals waiting over 10 days to enter treatment by 10%.

Strategies to attain the goal:

- Encourage case management services for IVDUs entering services to promote sustained recovery and manage the multiple issues that this population experiences when they participate in treatment services.

- Work with regional coordinating agencies to manage wait lists and expand services as needed to limit wait times for methadone treatment.

- Encourage the use of recovery support services to extend engagement and support retention.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Time to Treatment

Baseline Measurement: FY12 Baseline: 12.1% of individuals waiting over 10 days to enter treatment

First-year target/outcome measurement: FY14 Target: 10.8% of individuals

Second-year target/outcome measurement: FY15 Target: 9.7% of individuals

Data Source:

TEDS treatment admission record will be used to track the elapsed number of days between date of service request and actual services.

Description of Data:

Days of waiting are derived by subtracting the date of first request from the date of admission in the TEDS admission records.

Data issues/caveats that affect outcome measures::

None

Priority #: 8

Priority Area: Increased Access to Treatment

Priority Type: SAT

Population (s): PWWDC

Goal of the priority area:

Increase the percentage of parents with dependent children who continue 14 days in residential treatment by 5%.

Strategies to attain the goal:

- Outreach to collaborative partners to ensure that parents are identified as priority populations.

- Ensure that programs identified as serving pregnant and parenting women are able to serve the entire family or have agreements for referral to other agencies.

- Encourage the use of recovery support services to extend engagement and support retention.

- Encourage case management services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Parents with dependent children Access/Retention in Residential Care

Baseline Measurement: FY12 Baseline: 36.3% of parents with dependent children who continue 14 days in

residential treatment

First-year target/outcome measurement: FY14 Target: 37.3% of parents with dependent children

Second-year target/outcome measurement: FY15 Target: 38.2% of parents with dependent children

Data Source:

TEDS treatment admission and discharge data will be used to track the elapsed number of days between admission and discharge. Authorizations for stays less than 14 days would be excluded.

Description of Data:

Matched cases of admission and discharge TEDS data per individual in treatment.

Data issues/caveats that affect outcome measures::

None

Priority #: 9

Priority Area: Increase the use of integrated services

Priority Type: SAT

Population (s): Other (Individuals with Co-occurring Disorders)

Goal of the priority area:

Increase the percentage of integrated treatment expenditures by 10%.

Strategies to attain the goal:

- Encourage case management when an individual entering treatment is identified as having a co-occurring disorder (COD) to help manage the many issues resulting from their disorder.

- Encourage regions to provide technical assistance to those agencies working to become co-occurring capable and enhanced.

- Encourage the use of recovery support services to extend engagement and support retention.

- Build capacity to provide trauma-informed care.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of Substance Abuse Coordinating Agency (CA) expenditures on integrated services for individuals with co-occurring disorders.

Baseline Measurement: FY12 Baseline: 13.1% of expenditures

First-year target/outcome measurement: FY14 Target: 13.8%

Second-year target/outcome measurement: FY15 Target: 14.4%

Data Source:

Section 408 Legislative Report provides information on expenditures for integrated services for individuals with co-occurring disorders. TEDS admission and discharge data indicates those individuals who had HH modified encounters reported.

Description of Data:

Data are selected from line-item Block Grant expenditures per licensed provider and the integrated service sub-report.

Data issues/caveats that affect outcome measures::

None

Priority #: 10

Priority Area: Underage Drinking

Priority Type: SAP

Population (s): Other (Adolescents w/SA and/or MH, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Reduce childhood and underage drinking.

Strategies to attain the goal:

- Increase multi-system collaboration.

- Reduce adult abuse by engaging all segments of the community in establishing ROSC and increase the use of brief intervention.

- Engage parents in helping reduce underage drinking.

- Over the next five years all existing community coalitions will become Prevention Prepared Communities and implement at least one environmental strategy.

- Provide training on Communities that Care and Community Trials.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Past 30 days use of alcohol among youth 9th - 12th grade will be reduced

Baseline Measurement: FY11 Baseline: 30.5% of youth

First-year target/outcome measurement: FY14 Target: 29.0%

Second-year target/outcome measurement: FY15 Target: 26.0%

Data Source:

Michigan Profile for Healthy Youth (MiPHY); National Survey on Drug Use and Health (NSDUH); and Michigan State Police/Office of Highway Safety Planning (OHSP)

Description of Data:

Through the Michigan Department of Education, the MiPHY is administered during the years that the Youth Risk Behavior Survey is not conducted. The survey is intended to secure information from students in grades 7, 9, and 11, regarding health risk behaviors including substance abuse. The MiPHY results are extrapolated at the county level, and are useful for data-driven decisions to improve prevention programming performed in the counties.

Data issues/caveats that affect outcome measures::

The limited number of school districts participating in the MiPHY has been a concern. Through efforts of the state and community coalitions and other stakeholders, attention has been given to community readiness and responsiveness to

conducting the MiPHY, and the number of school districts now participating has increased substantially.

Priority #: 11

Priority Area: Youth Access to Tobacco

Priority Type: SAP

Population (s): Other (Adolescents w/SA and/or MH)

Goal of the priority area:

Reduce youth access to tobacco

Strategies to attain the goal:

- Synar and Non Synar compliance checks to discourage sells to minors.

- Increased youth engagement.

- "Read the Red" vertical driver's license education.

- Encouragement through positive community recognition.

- Vendor education.

- Increased community awareness of health issues and access through coalitions and health departments.

- "Kick Butts" annual smoking cessation day.

- Improved English language proficiency, multi-lingual signage availability.

- Use of research-based curriculum.

- Increased law enforcement involvement.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator:	Effect a 10% retail merchant sells rate to minors
Baseline Measurement:	FY12 Baseline: 14.9% Michigan Retailer Violation Rate
First-year target/outcome measurement:	FY14 Target: 10%
Second-year target/outcome measurement:	FY15 Target: 10%

Data Source:

Annual Synar Survey

Description of Data:

The state must conduct a formal Synar survey annually, to determine retailer compliance with the tobacco youth access law and to measure the effectiveness of the enforcement of the law. The state must achieve and maintain a youth tobacco sales rate of 20% or less to underage youth during the formal Synar survey.

Data issues/caveats that affect outcome measures::

None

Footnotes:

Y. Comment on the State BG Plan

MDCH will be offering several avenues for the citizens of Michigan to provide public comment on the Fiscal Year 2014-2015 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant Application including, but not limited to, the following:

- The application will be posted on the Department of Community Health's website with information on how to provide comments on the plan.
- All Prepaid Inpatient Health Plans, Community Mental Health Services Programs, and Substance Abuse Coordinating Agencies in the state will be given information on the availability of the plan and contact information for comments. A notice soliciting comments will be provided for them with the request that they post it in their lobbies. They will also be asked to provide the information to all of their subcontract agencies.
- A press release will also be issued by the MDCH's Communications Office for publication in newspapers. As a result of efforts in past years, numerous comments have been received from the public on the block grant program and on services in general.
- All meetings of the Behavioral Health Advisory Council (Planning Council) are open to the public with an opportunity for public comment listed on each agenda. The dates of the meetings are posted on the department's website.