

IV: Narrative Plan

H. Trauma

Narrative Question:

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

H. Trauma

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?

As part of the Children's Trauma Initiative, participating CMHSPs utilize Trauma Informed Screening and Trauma Informed Assessment (Trauma Symptom Checklist for Young Children and the Northshore UCLA PTSD) as part of the intake process for children and youth with serious emotional disturbance (SED).

For adults with serious mental illness, there are no policies for screening for personal history of trauma. There are Trauma Informed and Trauma Specific subcommittees, which are beginning to communicate with each other.

There are no policies for substance use. However, many providers do screen clients as part of the bio-psychosocial assessment.

2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?

Each CMHSP that participates in the Children's Trauma Initiative have clinical staff, supervisors and parent support partners trained to implement each component of the initiative. The components are: the Trauma Informed Screening and Trauma Informed Assessment (Trauma Symptom Checklist for Young Children and the Northshore UCLA PTSD) as mentioned above; for those determined to be appropriate after assessment, trauma treatment through the implementation of the evidence-based Trauma Focused Cognitive Behavioral Therapy (TF-CBT) is available; and finally, caregiver education for biological, adoptive, and foster parents is available through the Resource Parent Training curriculum. This curriculum is also used to train community partners. The training is provided by clinical staff and parent partners. MDCH is currently investigating a group trauma treatment model to pilot with children and youth as well.

There are no policies for adults with serious mental illness or for substance use.

3. Does your state have any policies that promote the provision of trauma-informed care?

The focus of the Children's Trauma Initiative is to provide clinical staff and their supervisors with the skills needed to provide trauma-informed care and trauma treatment to children with SED and their families to ensure appropriate clinical intervention to a population that has a high probability of trauma.

There are no policies for adults with serious mental illness or for substance use.

4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?

Please see Question # 2 for information about trauma-specific interventions for children with SED and their families.

There are multiple interventions for adults with serious mental illness that are offered at the provider level. They include Seeking Safety, Beyond Trauma, Helping Women Recover, TREM (Trauma, Recovery and Empowerment Model) and M-TREM (male-specific version).

5. What types of trainings do you provide to increase the capacity of providers to deliver trauma-specific interventions?

The Children's Trauma Initiative collaborative participants attend 3-4 day training with topics focused on Complex Trauma and Trauma Informed Assessment measures, including assessment to determine child/parent readiness for TFCBT and/or other potential treatment strategies, as well as TFCBT principles, practices, implementation. They participate in coaching conference calls, twice per month for clinicians/supervisors and monthly coaching calls with supervisors to address supervisory issues and attend follow-up trainings to review cases assessments/assessment processes, TFCBT implementation, and evaluation. They also complete monthly evaluation metrics to assure fidelity which are entered on the online training site.

In addition, conference calls with senior leadership (CMHSP Children's Services Directors, Executive Directors) and TFCBT faculty regarding system implementation and potential agency barriers to implementation are facilitated by MDCH staff.

This initiative has been supported with block grant funding for several years and has resulted in the participation of 36 out of 46 CMHSPs in Michigan. The initiative continues with the goal of expanding statewide.

For adults with serious mental illness, statewide and regional trainings are being held for TREM and M-TREM.

Multiple trainings on trauma have been supported by BSAAS as well. Five have addressed the basics of trauma-informed care and how to establish an environment that does not re-traumatize individuals. Three of these were presented in collaboration with a CSAT Technical Assistance request. The same information was offered in three locations around the state to afford those in outlying regions the opportunity to participate. Four of the basic trainings were specific to women's programming. We have also held a training that specifically addresses the Seeking Safety model. Other opportunities are in the planning process.

IV: Narrative Plan

I. Justice

Narrative Question:

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{42,43} Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.⁴⁴

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?
4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

⁴² The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman, 2000.

⁴³ A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

⁴⁴ Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

Footnotes:

I. Justice

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?

Medicaid expansion in Michigan remains undecided.

2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

MDCH administers both the public mental health service delivery system and the state's substance use disorder prevention and treatment system thus also enabling screening and other appropriate services to be provided to those with behavioral health issues including those with co-occurring disorders.

The Michigan Mental Health Code requires that local CMHSPs provide services to divert persons with serious mental illness, serious emotional disturbances, or developmental disabilities from jail incarceration when appropriate. Although jail diversion requirements have had some impact diverting mentally ill persons into treatment, a large number remain incarcerated due to a number of factors such as State law that does not permit the CMHSP to pay for mental health services provided to inmates of local jails unless the jail and the CMHSP have a contractual arrangement to administer/pay for jail-based mental health treatment services.

The state requires that an alcohol screening/assessment be completed on individuals convicted of any alcohol related offence prior to sentencing. Most Michigan district courts are licensed to conduct substance abuse screenings/assessments which are completed by the probation department and include recommendations to the sentencing judge on referral to appropriate rehabilitative treatment services.

3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?

Diverting justice involved persons with behavioral health issues from incarceration is a top strategic priority of Michigan's Governor Snyder. In March 2013, Executive Order 2013-7 was issued which created a 14-member Mental Health Diversion Council within DCH to provide an ongoing examination of mental health issues in Michigan. The Council is tasked with assessing, implementing practices to improve diversion activities. MDCH has also recently been invited to participate on a cross-system committee coordinated by the Michigan Department of Human Services that is re-evaluating re-entry procedures for youth with disabilities.

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

For justice involved individuals that meet the SPMI criteria, the full array of CMHSP services are made available and are subject to the needs of the participant and their Person Centered Plan. Person Centered Planning is also required under the Mental Health Code and ensures that individuals are to be directly involved in the process of planning for their mental health supports and services. For youth who are transitioning out of juvenile justice residential facilities, special

provisions in the location of service language in the Michigan Medicaid Provider Manual added in FY12 allows for public mental health system case management and/or wraparound services to begin prior to discharge from the facility to assure youth and their families are linked up with appropriate mental health and other supportive services upon discharge.

5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

MDCH provides training that addresses clinical needs of MDCH, PIHP, and CMHSP staff. Training workshops also include promising or best practices of locally developed programs conducted by both clinical and justice staff directly involved with such programs. Jail diversion teams and mental health court teams are examples of workshops recently presented. MDCH also participates in the Juvenile Justice Vision 20/20 Project, which is an ongoing cross-systems collaborative group that began work in 2011 to assess and make recommendation to improve the juvenile justice system in Michigan. The focus of priority projects for this group includes: the unique purpose of the juvenile court; effective outcomes for juveniles, families and communities; juvenile court operational performance; adequate and sustainable funding and a strong juvenile justice workforce. One of the main activities of the sub-committee working on strengthening the juvenile justice workforce is to plan and host regional and statewide trainings in collaboration with the Michigan Judicial Institute and other stakeholders.

As discussed earlier in the application, Michigan has a long history of implementing successful problem solving courts that address the unique needs of justice involved persons. Cross training is also provided through collaborative state level efforts through MDCH, State Court Administrator's Office, Department of Human Services and Department of Corrections, as well as associations such as the Michigan Association of Drug Court Professionals.

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?
4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
6. Describe how your behavioral health providers are screening and referring for:
 - a. heart disease,
 - b. hypertension,
 - c. high cholesterol, and/or
 - d. diabetes.

Footnotes:

K. Primary and Behavioral Health Care Integration Activities

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

'Integrated healthcare' (IH) is a general term used in Michigan to describe the improved coordination of care between primary and behavioral health care services. Providers of substance use and mental health services (i.e., behavioral health) as well as providers of primary care and other specialty medical care have struggled in varying degrees to coordinate and/or integrate comprehensive healthcare services. Degrees of healthcare integration fluctuate throughout the behavioral health system. While under statewide implementation, irregular development within and between the individual providers themselves has become apparent and each agency/PIHP is working independently while working within the existing system to increase and improve integration. The result of care integration positively impacts physical health and life expectancy outcomes for people receiving behavioral health services in the public behavioral health system. The importance of integrated and whole person care cannot be underestimated.

The Michigan Department of Community Health (MDCH) Behavioral Health and Developmental Disabilities Administration (BHDDA) have provided targeted support to provider infrastructure development of IH for mental health consumers, to continue what was previously begun and to build upon other work being done in the community. This has been accomplished through multiple communication and learning venues.

Agreeing that this is a critical concern, MDCH has developed a cooperative alliance with the Michigan Association of Community Mental Health Boards (MACMHB), and contracted with The National Council for Behavioral Healthcare. PIHP and Drop-In Center grants and technical assistance has been developed and is provided. Some of the efforts achieved through mental health block grant funding and technical assistance provided through this process include:

- I. A Statewide Integrated Health Learning Community (IHLC) - MDCH has partnered with MACMHB and the National Council to deliver a yearlong Integrated Primary and Behavioral Healthcare Learning Community. Any Michigan community mental health center or partnering primary care health center is encouraged to participate. Quarterly Activities (team planning and technical assistance including coaching reviews of IH work plans) have had outstanding participation in a non-competitive and supportive environment.
 - a. Discussion forums on a designated website (www.improvingmipractices.org) that allows all partners to provide and discuss concerns and information.
 - b. Additional resources may be shared, provided or gathered through in areas such as Financing & Sustainability, Clinical Practices, Administration Health Information Management and the IH Workforce are readily accessible to those seeking further information on [improvingmipractices.org](http://www.improvingmipractices.org).
 - c. Webinars on topics pertinent to IH development such as 'Evolving Models of Integration' and 'Health Information Technology and Quality Improvement.' This first effort drew 85 participants.

Seventeen of Michigan's Prepaid Inpatient Health Plans (PIHP) have developed a work plan through noncompetitive block grant funding to support and further the development of regional IH. Attention was focused on meeting with and assisting each PIHP at the current IH development level. Each PIHP assessed their level of implementation and began to build upon IH from that point. Participants completed a self-assessment tool for readiness. Logic models were required in addition to goals, objectives, activities, data collection, and timeframes for assessing progress and the specific staff responsible to achieve the success measures. Significant technical assistance was provided at a statewide meeting where grant specialists worked closely with grantees. Some projects included having IT Health Home functionality in their work plan; workforce competency in moving from case management to care management; providing wellness programs; and establishing a train-the-trainer model for staff and peers to assist others in improving behavioral changes and health outcomes. Further assistance is provided as needed with the new requirements that indicate success. Technical/coaching phone calls are conducted that include PIHP staff, MDCH staff and National Council consultants.

To further support this steep learning curve, participants shared information on a dedicated website called "www.improvingmipractices.org". This information includes:

- a. A work plan, contact information and brief grant summary.
- b. Quarterly progress reports.
- c. Opportunities to learn from each other.

Each PIHP has access both for posting and gathering multiple resources related to IH. Representatives have given positive comments regarding the effectiveness of sharing available materials, perusing through multiple agencies for inspiration, ideas and self-comparisons. This approach has been touted as original and innovative, efficient and constructive.

Drop-In Center Wellness projects are another mental health block grant funded initiative to provide additional State supported resources to the advancement of wellness programming and physical activity in for Drop-In Center participants. 56 individual centers currently have work plans demonstrating a wide variety of initiatives centering on themes of healthy behaviors (exercises like walking, biking, Wii games, coaching support, shopping, cooking and eating).

The examples below give a flavor of the range of the commitment and innovations being used:

- Walking, healthy eating and interactions (Washtenaw);
- Improve fitness level and manage chronic pain (Lifeways);
- Healthy Behaviors such as increased activity using the Wii is popular, PATH and Smoking Cessation (Ventures);
- Resources and Support for relaxation, increased physical activity, knowledge of disorders, and weight management opportunities (Southwest);
- Exercise equipment and pedometers (NW Affiliation);
- Increasing activity by promoting activities that members can incorporate into their daily life (Pathways);
- 33% of members will use exercise bike 5 minutes, then minimum of 5 minutes, then 10 minutes to improve health (Copper Country);

- A therapeutic healing garden that has been carefully planned and is being implemented with ownership and pride (network180).

Results of quarterly progress are available for sharing and problem solving on www.improvingmipractices.org.

2. Are there other coordinated care initiatives being developed or initiated in addition to the opportunities afforded under the Affordable Care Act?

The Behavioral Health and Developmental Disabilities Administration are involved in multiple initiatives pursuing improved health for the citizens of Michigan. A healthy population is priority #1. Integrating mental health and substance abuse agencies and treating the whole person is in many stages of development throughout Michigan. There are four regions in Michigan that will begin Dual Eligible (Medicaid and Medicare) projects in July of 2014.

Culturally-sensitive access to all services for persons with disabilities is needed. Inclusion of often excluded populations, such as the deaf and hard of hearing community is important as is implementation of the Medicaid ABA benefit through waiver and state plan amendment.

In Michigan, three regions of the state are participating in 'Exploring 2703 of the AFA' which is a pilot program will develop Medicaid Behavioral Homes. January of 2014 is the begin date.

Diverting people with mental illness and substance use issues by providing early intervention services and preventing inappropriate incarceration is the task of the Governor's new Commission on Jail Diversion (December 2012). Additionally reducing the percent of people with mental illness or substance use diagnoses in jail, through diversion programs and the implementation of the currently forming action plan will decrease jail/prison populations and allow for appropriate interventions to this population. Michigan currently has 16 Mental Health Courts that strongly assist in this effort.

At the same time, Governor Snyder also commissioned, a Mental Health and Wellness Commission, tasked with looking at the system specifically to identify gaps. Within the year, five workgroups are expected to provide results by addressing the following areas:

1. Workgroup on education, employment and veteran items will be headed by Senator Rebekah Warren (D-Ann Arbor).
2. Workgroup on housing, independent living support and long term care, will be headed by Department of Community Health (DCH) Director James K. Haveman.
3. Workgroup on mental and physical health integration and services delivery will be led by Rep. Phil Cavanagh (R-Redford Twp.).
4. Workgroup on public safety, beneficiary rights and protection items, will be headed by Rep. Matt Lori (R-Constantine).
5. Workgroup on societal impacts, data and stigma reduction and awareness, will be led by Sen. Bruce Caswell (R-Hillsdale).

Older adults, increasing exponentially, already receive many services through primary care. Mental Health, Substance Abuse, Developmental Disabilities, Dementia, etc., are areas currently treated but often without extensive expertise; thus education is needed at the primary care level. Integrated healthcare training related to mental health, dementia and substance use continue to be developed and provided by monthly webinar to 46-50 healthcare sites throughout the state, primarily in the mid-northern part of the state and the Upper Peninsula. A cooperative partnership between the Geriatric Education Center of Michigan (located at Michigan State University) older adult behavioral health/dementia specialists from BHDDA has been developed and continues to grow. Specialists have edited and assisted in Dementia and Alzheimer's curriculums and assisted in identifying a FQHC to dual train physical and behavioral health staff.

SOAR training are increasing to expedite disability determination for those who are homeless and at risk of homelessness.

Timely implementation of a Veteran's Action Plan will improve access to federal benefits and local services. Michigan ranks in the lowest quartile of veteran's taking advantages of benefits they have learned.

Michigan's publically-funded substance use disorder (SUD) system engages in an action plan process. Through this effort all of the coordinated regions for SUD services in the state are required to develop a plan for service for a designated three year period. The plan for SUD services is developed in accordance with a guidance document which is provided by the Behavioral Health and Developmental Disabilities Administration (BHDDA), Bureau of Substance Abuse and Addiction Services (BSAAS). This guidance provides the parameters for the provision of SUD services inclusive of state and federal regulations and requirements, priority services as identified by the BHDDA and the MDCH (of which BHDDA and BSAAS are a part), and special projects to be addressed during the Action Plan period.

The current Action Plan period is 2012 through 2014. Within the overall Action Plan the emphasis has been on the publically funded SUD services system continued transformation to a recovery oriented system of care (ROSC). The BSAAS/System ROSC transformation process was announced and initiated at the 2009 Statewide SUD Conference. ROSC transformation is important for many reasons. However, it is of particular importance to the integration of primary and behavioral health care for the infrastructure and culture of care that is established. Successful coordinated care cannot exist without the presence of a recovery oriented system as its foundation.

Additionally, the 2012 through 2014 Action Plan identified two priority projects in which all areas of the state must plan and engage. The two project priorities are: 1) a NIATx practices improvement initiatives (intended to improve the capacity and effectiveness of services and their delivery), and 2) a behavioral health and primary health care integrated services project (intended to utilized principles of ROSC, initiate or further enhance critical relationships and key partnership for, and develop and implement an integrated healthcare pilot project). The 16 regional coordinating agencies within the State of Michigan all submitted and are engaged in the planning, development and implementation of their integrated health care projects. The regions are halfway into the Action Plan period and their projects.

As mentioned above, in 2009 the BSAAS announced at the 2009 Statewide SUD Conference that the publically funded SUD services system would be engaging in a transformation to ROSC. Also explained in response (A.) is the importance and necessity of establishing a ROSC as a foundation to a successful behavioral health and primary health care integration. As a matter of fact, in the regions of Michigan where recovery oriented transformation is strong, the development of collaborations and partnerships naturally lead to coordinated initiatives between the behavioral health and the primary health care systems. As an example, one product of such collaboration lead to an emergency room doctor studying and tracking the utilization of hospital emergency department incidents of care (both emergency and non-emergency) for substance abusing and addicted individuals. This lead to the opening of a specialized clinic to assess, plan and provide services to these individuals. The concept of the clinic is to assess the healthcare and SUD status of the individuals via co-located services and providers within the clinic. Once an individual has been stabilized (primary health and SUD) they will be connected to a primary care provider for ongoing health care management.

Much has been accomplished within the SUD ROSC Transformation, but much has yet to be done. Just as an individual's SUD recovery is not an event but a journey, a systems transformation is much the same. Be it conceptual, practice of contextual strategies at work there is always more to do. Transformation efforts to date have included, but are not limited to: collaboration and partnership development; communication, language and educational tools and initiatives; Infrastructure planning and modifications; policy and regulatory changes and enhancements; peer recovery services and supports (inclusive of SAMHSA BRSS TACS grant); prevention/wellness efforts, and maintaining cultural competence and best practices within a recovery oriented service environment.

Part of the ROSC work involved in creating a Transformation Steering Committee (TSC) was established as the partner to BSAAS in decision making and moving transformation forward. With integrated health care as a priority within the state, its prominence with the approach of 2014 and the work that needs to be done in preparation for 2014; the TSC has primary health care coordination as a standing priority within its agenda and meetings.

In 2012 the BSAAS issued an RFP for Screening and Brief Intervention and Referral to Treatment (SBIRT) pilot projects. Four regions to the state were awarded grants of \$500,000.00 each to implement their proposed MI-SBIRT Projects. All of the projects include: the co-location of behavioral health personnel within medical settings; training of medical staff at all levels about the SBIRT purpose and process; inclusion of prevention and education services; and partnering of medical, SUD and mental health providers for persons needing primary care and behavioral health services beyond the initial SBIRT interaction. One of the strengths of the MI-SBIRT initiative is the variety of primary care institutes as partners in the MI-SBIRT projects – include: hospital residency programs, hospital emergency departments, community-based health care clinics, and Federally Qualified Health Centers entities.

Although these pilot projects will not be complete until September, 2013 – with follow-up to extend an additional 6 months – BSAAS is already seeing positive outcomes. These outcomes include but are not limited to: the openness by which individuals/patients have accepted the MI-

SBIRT process; the ancillary outcome from the training of medical personnel (the training focused on the SBIRT process and engaging individuals as part of that process, but also identifying and bridging the gap on how unfamiliar and unknown the issues of SUD were to medical practitioners); and the relational benefit of co-located service provision within the medical settings. At the conclusion of the pilot projects BSAAS anticipates the continuation of the MI-SBIRT initiatives, as the elements and practices of SBIRT will have become imbedded within the welcoming and orientation process, as well as referral and treatment mechanisms within the medical facility.

3. Are you working with your State's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publically funded behavioral health providers.

BHDDA and BSAAS have forged a relationship with Michigan's Primary Care Association (MPCA). There has been a requisite collaborative effort established with the state and the MPCA. Demonstration of this relationship can be found in the following examples:

- A representative from the MPCA is a member of the ROSC TSC
- On multiple occasions BSAAS and regional SUD agency personnel have been asked, and have presented SUD and ROSC information to the MPCA, and have presented and participated in the MPCA annual conference
- Information on the effectiveness of recovery oriented systems has been provided by regional SUD providers and stakeholder

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

Tobacco, the awareness of health dangers and complications, addiction, and treatment are relatively new areas of focus in mental health and recognizing the severe consequences of use in health and life expectancy, especially over time has created a new awareness and urgency to address use. Staff, peers and consumers are involved in smoking cessation or awareness programs and initiatives.

CMHSPs are screening for tobacco use at admission and at agency specified time periods reassess. Consumers are offered assistance at the appropriate level through developing a person-centered plan that includes reduction and/or cessation.

There are 44 clubhouses in Michigan which are independent non-smoking facilities located in the general community. Approximately 50% (22 in number) have smoking cessation classes. There are 56 consumer-run drop-in centers in Michigan. All are in non-smoking facilities with smoking tents on the outlying property.

Drop-in Centers in Michigan are smoke-free facilities. About 50% of the drop-in centers have smoking cessation classes.

Certified Peer Support Specialists (CPSS) are able to participate in a tobacco recovery training, receive informational with brochures entitled “Everyone has the Right to be Healthy” and “Information for people with disabilities and their caregivers on how to Quit Tobacco” that they can share with the people they are working with. Additional curriculum providers include the American Lung Association, Denver curriculum and CHOICES out of New Jersey. Frequently, cessation or reduction goals are included when participating in PATH. MDCHs smoking cessation work with CPSS has received a smoking cessation award by the Michigan Cancer Coalition.

Resources range from the MDCH website to individual counseling. There is a focus within Public Health toward those people who have a disability and use tobacco. Significant resources are on the MDCH website for consumers, physical, substance and mental health providers and interested others, for example, 1-800-QUIT-NOW (784.8669), Public Health Resources for Primary Care -TOBACCO, The Providers toolkit.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that supports your efforts to address smoking.

Behavioral health provider organizations are addressing smoking and preparing staff to help clients by developing competencies in motivational interviewing. Case managers, nurses, and peers are encouraged to talk to clients about tobacco and the benefits of quitting. Implementation of awareness, formal and informal support programs, groups, goals, peer support and participation in cessation efforts vary across the state.

An effort by one provider involves smoking status and quantity tobacco during each annual Personal Health Review and documented in the individual’s record. When agreed upon by a client, a person-centered treatment goal for reduction or quitting tobacco use is utilized. This goal is continually assessed during nursing visits. This documentation allows evaluation of goal attainment at specific points in treatment. Additionally, at each of the three adult service sites affiliated with this provider, tobacco treatment groups are offered weekly. These groups are open to all clients who want to learn more about tobacco or who want to reduce/quit using. Last year two CO monitors were purchased. The monitors are able to be used by individual clients and are offered for use in groups. This provider has been able to change their electronic medical record to track CO values over time. Clubhouses and CPSS are also significant resources for smoking cessation programs and support as noted above.

6. Describe how your behavioral health providers are screening and referring for: heart disease, hypertension, high cholesterol and/or diabetes.

As multiple models and variations of training for case management to care management occurs across the behavioral health service system in Michigan, greater awareness and comprehension of life threatening chronic health conditions like heart disease, hypertension, high cholesterol, obesity, metabolic syndrome and/or diabetes is occurring. The physical effects of substance use, serious mental illness and medications related to treatment, the lifestyle of clients and economic situations are in turn being recognized for their impact on these chronic health conditions.

This process is not formalized in Michigan for SUD, but it is now being contractually required to screen and refer for chronic diseases.

The current commitment to integrated treatment ranges includes referrals to comprehensive, on-site care at a CMHSP or a local FQHC or community health clinic. Behavioral health experts are working with, and in some locations within FQHCs and community health centers. In turn, physical healthcare experts are working with the behavioral health service programs that have established in-house primary care clinics. As knowledge and cooperation from these learning collaboratives grows; closer watch, treatment and support of physical illness is increasing. Generally, it is beginning to be recognized and more adequately addressed with new knowledge that physical health treatment is indeed appropriate. Agencies are expected minimally to screen, refer, treat and provide adequate support for client success.

Historically Assertive Community Treatment (ACT) teams have always integrated behavioral and physical health. Michigan has approximately 90 ACT teams. ACT teams and ACT nurses, have been and continue to be providers of coordinated and integrated care. Nurses have continually educated team members about medication side effects, physical illnesses, disease symptoms and the impact on treatment and health. ACT team members, while remaining within their individual scopes of practice, educate, advocate and continue to assist those they serve to understand and build healthier and more meaningful lives in their own community.

Multiple PIHPs are in the process of adding screening and protocols to activities already in place; assuring that each person has a primary care doctor; or working with the FQHC to obtain the services. Some PIHPs and FQHCs have cooperatively developed integrated health models and are at the frustrating stage that requires integrated care encounter coding.

One example, in Oakland County PIHP, providers are using the health measures and Axis III diagnosis for screening and referring for heart disease, hypertension, high cholesterol and/or diabetes.

Another, PIHP, Saginaw notes heart disease, hypertension, high cholesterol and/or diabetes, along with other health conditions, including obesity, are part of the initial and annual assessment process. Many efforts to heighten the awareness and knowledge of our case managers and supports coordinators about chronic health conditions, consumer wellness promotion (including BMI charts) and the importance of primary care referrals, coordination and follow up continue. One core case manager mandatory training module is on consumer health and wellness; it includes chronic conditions resources. Agency policy clearly states that the expectation for staff is to become students of the health conditions behavioral health consumers' experience. Nursing staff also assist with more comprehensive health assessments and re-screening of health status at the time of psychiatry appointments. Currently expectations of health care integration knowledge and practices are included in staff evaluations. SCCMHA has also made primary care services available at the key service site in cooperation with the federally qualified health center. Also included in home manager trainings and messages is the critical importance of health care integration and follow up in the management of chronic conditions as well as site emphasis on health and wellness.

IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?
2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?
3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?
4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).
5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?
7. Does the state have an accreditation program, certification program, or standards for peer-run services?
8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?
2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?
4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

DRAFT

M. Recovery

Indicators/Measures

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

Yes, a state policy and practice guideline is under revision and will be finalized by the end of the fiscal year. The policy defines recovery, includes values and principles with the addition of measurements expected from the PIHPs. The document was developed with individuals with mental health, substance use, and co-occurring needs and was a direct result of a recovery dialog training that was part of the Michigan Bringing Recovery Services and Supports to Scale action plan. In addition to the policy, a definition of recovery can be found in the Recovery-Oriented System of Care (ROSC) Glossary of Terms. This twelve page glossary was developed by a behavioral health workgroup comprised of persons from both the substance use disorder and mental health services system. A primary principal in the ROSC transformation process is the importance and value of the voice of lived experience. Additionally, the ROSC implementation plan has goals, objectives and strategies related to recovery, recovery support services, and the integral involvement of individuals in recovery.

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state office of Community Affairs) within the state behavioral health system?

Within MDCH, an individual in recovery leads the Office of Consumer Affairs. Also within the state behavioral health system, there are a number of persons in recovery. However, the state has not documented these individuals in any way due to the anonymity of the circumstances and the stigma still surrounding the disease. The Michigan ROSC Implementation Plan has as an objective "To increase the number of people in recovery who are visible in leadership positions, within the system and throughout Michigan's communities."

3. Does the state's plan include strategies that involve the use of person centered planning and self-direction and participant directed care?

Michigan has a strong history and background in both person-centered planning and self-determination. Since 1996, person-centered planning has been a Mental Health Code requirement in how an Individual Plan of Services is developed. A variety of documents are on the state website that include information on the Choice Voucher System, agency with choice, how to develop an arrangement to support self-determination and a variety of user friendly documents for person's in recovery developed in a brochure format. One of the MDCH staff is part of the national advisory committee for the environmental scan of self-direction for persons with mental illness part of the Robert Wood Johnson and Boston College initiative. For substance use disorder services, since 2006 BSAAS has required individualized treatment planning within the Action Plan Guidance and the Contract with regional substance use coordinating agencies. Additionally, BSAAS has a Policy, *Treatment Policy #6 Individualized Treatment and Recovery Planning*, which was most recently updated on April 22, 2012.

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible?

Recovery supports and services include a mix of services outlined in the Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery support services (e.g., warm lines, recovery housing, consumer/family education, supported employment, peer-based crisis services, and respite care).

The BRSS policy academy and the Application for Participation (AFP) were grounded in the values and principles of the Good and Modern Continuum of Care publication. In the AFP one of the five policy sections was devoted to Recovery with many of the requirements cohesive to this area of focus. The CPSS workforce enhance services and supports in the areas listed above which are a covered service in the Managed Care and Specialty Services 1915 (b)(c) Waiver. In addition, the Action Plan Guidance and the ROSC implementation plan outline a variety of recovery services and supports. There are some that are considered as primary to effective recovery, and others that are considered as ancillary to specific types of services.

Additionally, the ROSC TSC developed a benefits package with support documentation inclusive of the services and supports believed to be necessary to achieve and maintain recovery from drug and alcohol dependence and addiction. The basis for the benefits package and support paper is the SAMHSA Good and Modern document and the Coalition for Whole Health document.

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veteran and military families, people with a history of trauma, members of racial/ethnic, LGBT populations, and families/significant others?

All of the populations mentioned above benefit from recovery-oriented services systems, however, there is only one specialty population receiving targeted peer delivered services at this time and that is Women with children and women of childbearing age. Additionally, BSAAS has developed a technical advisory in this regard, *Treatment Technical Advisory # 8 Enhanced Women's Services*. As the ROSC Transformation continues, additional targeted specialty population initiatives are anticipated. MDCH trains veterans for peer support certification side by side with individuals in mental health and co-occurring conditions. This partnership has provided a variety of benefits to individuals served across the state at Community Mental Health Services Programs, the Veterans Administration and regional offices. The Michigan training curriculum developed in partnership with the Appalachian Group of Georgia (ACG) and the Depression Bi-Polar Support Alliance (DBSA) is nationally recognized by the federal Veterans administration as an approved curriculum for certification recognized in all states. In addition to the certification process, a variety of continuing education events related to trauma, cultural competency, and Family Psychoeducation are provided across the public system. Several groups are provided in the state specific to the LGBT population. One of Michigan's partners, Michigan Disability Rights Coalition, serves as a peer run organization that provides information and technical assistance to the LGBT community.

6. Does the state provide training for the professional workforce on recovery principles and recovery oriented practice and systems, including the role of peer providers in the continuum of services?

Since the announcement of the transformation to a ROSC both the annual Statewide substance use conference and the BSAAS substance use disorder training contract and plan have focused

primarily on recovery oriented system, principals, and practices. Members of the ROSC TSC are seated on the conference and training contract planning committee, and are diligent in their effort to assure that the states ROSC transformation priorities are represented within the training plan. Training related to peer recovery support services are part of both training forums, and additional recovery coach training is offered through separate forum at the regional level. The BSAAS is also pursuing ways in which SUD ROSC trainings can be made available through online capabilities.

The PIHP regional authorities provide regular and ongoing education on recovery with staff across entire agencies which are included in strategic planning efforts. The area of working with peer providers has been addressed both formally and informally. At the end of this fiscal year a specialized evaluation tool will be piloted that assesses and opens discussion on the strengths of what paid peer providers offer in the continuum of care and the view of supervisors/managers on effective delivery of peer services. This tool is being piloted at Georgia at the same time as Michigan. Many agencies have developed on-line learning and contracted with other organizations in the country to provide information in the areas of recovery and peer providers. Webinars that are offered nationally are attended by MDCH staff, regional and local providers and peers. MDCH publishes webinar opportunities broadly in all regions of the state. This area of focus is part of the MDCH Application for Participation on the expectations of recovery services and supports.

7. Does the state have an accreditation program, certification program, or standards for peer run services?

Currently, individuals who complete training to be a recovery coach are certified as peer recovery coaches. Beginning in June 2011 the first Connecticut Community Alliance for Recovery (CCAR) training of recovery coaches took place. Of the 45 individuals trained, all 45 were certified as peer recovery coaches and 15 were also trained to be trainers of peer recovery coaches. Since that initial training approximately eight trainings have been conducted at regional levels throughout the state.

BSAAS has also developed and adopted a Technical Advisory (TA), *Technical Advisory #7 Peer Recovery Support Services*. This TA was originally issued March 17, 2008 and has since been revised and made effective September 1, 2012. Within the TA the roles of peer recovery coaches and peer recovery associates are defined, as well as providing the minimal elements to be included in the training of peer recovery coaches, should an alternative to the CCAR training be utilized. There has been a concerted effort to keep the cost of the recovery coach to a minimum. The desire is that cost does not prohibit an individual in recovery from becoming a peer recovery coach, or to engage in other aspect of giving back and assisting others in their recovery journey.

For persons with a serious mental illness and/or co-occurring needs a curriculum for certification has been developed and enhanced since 2005. Currently 1140 individuals have been certified in the state and are required to be employed at least 10 hours per week in a position with job responsibilities outlined in the Medicaid Provider Manual. Michigan was one of the first states to received approval from the Center for Medicare and Medicaid Services to cover CPSS services through the Managed Care and Specialty Services 1915 (b) (c) waiver authority. The

statewide job description is outlined in the provider manual. Several Michigan CPSS have been involved and instrumental in the work and efforts of developing national standards for peers.

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advances the state-of-the-art in recovery oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery support services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

MDCH has engaged in a number of activities to promote utilization of peer support services, disseminate information related to ROSC innovation/best practices, and other innovative services. These activities and initiatives include, but are not limited to:

- development and utilization of a ROSC implementation plan for Michigan's publically funded SUD system;
- development and dissemination of ROSC information via ROSC orientation power points, fact sheets and newsletters;
- training of peer recovery coaches;
- adoption of technical advisories, policies, requirements and regulations related to ROSC initiatives, peer support services, best practices, access to services, etc.;
- provision of educational forums and trainings (i.e., training contract workshops, statewide SUD conferences, peer focus groups (one on accessing medical care and one on the development of peer support services), ROSC regional symposiums);
- application and receipt of a SAMHSA BRSS TACS grant;
- utilization of Action Plan Guidelines requiring the continued transformation to a ROSC, the use of peer support services, and special projects related to NIATx and Integrated primary health care;
- development of a glossary of ROSC terminology to improve communication regarding ROSC;
- development of an essential benefits package for recovery from substance use disorders based on SAMHSA's Good and Modern document and the Coalition for whole health document;
- support for the transformation of a recovery workgroup that was part of the ROSC TSC work into Michigan Recovery Voices statewide recovery organization;
- placement of CPSS in Federally Qualified Health Centers;
- inclusion of roles of CPSS in a Stanford research study for the Chronic Disease Self-Management Program;
- partnership with Michigan Primary Care Association to integrate whole health action planning in primary care settings; and
- Veterans Policy Academy initiatives.

Involvement of Individuals and Families

1. How are individuals in recovery and family members utilized in planning, delivery, and evaluation of behavioral health services?

The planning of substance use disorder services is an undertaking of the state's regional substance use coordinating agencies. The methods that they utilize to gather this information for the planning, delivery, and evaluation of behavioral health services includes the following: client satisfaction score, public hearings, strategic planning initiatives, and family interaction in training sessions. This same process is integrated with mental health services and supports. In addition evidence-based practices, including Family Psychoeducation, is implemented statewide. MDCH has developed a strong relationship with NAMI state and local organizations to ensure efforts at the state level are carried over to the local levels. The Application for Participation has several requirements which include guidance on how to engage persons with lived experience, family members and natural supports in the planning, delivery and evaluation of behavioral health services.

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health services system and develop a process for addressing these concerns?

The state sponsored a peer symposium for the purpose of engaging individuals in recovery in the ROSC transformation process. During this event there was significant discussion on what is need to support successful substance use disorder recovery, what recovery really looks like, and the issue of stigmatization of persons struggling with a substance use disorder. The event was successful and there has been a request to continue these types of forums in the future.

Individuals in recovery are members of the ROSC TSC, they are also represented in work groups convened for the purposes of planning services, and of those developing policy regarding the needs and nature of recovery oriented services.

In January 2013, the state convened a Behavioral Health Advisory Council (BHAC), which is the state's Planning Council, for the purpose of advising the MDCH concerning proposed and adopted plans affecting both mental health and substance use disorder services provided or coordinated by the State of Michigan and the implementation thereof. Approximately 55% of the BHAC membership is comprised of persons in recovery. This council forum will provide the opportunity for persons in recovery to make recommendations, and express ideas and concerns on a regular basis.

In additional to the TSC and the BHAC the Michigan Recovery Council provides information and guidance to the PIHPs with representation of individuals with lived experience across the entire state. Information that is presented at the meetings is conveyed to MDCH with actions taken to address the input of the Council. The Council Co-Chairs include an individual with lived experience and the Director of the Bureau of Community Based Services.

The vast representation of the three groups provide unique opportunities to collectively identify stakeholders of each represented area leading to an integrated process for MDCH to incorporate in state level communications to the PIHP regions in the state.

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system, participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

Methods include the requirements in the Mental Health Code for person-centered planning, self-determination and person-centered planning contract attachment with PIHPs, individualized treatment and recovery planning for which the state has a policy (*Treatment Policy #6 Individualized treatment and recovery planning*), representation on the State BHAC, communicating with the regional substance abuse coordinating agencies and/or a representative of the ROSC TSC and PIHPs, through participation on the SUD coordinating council board, PIHP/CMHSP and Provider agency boards and consumer advisory councils, and through participation in public hearings regarding legislation, appropriations, and changes, recommendations in the integrated service delivery system.

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery oriented services?

Many of the central office staff organizes develop agendas and provide information to the executive management team regarding the voices and input of persons with lived experience. This includes integrated statewide recovery organizations, consumer run drop-in centers and the vast array of recovery oriented service networks. The input provided is utilized in the development of recovery principles and practice documents and strategic planning. The recovery community is involved in the development and review of the AFP including stakeholder input into the PIHP contracts each fiscal year. Statewide central office committees include a variety of individuals and families with lived experience guiding and steering the process in leadership positions.

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

The State has included as part of the Action Plan Guidance the required consideration of how housing supports can be provided to persons seeking recovery. Due to this portion of the Action Plan Guidance, several regions of the state have established recovery housing, or are considering how this may be achieved within their region. The state has also recommended that key partnerships be pursued with HUD and other housing authorities at the state and regional level.

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

The State has implemented multiple collaborative projects to ensure housing needs and community engagement for persons served. In 2006 the State and key community partners implemented Michigan's Campaign to End Homelessness. The vision of the Campaign is to end homelessness by providing the most vulnerable members of our society with access to housing, services and income supports they need in a timeframe they deserve.

Within this campaign ongoing strategies include ending chronic homelessness given this has a huge financial impact on the funds made available from the state and federal government.

Interdepartmental collaboration between the Michigan State Housing Development Authority, Department of Human Services, and Department of Community Health ensures that housing and health resources are integrated. The current key tasks within the Campaign are:

- Steering Campaign partner resources to support central points of housing assistance that align and coordinate systems of care, continually improve services and systems, and thoughtfully prioritize services to the most vulnerable.
- Increase Safe and affordable housing opportunities with necessary services to allow the most vulnerable to attain success.
- Collect and report quality data for accountability and decision making.

The State provides the following housing programs which also include support services for households with a disability: Low Income Housing Tax Credits with Permanent Supportive Housing; Tenant Based Rental Assistance; Emergency Solutions Grant Rapid Re-Housing; Housing Choice Voucher Program; VASH Vouchers; Project Based Vouchers; Prisoners Using Supportive Housing; SSI Outreach, Access and Recovery, and Shelter Plus Care.

IV: Narrative Plan

N.1. Evidence Based Prevention and Treatment Approaches for the SABG

Narrative Question:

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
5. How is the state's budget supportive of implementing the Strategic Prevention Framework?
6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)
7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Footnotes:

N.1. – Prevention – SA

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the type of primary prevention services that are needed?

As identified in Table 1: Step 2, the mission of Michigan's 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 the quality of life for citizens of Michigan. Through the use of various data sources, the State Epidemiological Profile is updated on an annual basis. This process includes review of residents' consumption patterns, intervening variables, and substance abuse consequences as well as mental health well-being. The SEOW makes recommendations on priorities to be addressed, which in turn will lead to the ultimate decision resting with BSAAS. Once priorities are identified, CAs are contractually required to submit multiple-year Action Plans to BSAAS which address the priority problems identified and target specific interventions related to the appropriate intervening variables in their communities.

Priorities that have been identified in the Action Plan are to reduce childhood and underage drinking; reduce prescription and over-the-counter drug misuse and abuse; and reduce youth access to tobacco. If needed, CAs are also able to identify a fourth priority area given their local needs and based on epidemiological evidence. The CAs must complete a comprehensive strategic plan based on a data-driven planning process, and complete a planning chart using a logic model approach with their submission. CAs are expected to employ any of the six SAMHSA Center for Substance Abuse Prevention (CSAP) strategies (information dissemination; education; alternative programs; problem identification and referral; community-based process; and environmental) to engage individuals and the community to effect population-based change. It is critical to note that, especially in the case of information dissemination and alternative programs, multi-component community-based strategies are more effective than single-component strategies. These two strategies should only be implemented as part of a multi-faceted effort.

A multi-component and strategic approach in each CA region should cover age groups including support for children, senior citizens, socio-economic classes, diverse cultures, minority and under-served populations, service men and women, gender-specific and targeted high-risk groups, as has been identified in each of the CA regions as part of a comprehensive needs assessment process.

The ultimate goal of implementing the six strategies is to enhance the development of PPCs with community norms that reduce alcohol and other drug consumption, or modify the conditions under which they are consumed. This will, in turn, reduce SUDs.

2. What specific primary prevention program, practices and strategies does the state intend to fund with SABG prevention set aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

As part of the CA Action Plan process, a planning chart logic model is submitted by each CA. For each priority area identified by the state, the CA logic model first identifies the consequence to be addressed in their region, with supporting data for that consequence identified. Associated intervening variables are then noted, with the primary federal strategy and appropriate evidence-based service or intervention to address that intervening variable. CAs further identify the population type, as well as immediate and long-term outcomes (which are linked to National Outcome Measures). Finally, training and technical assistance needs (if any) are identified as the final step of this logic model. In order for CAs to be able to address their local needs in the least restrictive way possible within the parameters given, the state has not developed a specific list of primary prevention program, practices and strategies eligible for funding. CAs are directed to the National Registry of Evidence-Based Programs and Practices (NREPP) for guidance and programs, practices and strategies appropriate to address the consequence and variables identified. In addition, Michigan developed a *Guidance Document on Selecting, Planning and Implementing Evidence-Based Interventions for the Prevention of Substance Use Disorders* in January 2012 for CAs to use with their local community coalitions and providers to determine appropriate “fit” and selection. CAs are required to assure that at least 90% of prevention services funded with SABG prevention set aside dollars are evidence-based.

3. How does the state intend to build the capacity of its prevention system including the capacity of its prevention workforce?

The primary purpose of the SPE project was to strengthen and expand our state prevention framework, thereby increasing state capacity to support effective substance abuse prevention and mental health promotion services across systems. Five CA communities were identified to be targeted as part of the SPE, with lessons learned and goals achieved used as a template by BSAAS for statewide expansion of PPCs. During this project, an environmental scan and workforce development survey was administered to identify gaps in training and technical assistance and develop a plan to fill those gaps. Sixty-three completed responses were collected from provider networks in the five SPE target communities. Compiled results were then shared with the other eleven CA regions seeking input on concurrence or non-concurrence with the issues identified in the five regions. Based on these responses and other CAs input, a plan was developed to fill specific gaps identified.

Assessment of training and technical assistance needs is also conducted by BSAAS based on requests provided by CAs in their Action Plans. Another assessment is conducted by the advisory committee of the Michigan Prevention, Treatment and Education (MI PTE) project. All of these assessments are reviewed and prioritized by BSAAS staff and are incorporated into a yearly training plan.

Through this yearly training plan, BSAAS provides training and technical assistance to prevention (as well as treatment) practitioners in the state via a contract with the MI PTE. Funding for the training and technical assistance is supported by SAPT Block Grant and State General Fund dollars. Historically, about one-third of the training budget has been dedicated to prevention. Content experts in the state are identified and secured for training and technical assistance. BSAAS also has a Training Cadre for prevention that has been well-trained in the SPF five-step model, and many of these Training Cadre members recently completed the Substance Abuse Prevention Skills Training (SAPST) and SAPST Training of Trainers (TOT). CSAP and the Center for Applied Prevention Technology (CAPT) have also been used as resources for training; providing training and technical assistance both face-to-face and via webinar.

In an effort to encourage workforce development, the cost of training and technical assistance has been minimal and all workshops offer credit toward certification to encourage attendance by as many practitioners as possible. BSAAS also holds an annual substance abuse conference including workshops on evidence-based practices, and include plenary sessions performed by national experts representing behavioral health administration and service delivery.

In addition to the above formal training opportunities, SEOW members are available to provide technical assistance on the use of data, trends, and the use of a data-driven process to local communities.

It is planned all of the above efforts will continue through 2015.

4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

Performance management, evaluation process and methodology are accomplished through various mechanisms. Michigan has established a Prevention Data Set (PDS) to collect process data, which has been effective for both state and community-level data collection. In addition to basic information related to core strategies and demographic information of the recipient, evidence-based programs are reported to the PDS. In the future, this system is planned to be expanded to allow pre- and post-assessment of program effectiveness and to track perception of harm, 30-day use, and behavior changes tied to national outcome measures. Currently, outcome data is collected on past 30 day use alcohol among youth; perception of risk among youth that 5+ drinks/weekend is moderate or great risk; Synar compliance; and alcohol related traffic crash deaths. It is anticipated these outcome measures will continue to be monitored. In addition, two outcome measures will be added in ten target communities in the state as part of the PFS II project: past 30 days prescription drug misuse/abuse and family communication.

Site visits are conducted by CAs to their providers, and by BSAAS to the CAs. The focus of these site visits is to assure contract compliance, as well as provide technical assistance and quality assurance monitoring consistent with the fifth step of the SPF SIG planning framework. BSAAS has also developed a closer collaboration with Wayne State University to strengthen our evaluation processes.

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

As previously noted, CAs are contractually required to submit multiple year Action Plans to BSAAS, which address priority problems identified by the state, and target specific interventions related to the appropriate intervening variables in their region. These prevention strategies are to illustrate evidence of the five-step SPF planning process by utilizing local community coalitions, and parents and youth as part of this ongoing planning process. The CAs must complete a comprehensive strategic plan based on this data-driven planning model process. By doing the Action Plan in this manner, the SPF has been institutionalized as "the" process to be used in Michigan for prevention services.

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

In FY2012, 20.8% of the prevention set-aside went to community based processes. Of this amount, about half of it stays with the licensed providers, while the other half funded community organizations.

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies?

In FY2012, 96.7% of prevention set-aside was directed toward evidence-based practices. This high percentage is due, in part, to Michigan's requirement for a number of years that 90% of funded services be evidence-based.

In FY2012, 5.12% of prevention set-aside was directed toward environmental strategies.

IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?
3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:

O. Children and Adolescents Behavioral Health Services

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

Michigan has achieved some success in creating the foundation for a statewide system of care (SOC) for children with serious emotional disturbance (SED) and co-occurring disorders (COD). All public mental health providers in Michigan utilize a standard definition of SED and uniform access standards, as outlined in an attachment to the Michigan Department of Community Health (MDCH) contract with the Pre-Paid Inpatient Health Plans (PIHPs) and with the Community Mental Health Services Providers (CMHSPs). 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 SOC. 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).

As indicated earlier in this document, recent legislation passed in Michigan is requiring that each Coordinating Agency (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 already placed a specific focus on training on COD for youth and these include Oakland and Central Michigan. Oakland County PIHP has held training in Motivational Interviewing in order to increase engagement of families in treatment, 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 CODs. There continues to be a need for additional cross-agency cooperation between mental health and substance abuse services with regard to serving youth with CODs. The integration of the CAs into the public mental health system statewide may contribute to additional solutions in this area as well. The state also plans to use the treatment guidelines in the process of being developed at the national level to develop local policy that governs adolescent substance use disorder treatment.

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.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

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.

Individualized treatment and recovery planning is also required for every individual entering substance use disorder treatment in Michigan. This is also addressed through treatment policy #06, initially issued September 2006 and revised February 2012. It is required that the individual be allowed to include any family, friends or significant others in the treatment and recovery planning process. Progress reviews on this plan must occur on a regularly scheduled basis and frequency is determined by the length of time the individual is in treatment. The individual's participation in the planning process must be documented, as well as any other professionals (probation/parole/juvenile justice) who have input.

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

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.

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, 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.

For many years Michigan had a Substance Abuse and Child Welfare State Team. However, increasing responsibilities and decreasing funding have made it difficult to maintain this statewide effort. Most collaboration efforts take place at the local level at this point. Regional Coordinating Agencies and local providers make connections with their local child welfare, juvenile justice and education professionals as needed and provide education and support.

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

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)¹ and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (Cohen, Mannarino, Deblinger, 2006)². Local communities have also identified evidence-based practices that they would like to implement and have applied for and been awarded block grant contracts from MDCH to train CMHSP staff in EBPs that will meet the needs of their local communities. These have included joint projects with CMHSPS and local courts/DHS to serve youth involved with the juvenile justice system with relevant EBPs.

The MI-PTE (Michigan Institute of Prevention and Treatment Education), Michigan's SUD Training Project, provides support in this area as well. Each year, the SUD field is given the opportunity to request training on specific topics in addition to the topics identified as a need at the state level.

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Standardized, validated and reliable outcome measures, the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 1989)³ for youth ages 7-17 and its counterpart for children ages 3-7 the Preschool Early Childhood Functional Assessment (PECFAS) (Hodges, 1994a)⁴ are used to assess treatment effectiveness for all children served in the public mental health system. MDCH has a contract with Dr. John Carlson at Michigan State University who analyzes statewide CAFAS and PECFAS data

¹ 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.

² Cohen, J., Mannarino, A., Deblinger, E. (2006) Treating Trauma and Traumatic Grief in Children and Adolescents, London and New York: The Guilford Press.

³ Hodges, K. (1989). Child and Adolescent Functional Assessment Scale. Ypsilanti: Eastern Michigan University.

⁴ Hodges K. The Preschool and Early Childhood Functional Assessment Scale. Ypsilanti, MI: Eastern Michigan University, Department of Psychology; 1994a.

and provides reports to the state and CMHSPs regarding outcomes of children/youth receiving treatment in the public mental health system.

All providers also submit encounter data to MDCH regarding service utilization and cost and annual reports are generated by the Performance Measurement and Evaluation Section of MDCH. Copies of the reports can be found here: http://www.michigan.gov/mdch/0,4612,7-132-2941_4868_4902---,00.html and here: http://www.michigan.gov/mdch/0,4612,7-132-2941_4871_45835---,00.html

Additional outcomes are tracked at the local level and reported to the state via the annual Legislative Report. Furthermore, there are opportunities at site visits with Regional Coordinating Agencies to review this information and provide technical assistance where needed.

DRAFT

IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 10 - 13
2. STATE: Michigan

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH FINANCING ADMINISTRATION
DEPARTMENT OF HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2010

5. TYPE OF PLAN MATERIAL (Check One):
 NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902(a)(73)

7. FEDERAL BUDGET IMPACT:
a. FFY 10 \$ -0-
b. FFY 11 \$ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Preprint page 9, page 9 continuation
See per state approval

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):
Preprint page 9

10. SUBJECT OF AMENDMENT:
Tribal consultation requirements

11. GOVERNOR'S REVIEW (Check One):
 GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
 OTHER, AS SPECIFIED:
Stephen Fitton, Director
Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Stephen Fitton

13. TYPED NAME:
Stephen Fitton

14. TITLE:
Director, Medical Services Administration

15. DATE SUBMITTED:
August 31, 2010

16. RETURN TO:
Medical Services Administration
Program/Eligibility Policy Division - Federal Liaison Unit
Capitol Commons Center - 7th Floor
400 South Pine
Lansing, Michigan 48933
Attn: Nancy Bishop

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 1, 2010 8-31-10

18. DATE APPROVED:
MAR 30 2011

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2010

20. SIGNATURE OF REGIONAL OFFICIAL:
Verlon Johnson

21. TYPE NAME:
Verlon Johnson

22. TITLE:
Associate Regional Administrator

23. REMARKS:

MICHIGAN MEDICAID STATE PLAN

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Michigan

Citation
42 CFR
431.12(b)

1.4.a. State Medical Care Advisory Committee

There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.

42 CFR
438.104

The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.

B. Tribal consultation requirements

Section 1902(a)(73) of the social security act (the act) requires a state in which one or more indian health programs or urban indian organizations furnish health care services to establish a process for the state medicaid agency to seek advice on a regular, ongoing basis from designees of indian health programs, whether operated by the indian health service (ihs), tribes or tribal organizations under the indian self-determination and education assistance act (isdeaa), or urban indian organizations under the indian health care improvement act (ihcia). Section 2107(e)(l) of the act was also amended to apply these requirements to the children's health insurance program (chip). Consultation is required concerning medicaid and chip matters having a direct impact on indian health programs and urban indian organizations.

The tribal liaison is to be informed of all proposed state plan amendments, proposals for demonstration projects, waiver requests, renewals, extensions or amendments that may have a direct impact on services provided for native americans, indian health programs or urban indian organizations. This would apply to any changes that are more restrictive for eligibility determinations, changes that reduce payment rates or changes in payment methodologies to providers, reimbursement to providers, or reductions in covered services.

The tribal chairperson, tribal health directors, urban indian health director, and indian health services representative will receive written notification from the tribal liaison of all proposed state plan amendments, proposals for demonstration projects, waiver requests, renewals, extensions or amendments that may have a direct or adverse effect on native americans, indian health programs or urban indian organizations.

The notice will be sent sixty (60) days prior to the submission date and provide a brief synopsis of the proposal and impact on the native american beneficiaries, tribal health clinics and urban indian organizations. In situations where it is not possible to adhere to the sixty (60) days notification, the tribes will be notified as soon as possible. The procedures and timeline for submitting comments on the proposed changes will also be addressed in the notice. Additional information for a proposal will be provided by the liaison upon request. A cover letter is included in the correspondence encouraging input regarding the proposed changes through in person consultation or by telephone conference depending on the tribe's preference. A consultation meeting is set up either as a group or individually, again according to the tribe's preference. During the consultation, concerns are addressed and any suggestions revisions or objections voiced by the tribes are noted and relayed to the author of the proposal.

TN No.: 10-13
Supersedes
TN No.: 03-13

Approval Date MAR 30 2011

Effective Date: 07/01/2010

MICHIGAN MEDICAID STATE PLAN
9 (continued)

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Michigan

Occasionally, federal policy changes require immediate implementation. When this occurs, tribes are notified as soon as the tribal liaison is made aware of the proposed changes. Consultation is then held within twenty-one (21) days of notification.

Consultation with tribal chair representatives, tribal health directors, and indian health services representatives will be conducted at the quarterly tribal health director meetings, or another venue at the request of the tribes. Consultation may be in person or by conference call.

The tribal liaison will acknowledge electronic mail or regular mail, all comments received during the consultation period.

All comments submitted by tribes will be forwarded by the tribal liaison to the medicaid policy staff responsible for the proposed changes.

The tribal liaison will ensure that tribes commenting on proposed changes receive a response to their concerns arising from the proposed changes.

Tribes requesting changes to the proposed state plan amendment, waiver request, renewal, or amendment will receive confirmation from the tribal liaison regarding their request, and whether their comments have been included in the proposals submitted to cms. If the tribe's comments are not included in the proposed changes when submitted to cms, it is the liaison's responsibility to explain why their comments were not included.

Tribes will be informed by the liaison when cms approves or denies state plan or waiver changes. The liaison will also be responsible for including the rationale for cms denials.

The tribal liaison will be responsible for maintaining records of the notification process, consultation process, all written correspondence from tribes and tribal representatives, meeting notes, and all other discussions such as conference calls for all state plan or waiver changes that may impact the tribes. The tribal liaison will also document the outcome of the consultation process.

The spa was sent to all of the tribes for review in march 2010. Consultation with the tribal health directors was held in april 2010 at the quarterly tribal health directors meeting and discussed at length. The tribal health directors concurred that the proposed spa language was acceptable with no objections or revisions.

TN No.: 10-13
Supersedes
TN No.: New

Approval Date MAR 30 2011

Effective Date: 07/01/2010

IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

DRAFT

Q. Data and Information Technology

Each state should:

Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data:

The capacity to provide unique, client level data already exists. The Michigan Department of Community Health (MDCH) is developing a Master Person Index (MPI) that will serve as the single identifier across all systems. This will allow analysts to make better use of the full MDCH Data Warehouse. The target date for the full implementation of the MPI is January 1, 2014.

List and briefly describe all unique information technology systems maintained and/or utilized by the state agency:

The systems identified and described in the prior application remain unchanged.

Substance Abuse Prevention and Treatment Statewide Provider Search

The Department of Licensing and Regulatory Affairs (LARA) continues to maintain the JavaScript-enable Oracle database of all licensed sites for Substance Use Disorders. This database is accessed via the internet at http://www.dleg.state.mi.us/bhs_car/sr_sal.asp. The system is searchable by license number, county, city, zip code, program name, or clickable map. The database contains contact info (address, phone, and director). It also stores information on the licensed services and accrediting bodies. Client Enrollment, Demographics, and Characteristics and Admission, Assessment, and Discharge:

Treatment Episode Data Set (TEDS) Collection System

A web-enabled Substance Abuse Treatment Oracle 10G platform (JavaScript SATWEB) processes, collects, and stores TEDS Admission and Discharge data for services funded in whole or in part by the SAPT Block Grant. This system processes electronically submitted text files and either accepts or rejects each record. Accepted records are stored in a data repository. Rejected ones go to an error master where the submitter has the opportunity to use an On-Line Error Correction System (OEC) to fix the errors. CA submitters can access the application on-line via the State Single Sign On.

Community Health Automated Medicaid Processing System (CHAMPS)

The Community Health Automated Medicaid Processing System (CHAMPS) processes submitted claims and encounters and stores the HIPAA 837 encounter information. CHAMPS collects all reported encounters (HCPCS and CPT codes) for persons served with MDCH-administered dollars. The standard HIPAA 837 transaction is utilized. That transaction contains complete information on the clients, payers, and rendering providers. CHAMPS interfaces with the MDCH Data Warehouse. CHAMPS was certified by CMS in 2011.

Prevention Data System (PDS)

Michigan has gone live in late 2012 with a new and improved Prevention Data System that collects information on prevention activities, including dates of service, strategies, IOM categories, and evidence-based practices. This is a subscriber-based web application that is used by all regional CAs. This system allows Michigan to collect the required data to complete all the required prevention tables in the Block Grant Report.

The Michigan Automated Prescription System (MAPS) --Prescription Drug Utilization

The Michigan Automated Prescription System (MAPS) is the prescription monitoring program for the State of Michigan. Prescription monitoring programs are used to identify and prevent drug diversion at the prescriber, pharmacy and patient levels by collecting Schedule 2-5 controlled substances prescriptions dispensed by pharmacies and practitioners. Collection of this prescription information allows physicians, dentists, pharmacists, nurse practitioners, physician's assistants, podiatrists and veterinarians to query this data for patient-specific reports which allow a review of the patient's Schedules 2-5 controlled substance prescription records. This enables the practitioner to determine if patients are receiving controlled substances from other providers and to assist in the prevention of prescription drug abuse.

Mental Health Quality Improvement File

PIHPs are required to report to the MDCH warehouse demographic or quality improvement (QI) data for every PIHP and affiliate CMHSP consumer served using an MDCH proprietary format and process. This information is linked via the data warehouse to the encounter and claim information submitted to CHAMPS via the 837. This file includes individual client information such as residential living arrangement, employment status, involved with criminal justice and level of education.

PIHP Event Reporting System

The MDCH Event Reporting System is a file-based system to submit consumer-specific information about five specified events on a timely and regular basis from CMHSP's/PIHP's to MDCH. The five specific reportable events are: Suicide, Non-suicide Death, Emergency Medical Treatment due to Injury or Medication Error, Hospitalization due to Injury or Medication Error and Arrest of Consumer. Each type of Reportable Event has a "reportable population." While some of these events are reported for all active consumers, others are only reported for certain identified groups of consumers. For instance, many types of events are only reported for populations considered especially vulnerable.

Provide information regarding its current efforts to assist providers with developing and using EHRs; identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment:

There are no barriers here. Michigan moved to collecting full encounter data on SAPT Block Grant in 2001 and mental health encounters in 2004. Encounter data contains information on the service provider, the service recipient, the date(s) of service, the procedure code, the code modifiers, and the charged and paid amounts. The CHAMPS system collects only valid, national HCPCS and CPT codes in either claims or encounters.

Since 2012, the estimated percentage of providers utilizing an Electronic Health Record (EHR) has increased from approximately 15% to nearly 35%. The regional Coordinating Agencies (CA), Northern Michigan Substance Abuse Services (NMSAS) has contracted with CORE Solutions to implement both its 360 Provider Connect and 360 Payer Connect HER solutions. These products now services 30 of Michigan's 83 counties. There are currently several well-

developed CMHSP/PIHP projects to exchange information with the six Michigan Health Information Network (MiHIN) “Sub-State” Health Information Exchanges.

Identify the specific technical assistance needs the state may have regarding data and information technology.

No specific technical assistance needs are requested at this time.

DRAFT

IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

DRAFT

**STRATEGY FOR ASSESSING AND IMPROVING THE QUALITY OF MANAGED
SPECIALTY SERVICES AND SUPPORTS**

FY'12 through FY'14

Revision 2/16/13

[**Note: Revisions are noted in bold type and are highlighted in yellow**]

The following strategy is designed to assess and improve the quality of specialty services and supports managed by the Prepaid Inpatient Health Plans (PIHPs). The state agency responsibility for the components of the quality management system listed here resides in the Michigan Department of Community Health (MDCH), **Behavioral Health and Developmental Disabilities Administration (BHDDA)**, Division of Quality Management and Planning, except where otherwise noted.

I. **BACKGROUND: PROCESS FOR QUALITY STRATEGY REVIEW AND REVISION**

This quality strategy builds upon and improves the initial strategy developed for the 1915(b)(c) waiver application in 1997, and revised for each subsequent waiver renewal application. As with the previous quality strategies, this quality strategy was developed with the input of consumers, and the Mental Health Quality Improvement Council (QIC) that is comprised of consumers and advocates, and representatives from the Provider Alliance and the Michigan Association of Community Mental Health Boards. This revised and improved strategy also reflects the activities, concerns, input or recommendations from the MDCH Encounter Data Integrity Team, the **External Quality Review (EQR) activities**, and the **recommendations for improvement** from the Centers for Medicare and Medicaid Services (CMS) **previous** waiver approvals. **The Quality Strategy is intended to address the quality of all specialty supports and services covered by the 1915(b)(c) waiver for all adults and children served.**

II. **CERTIFICATION, ACCREDITATION, AND LICENSURE**

A. **Community Mental Health Services Program Certification:** The approved Plan for Procurement and the subsequent Application for Participation (2002) (AFP) required that each PIHP be a community mental health services program (CMHSP). The Michigan Mental Health Code (Code) requires that every CMHSP be certified by MDCH in order to receive funds. The certification consists of two elements:

1. Each CMHSP must be determined to have a local recipient rights system that is in substantial compliance with the requirements of the Recipient Rights Chapter 7 of the Code. This compliance is determined by on-site visitation by the MDCH Office of Recipient Rights.
2. Each CMHSP must be in compliance with a set of organizational standards established in Michigan's Administrative Rules, which have the effect of law. The rules cover the following dimensions:

Governance, mission statement, community education, improvement of program quality, personnel and resource management, physical/therapeutic environment, fiscal management, consumer information, education and rights, eligibility and initial screening, waiting lists, alternative services, array of services, medication, and individual plan of service.

It is required that the CMHSP and each of its subcontracting providers of mental health services meet these standards. If a CMHSP or its sub-contracting provider is accredited by a national organization, a limited review of the accredited agency is conducted by MDCH beyond assuring the existence of said accreditation. MDCH has granted deemed status to four national accrediting bodies: Joint Commission (JC), CARF, The Council on Accreditation (COA), and The Council. Certification may be granted for up to three years. CMHSPs must be certified prior to entering into a prepaid contract for services and supports for beneficiaries.

B. Provider Networks:

1. CMHSPs as "Affiliates" and other providers: Affiliates and sub-contracting providers must meet the certification requirements stated in A above.
2. Substance Abuse Coordinating Agencies and Providers: PIHPs may subcontract with Substance Abuse Coordinating Agencies (CAs) to manage the substance abuse treatment benefit. Eight PIHPs are currently CAs. CAs are not licensed or accredited for ongoing treatment services, but all of their subcontracting providers of outpatient, residential, intensive outpatient, sub-acute **detoxification** and methadone substance abuse services are required to be licensed under the Michigan Public Health Code. CAs must be appropriately licensed if operating their own **Access Management System**. In addition, state and federal funds administered by MDCH for treatment services may be contracted only with licensed providers accredited by one of the following national accrediting bodies: JC, CARF, COA, National Council on Quality Assurance (NCQA), **Accreditation Association for Ambulatory Health Care (AAHC)** and the American Osteopathic Association (AOA). Licensing actions are the responsibility of the **Michigan Department of Licensing and Regulatory Affairs**, Bureau of Health Systems, who consults with the CAs and the **Behavioral Health and Developmental Disabilities Administration (BHDDA)** and shares with, and consults on, all licensing findings to the administration.

Persons seeking substance abuse treatment must be assessed by **an appropriately trained and credentialed** professional and authorized for treatment. [Please see provider qualifications in the Medicaid Provider Manual] In completing the assessment, the American Society for Addiction Medicine (ASAM) Patient Placement Criteria must be applied to determine the appropriate level of treatment. These criteria are also **utilized** for continuing stay and discharge decisions by the treatment and/or assessment program.

3. Certification and Licensing for Settings Where Services are Provided:

- a. **Specialized Mental Health Residential Certification:** All adult residential service providers who receive funds for the provision of specialized mental health services must be certified by the Michigan Department of Human Services (MDHS). These standards address issues such as: accessibility, facility environment, fire safety, and staffing levels and qualifications. Specifically, these rules require that all staff who work independently and who function as lead workers must complete training which covers eight areas, including the role of residential care workers, introduction to the special needs of adults with developmental disabilities and mental illness, basic interventions for maintaining and caring for a recipient's health, basic first aid and CPR, medications, environmental emergencies, recipient rights, and non-aversive techniques for preventing or managing challenging behaviors. While these rules do not require a schedule of re-training, PIHPs will be required to assure that these staff be re-trained whenever the treatment needs of the resident(s) change and whenever there is a significant change in MDCH policy which would affect the delivery of services. In addition, PIHPs are required, as part of the CMHSP certification, to have a local process to assure that persons providing services and supports are competent to perform their duties.
 - b. **Adult Foster Care Licensing:** The MDHS also acts as the licensing agent for Adult Foster Care settings.
 - c. **Protective Services:** MDHS also has responsibility for Adult and Child Protective Services. PIHPs, along with their subcontracting provider networks, have a legal responsibility to report potential violations to the local MDHS offices
4. **Coordination On Issues Involving Adult Foster Care Settings**
- a. Staff from the MDCH **BHDDA** meet **monthly** with MDHS central office staff to share information, jointly revise policies, and trouble-shoot on various issues including self-determination, individuals' own homes, state plan home help services, critical incidents and sentinel events. For example, licensing problems identified by MDHS are forwarded to MDCH for follow-up as part of its contractual or site visit processes. PIHPs, in turn, and/or their subcontracting provider networks, have the responsibility to report potential problems to the MDHS for follow-up.

III. AFP AND CONTRACTUAL REQUIREMENTS FOR PIHPS' QUALITY MANAGEMENT SYSTEMS

Three areas addressed by the BBA and reviewed as part of the quality management system are: customer services, grievance and appeals mechanisms, and the CMS-approved Quality Assessment and Performance Improvement Programs. These elements were required as part of the 2002 AFP, are now part of the MDCH/PIHP contracts, and they are reviewed by MDCH staff and/or the EQR organization.

A. Customer Services

Customer services is required by the MDCH/PIHP contract to be an identifiable function of the PIHP that operates to enhance the relationship with the community, as well as with the beneficiary. Customer services is frequently a function delegated by the PIHP to affiliates or providers, including the substance abuse network. When delegated, the PIHP must monitor the entity to which the function is delegated. In 2006, MDCH developed Customer Services Standards and standard language for their Customer Services handbooks. The Standards and handbook language were included in the FY2007 MDCH/PIHP contract and are located on MDCH's web site at www.michigan.gov/MDCH, click on Mental Health and Substance Abuse, then Mental Health and Developmental Disabilities, then Customer Services. In addition, MDCH provided training to 110 customer services representatives in September 2006.

MDCH reviews and approves each of the PIHP's customer services handbooks and requires the PIHPs to resubmit the handbooks for review and approval anytime a substantive change is made.

PIHPs found out of compliance with these standards by the External Quality Review must submit plans of correction. MDCH staff and the EQRO follow up to assure that the plans of correction are implemented. Results of the MDCH on-site reviews and the EQRs are shared with MDCH BHDDA Management Team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

B. Appeals and Grievances Mechanisms

CMS approved the BBA revision of the appeals and grievance procedures, required by MDCH/PIHP contract. The EQR reviews the process for providing information to recipients and contractors, method for filing, provision of assistance to beneficiaries, process for handling grievances, record keeping, and delegation. In addition, the logs of appeals and grievances and their resolutions at the local level are subject to on-site review by MDCH. MDCH uses its Fair Hearings database to track the trends of the requests for fair hearing and their resolution and to identify PIHPs that have particularly high volumes of appeals. Results of the MDCH on-site reviews and the EQRs are shared with MDCH BHDDA Management Team and with the QIC. Information is used by MDCH to take contract action as needed, or by the QIC to make recommendations for system improvements.

C. Quality Assessment and Performance Improvement Programs

The MDCH contracts with PIHPs require that the QAPIP be developed and implemented. **There are planned changes for the QAPIP for the coming waiver period (see Attachment A.III.1.a).** The EQR monitors on-site the PIHPs' implementation of their local QAPIP plans that must include the 14 QAPIP standards. In addition, MDCH reviews on-site implementation of the following standards: VIII Sentinel Events, IX Behavior Treatment Review and XI Credentialing of providers. MDCH collects data for Standard VI, Performance

Indicators, VII Performance Improvement Projects, and XII Medicaid Services Verification, as described below.

1. Performance Indicators

Please see section VI.A of this Quality Strategy.

2. Performance Improvement Projects

The **BHDDA** Management Team, the QIC, and Division of Quality Management and Planning staff collaborate to identify the performance improvement projects for the each waiver period. Justification for the projects was derived from analyses of quality management data, EQR findings, and stakeholder concerns. For the upcoming waiver period Michigan will require all PIHPs to conduct a minimum of two performance improvement projects:

- a. All PIHPs conduct one mandatory two-year performance improvement project assigned by MDCH as identified above. In the case of PIHPs with affiliates, the project is affiliation-wide.
- b. PIHPs that have continued difficulty in meeting a standard, or implementing a plan of correction, may be assigned a specific project topic relevant to the problem. At the present time, PIHPs were allowed to choose a second performance improvement project in consultation with their QAPIP governing body.

PIHPs report semi-annually on their performance improvement projects. The EQR validates the PIHP's methodologies for conducting the projects. Results of the MDCH performance improvement project reports are shared with MDCH **BHDDA** Management Team and with the QIC **that meets every other month to review the outcomes of monitoring various aspects of the quality strategy.** Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

3. Medicaid Services Verification

PIHPs are required to develop and maintain a system for verifying that Medicaid-funded services identified in the plan of service were actually rendered. PIHPs submitted their plans for the Medicaid verification system to MDCH for initial approval in 2001 and are periodically asked to resubmit their methodologies. PIHPs report to MDCH annually on the results of their Medicaid verification systems.

4. Credentialing Policy

The External Quality Review Organization, Health Services Advisory Group, recommended that MDCH develop a state level credentialing policy. That was done and attached to the FY 2007 amendment to the MDCH/PIHP contract. The policy is in Attachment A.III.1.b

IV. EXTERNAL QUALITY REVIEW

For FY'12 and FY'13 MDCH will continue to contract with Health Services Assessment Group (HSAG) to conduct the EQR. The BBA compliance monitoring portion of the EQR consists of desk audits of PIHP documents and also includes either a two-day on-site visit or telephone conference with each PIHP. The decision to conduct an on-site review versus a telephone conference is based on past PIHP performance on the EQR BBA compliance monitoring reviews.

The contents of the review for **FY'12-13** are:

- a. Validation of Performance improvement projects:
 - i. For **FY'12-13**, the EQR will focus on the methods PIHPs employed to implement the MDCH-required project –**Increasing the proportion of Medicaid eligible adults with mental illness who receive at least one peer-delivered service or support. The PIP validation process included reviews of the following activities:**
 1. **Choosing the study topic**
 2. **Defining the study questions**
 3. **Selecting the study indicators**
 4. **Using a representative and generalized study population**
 5. **Using sound sampling methods**
 6. **Using valid and reliable data collection procedures**
 7. **Including improvement strategies and implementing interventions**
 8. **Describing data analysis and interpreting study results**
- b. Validation of performance indicators:
 - i. **In FY'12-13 EQR will look at data collection methods for all fifteen performance indicators and perform an ISCAT.**
 - ii. **EQR will review the results for each indicator and note areas for improvement and areas of strength for each PIHP.**
- c. Compliance with Michigan's Quality Standards per BBA:
 - i. **In FY'12-13 the EQR will focus on reviewing compliance with the following standards:**
 1. **QAPIP and Structure**
 2. **Performance measurement and improvement**
 3. **Practice guidelines**
 4. **Staff qualification and training**
 5. **Utilization management**
 6. **Customer services**
 7. **Recipient grievance process**
 8. **Recipient rights and protections**
 9. **Subcontracts and delegation**
 10. **Provider networks**
 11. **Access and availability**
 12. **Coordination of care and care management**
 13. **Psychiatric advanced directives**
 14. **Service authorization and appeals**
 15. **Credentialing**

- ii. In FY'13, the EQR will focus on following up on any problems identified in the FY'12 review cycle.
- d. In FY'12 the EQR will conclude its optional activity to study SMI-DD Coordination of Care/Medical Service Utilization.

Results of the EQRs are shared with MDCH BHDDA Management Team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

V. MDCH ON-SITE REVIEW OF PIHPs:

MDCH conducts comprehensive biennial site visits to all PIHPs. During the alternate years PIHPs are visited by state staff to follow up on implementation of plans of correction resulting from the previous year's comprehensive review. The comprehensive reviews include the following components:

A. Clinical Record Review

Reviews of clinical records to determine that 1) person-centered planning is being utilized; 2) **access to and information about independent facilitation of person-centered planning is made available**; 3) **access to, information about, and supports for self-determination, including individual budgets, is made available**; 4) health and welfare concerns are being addressed if indicated; 5) services identified in the plan of service are being delivered; and 6) delivery of service meet program requirements that are published in the Medicaid Provider Manual. Random samples of clinical records to be reviewed are drawn by the MDCH review. Limited advanced notice is provided to PIHPs about the records **that MDCH has** selected for review. An additional set of randomly selected records is requested without advance notice after the team has arrived on-site. Scope of reviews includes all Medicaid state plan and 1915(b)(3) services, and waiver programs, all affiliates (if applicable), a sample of providers, and an over-sample of individuals considered "at risk" (persons in 24-hour supervised settings and those who have chosen to move from those settings recently).

B. Administrative Review

The comprehensive administrative review focuses on policies, procedures, and initiatives that are not otherwise reviewed **through the EQR or accreditation reviews, if applicable**, and that need improvement as identified through the performance indicator system, encounter data, grievance and appeals tracking, sentinel event reports, and customer complaints. Areas of the administrative review focus on MDCH/PIHP contract requirements and include:

- o Compliance with the Medicaid Provider Manual
- o Written agreements with providers, community agencies
- o The results of the PIHPs' annual monitoring of its provider network
- o Adherence to contractual practice guidelines
- o Sentinel event management

C. Consumer/Stakeholder Meetings

During the biennial comprehensive review, the team meets with a group of consumers, advocates, providers, and other community stakeholders to determine the PIHP's progress to implement policy initiatives important to the group (e.g., person-centered planning, self-determination, employment, recovery, rights, customer services); the group's perception of the involvement of beneficiaries and other stakeholders in the QAPIP and customer services; and the PIHP's responsiveness to the group's concerns and suggestions.

D. Consumer Interviews

Review team members conduct interviews with a sample of those individuals whose clinical records were reviewed, using a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-centered planning, independent facilitation of person-centered planning, self-determination arrangements and individual budgets, access to transportation, psychiatric advanced directives, and satisfaction with services. Interviews are conducted where consumers live and in a variety of other locations including PIHP offices, service sites or over the telephone.

A report of findings from the on-site reviews with scores is disseminated to the PIHP with requirement that a plan of correction be submitted to MDCH in 30 days. Reports on plans of correction are submitted to MDCH. On-site follow-up is conducted the following year or sooner if non-compliance with standards is an issue. Results of the MDCH on-site reviews are shared with MDCH BHDDA Management Team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

Overall PIHP site review responsibility is located in the Division of Quality Management and Planning. The PIHP site review team is currently composed of MDCH **professional staff who include** nurses, social workers, analysts, and individuals who have a mental illness and meet the qualifications for, and are employed as, state civil servants. The Office of Mental Health Services to Children and Families provides additional staff to conduct the portion of the review that focused on the Children's **Home and Community Based Waivers**.

VI. DATA SUBMISSION AND ANALYSES

A. Performance Indicators

Medicaid performance indicators measure certain aspects of performance of the PIHPs. The specific Medicaid performance indicators (listed in Attachment A.III.1.c) have been extracted from the more comprehensive Michigan Mission-Based Performance Indicator System that has evolved since 1997 based on adoption of core indicators by national organizations or federal agencies (e.g., Center for Mental Health Services and Center for Substance Abuse Treatment). The performance indicators were revised in 2005 by the QIC. The indicators are categorized by domains that include access, adequacy, appropriateness, effectiveness, outcomes, prevention, and structure/plan management.

Indicators are used to alert MDCH management of systemic or individual PIHP issues that need to be addressed immediately; to suggest that there are trends to be watched; to monitor contractual compliance; and to provide information that the public wants and needs. Most of the information used in these indicators is generated from the encounter and QI data located in the MDCH data warehouse. Any data that are submitted by PIHPs, and the methodologies for doing so, are validated **through** the EQR. Analyses of the data result in comparisons among PIHPs and with statewide averages. Statistical outliers are determined for the identification of best practices or conversely, opportunities for improvement. Those entities found to have negative statistical outliers in more than two consecutive periods are the focus of investigation, leading up to PIHP contract action. Technical information from the performance indicators is shared with the PIHPs; user-friendly information is shared with the public using various media, including the MDCH web site. Results of the performance indicators are shared with MDCH **BHDDA** Management team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements. *February 6, 2013 note: This same process noted above is used to collect and analyze data for the Habilitation Supports Waiver performance measures, and will be used for the performance measures required by the State Plan Amendment(i) for the Autism benefit.*

B. Encounter and Quality Improvement Data

Demographic characteristics as well as summary encounter data have been reported to MDCH annually for each mental health service recipient since the early 1990s. Individual level demographic data and admission and discharge records for persons receiving substance abuse treatment services have been collected by MDCH since 1980. Beginning in FY'03, individual level encounter data were reported electronically in HIPAA-compliant format each month for all services provided in the previous month and for which claims have been adjudicated. "Quality improvement" or demographic data were also reported monthly for each individual. **Beginning in FY'11, PIHPs began reporting on certain individual-level health conditions (e.g., obesity, diabetes) for all populations served, and an expanded version of developmental disabilities characteristics in order for MDCH to know what beneficiaries are most vulnerable and to be able to compare that information with service utilization.** Data are stored in the MDCH data warehouse where Medicaid Health Plan and Pharmacy encounter data are also stored. MDCH **BHDDA** staff with access rights to the warehouse analyze mental health, substance abuse, pharmacy and health plan data to evaluate appropriateness of care, over- and under-utilization of services, access to care for special populations, and the use of state plan service versus 1915(b)(3) services.

Aggregate data from the encounter data system are shared with MDCH **BHDDA** Management Team, the Encounter Data Integrity Team (EDIT), and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

C. Medicaid Utilization and Net Cost Data

PIHPs are required by contract to submit Medicaid Utilization and Net Cost Reports annually. The cost reports provide numbers of cases, units, and **total Medicaid** costs for each covered service provided by PIHP. The report also includes the total Medicaid managed care administrative expenditures and the total Medicaid expenditures for the PIHP. This data enables MDCH to crosscheck the completeness and accuracy of the encounter data. Cost data are shared with MDCH BHDDA Management Team, the EDIT, with the State's actuary, and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

D. Event Reporting System

The Event Reporting System captures information on five specific reportable events: **suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrest of consumer.** The populations on which these events must be reported differs slightly by type of event. For example, suicides and non-suicide deaths must be reported for a broader population (any consumer who is actively receiving services) than emergency medical treatment due to injury or medication error (consumers residing in specialized residential settings, child caring institutions, and consumers receiving Habilitation Supports Waiver, Children's Waiver, or SED Waiver services). This system was designed to replace the Department's previous sentinel event reporting process as well as a separate death reporting process.

PIHPs were contractually required to report events into the system beginning October 1, 2010.

The Department implements formal procedures for analyzing the event data submitted through this system. This includes criteria and processes for Department follow-up on individual events as well as processes for systemic data aggregation, analysis and follow-up. Information will also be used by the Department to take contract action as needed or to make recommendations for system improvements.

Note: Sentinel events involving persons who receive Targeted Case Management, or are enrolled in the Habilitation Supports Waiver, or live in 24-hour specialized residential settings, or live in their own homes receiving ongoing and continued personal care or community living supports services are reported, reviewed, investigated and acted upon at the local level by each PIHP or its delegated agent. Sentinel events include, but are not limited to: death of the recipient, any accident or physical illness that requires hospitalization, incidents that involve arrest or conviction of the recipient, emergency physical management interventions used for controlling serious

challenging behaviors and medication errors. MDCH reviews each PIHP's sentinel event process during its biennial visit.

Michigan law and rules require the mandatory reporting of the issues above to the Adult Foster Care Licensing Division of MDHS within 48 hours for **adults** in licensed residential settings (**and for children in foster care, 24 hours**), and to the CMHSPs' Office of Recipient Rights for all others. There is specific language in law to establish the duty to report to law enforcement suspected abuse and neglect. The reporting of sentinel events is the primary responsibility of residential workers for persons in licensed settings, and case managers or supports coordinators for all others. This information is reviewed for trends, and becomes a focus of the on-site visitation conducted by MDCH to PIHPs.

Aggregate data are shared with MDCH **BHDDA** Management Team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

E. Recipient Rights

Local CMHSP offices of recipient rights report semi-annually summaries of numbers of allegations received, number investigated, number in which there was an intervention, and the numbers that were substantiated. The summaries are reported by category of rights violations, including: freedom from abuse, freedom from neglect, rights protection systems, admission/discharge/second opinion, civil rights, family rights, communication and visits, confidentiality, treatment environment, suitable services, and treatment planning. An annual report is produced by the state Office of Recipient Rights and submitted to stakeholders and the Legislature. Data collection improvements will distinguish Medicaid beneficiaries from other individuals served. This information is aggregated to the PIHP level where affiliations of CMHSP exist. Aggregate data are shared with MDCH **BHDDA** Management Team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

G. Administrative Cost Report

In FY'10 MDCH developed and implemented a uniform administrative cost report requirement for identifying and reporting the administrative costs associated with managing this and all other Medicaid waivers within the Mental Health and Substance Abuse administration. The methodology as reported for the previous waiver cycle was revised for FY09 reporting to: consistently apply the same administrative function definitions across the various waivers and funds administered by MDCH; to be consistent with the managed care administrative functions which are: quality management; customer services; utilization management; provider network management; information systems management; financial management and general management.

All PIHP cost allocation methodologies must be consistent with OMB Circular A-87 requirements and the annual compliance exam tests for compliance. Reports are due annually to MDCH and reviewed for: compliance exam findings; reasonableness and consistency with other financial reports. For reporting integrity and consistency, training is provided and a workgroup is charged with identifying ways to present the information such as conference panel discussion and mentor across PIHPs. Annual training on preparation of the report is available.

VII. FINGER TIP REPORTS

Performance information on the 18 PIHPs is published in a series of summary tables that include **such things as:** expenditures of Medicaid funds, service utilization, MDCH site review scores, external quality review scores, , reporting timeliness, and Medicaid performance indicators. The information is used internally by MDCH for **tracking, trending, follow-up, policy development** and decision-making. **PIHPs and their provider networks use the information for benchmarking. The general public can access the information** on the MDCH web site at www.michigan.gov/mdch click on Mental Health and Substance Abuse, the Mental Health and Developmental Disabilities, then Statistics and Reports.

VIII. STATE WIDE SURVEY

An annual statewide consumer satisfaction survey is conducted of adults with mental illness using the Mental Health Statistics Improvement Program (MHSIP) 44-item adult questionnaire and the 26-item MHSIP Youth Services Survey for families of children with serious emotional disturbance. Michigan uses a convenience sample of individuals who receive services during one month of the year

VIII. MENTAL HEALTH SYSTEMS TRANSFORMATION

In 2009 MDCH issued an Application for Renewal and Recommitment (ARR) that solicited responses from the 18 PIHPs on how they planned to improve their services systems in eleven topic areas¹. Since then, teams of MDCH staff meet regularly with the PIHPs, mostly via telephone, to discuss progress on achieving their goals. This quality improvement effort will be continued during the upcoming waiver period. Most PIHPs have incorporated their QI activities into their Quality Assessment and Performance Improvement Programs.

Creating a “Culture of Gentleness” has been an ongoing training effort to improve the skills of direct care workers and their supervisors in their support of people with developmental disabilities who have behaviors that put themselves or others at risk of harm. Since this initiative began two years ago, over 2,700 staff have been

¹ Topic areas are partnering with stakeholders in design, delivery and evaluation of services, improving the culture of the system of care, assuring active engagement of the people served, supporting maximum consumer choice and control, expanding opportunity for integrated employment, treatment for people in the criminal justice system, assessing needs and managing demand, coordinating and managing care, improving, the quality of supports and services, developing and maintaining a competent workforce, and achieving administrative efficiencies,

trained. The results have been positive: of the 120 people with developmental disabilities who had previously resided in the ICF/MR unit at the Mt. Pleasant Regional Center, those who went to small homes with staff trained in culture of gentleness approaches have been successful in their communities. For the upcoming waiver period, MDCH intends to expand the training in order to build statewide capacity of trained workers.

MDCH requires PIHPs and their provider networks to promote and support family-driven and youth-guided practice at the child and family level, system level and peer-delivered level.

XI. CONTRACT COMPLIANCE REVIEW AND ACTION

The controlling document to assure that quality mental health and substance abuse services will be maintained is the contract between the MDCH and the PIHPs. The contract includes specific language regarding issues of general compliance, the compliance review process, and the dispute resolution process. Specific language allows for emergency reviews by MDCH whenever there is an allegation of fiscal impropriety, or endangerment of health and safety of beneficiaries. The contracts make clear that MDCH may utilize a variety of remedies and sanctions, ranging from the issuance of a corrective action plan to withholding payment to contract cancellation.

IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document *Guidance for State Suicide Prevention Leadership and Plans* available on the SAMHSA website at [here](#).

Footnotes:

DRAFT

S. Suicide Prevention

The Suicide Prevention Plan for Michigan was released in 2005 by The Michigan Association for Suicide Prevention (MASP). It reflects the input of dozens of people from across the state, and incorporates some of the work from the state's first effort in the 1990s at developing a plan. It is based on the most valid information we now have about how to reduce suicide deaths and attempts using a community-based, public health approach.

Six years into the implementation of *The Suicide Prevention Plan for Michigan*, two statewide surveys were completed and were attempting to assess the implementation successes, identify the gaps, and make recommendations for moving the plan forward. MASP realized after a period of time that their work was lacking concrete data with which to make recommendations. In November 2011, MASP commissioned ReFocus, L.L.C. to conduct a data based evaluation of the plan. This result of this effort was released on May 1, 2012, in the *Suicide Prevention Plan for Michigan Evaluation*.

MDCH staff has worked with MASP regarding the evaluation of the plan, the Suicide Prevention Community Conference (October 2012) and other training activities. In early 2013, work on revising *The Suicide Prevention Plan for Michigan* began with a review of the activities of last year and the evaluation and what it tells us. Decisions were made to work on education for males ages 22-45 whose death rate is very high. One of the MASP members will be facilitating discussion of the plan revision. At the time of this writing, there is no completion date.

***SUICIDE
PREVENTION
PLAN***

for
MICHIGAN

2005

Developed by the
Michigan Suicide Prevention
Coalition



One Year Later

I've Learned

Someone you know and love can be hurting very badly without your knowledge

That life can be tough even when you are faithful

That most people don't know how to help you grieve

Hell can exist on earth

That you can pray daily for someone yet, in the end, their choice prevails

Grief can overtake you ... but only temporarily

That everyone grieves differently

That witnessing others grieve is almost more painful than your own hurt

That silence is the most wicked sound I have ever heard

Goodbyes can be hard but they are far easier than no goodbye

That with faith, family, friends and inner strength one can survive anything

and everything

Elly, 2004

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We present this plan with pride, fervent hope, and belief that—with the initiation of the actions set forth in this plan—Michigan’s families, schools, neighborhoods, workplaces, and communities will be spared the tragedy and grief of suicide.

Michigan Suicide Prevention Coalition

INTRODUCTION

MICHIGAN NEEDS A SUICIDE PREVENTION PLAN...

Suicide is preventable, yet suicide trends in Michigan are headed in the wrong direction. From 2001 to 2002 alone, the state moved up six spots—from 38th to 32nd—in the rate of suicides in the population when compared to the other states. As we learn more about what communities can do to prevent suicides, it is time for our state to adopt a comprehensive suicide prevention strategy that offers the hope of reducing the number of suicides in Michigan by at least 20% in the next five years.

At one time, the State of Michigan was at the forefront of suicide awareness. Michigan's legislature, following the lead of the U.S. Congress, in 1997 and 1998 approved two resolutions (SR77 and HR374) recognizing suicide as "a serious state and national problem, and encouraging suicide prevention initiatives" (see Appendix A). This state action contributed to the groundswell of ongoing work in this nation to reduce the toll of suicide deaths and attempts.

The Michigan Department of Community Health (MDCH) responded to the state resolutions by forming a work group to begin drafting a state suicide prevention plan. Work continued until the end of 2000, but the group was unable to complete a plan before it became inactive. Michigan communities also responded. Small, community-based groups have addressed suicide in a number of ways, but the work is often fragmented, and has had little impact on overall state suicide rates.

The publication of the National Strategy for Suicide Prevention¹ in 2001 renewed efforts by states to develop their own suicide prevention plans, which are also a prerequisite to access Federal suicide prevention funding. Elsewhere in the nation, 24 state task forces and coalitions now have approved state plans.

In every year since the Michigan legislature approved the suicide prevention resolutions, more than 1,000 Michigan residents have died by suicide. And, each year, an estimated 25,000 more make attempts that often require medical intervention and which can result in short and long-term disability.

Almost five times as many suicides occur each year in this state as deaths from HIV/AIDS, and over one and a half times more suicides than homicides take place annually. In those startling statistics, Michigan is not alone—our experience mirrors the nation's.

It is past time for Michigan to construct, approve, and begin implementation of a

Suicide Facts²

Most suicides are preventable with appropriate education, awareness and intervention methods.

For every suicide death, there are an estimated 25 attempts.

Elderly are the highest risk group per capita.

For youth, suicide is the 3rd leading cause of death.

More than 90% of people who die by suicide have a diagnosable mental disorder present.

Firearms are the most frequent method used.

coordinated, effective, and proven approach to reducing suicide deaths and attempts, using the National Strategy as a blueprint.

The Michigan Suicide Prevention Coalition (MiSPC), which formed in October 2003, has taken on the task. Our broad-based membership includes public and private organizations and agencies, foundations, individuals involved in suicide prevention, survivors (those who have lost a loved one to suicide), and professionals from around the state (see Appendix B). We have used our combined experience with survivorship, advocacy, and service to present an honest and critical assessment of what prevention efforts in Michigan require.

At a time when there are limited resources and funds available for suicide prevention, it is imperative that Michigan's suicide prevention community works in a collaborative way—with the support of state government and agencies—to implement best practices statewide. The first step is development of this plan and its acceptance by key state officials.

MiSPC members are very aware of the scarcity of state resources to initiate and support new programs. However, coalition members strongly feel that there are steps set forth in this plan that can be undertaken and accomplished with little or no new monetary resources. Successful initiation of the objectives in this plan will build a strong foundation for future efforts and place the State of Michigan and its communities in an excellent position to capitalize on upcoming opportunities for federal funds.

The following plan addresses the major public health problem of suicide for all of Michigan's residents, regardless of age, gender, economic or social background. This broad-based approach is necessary in light of the state's suicide statistics:

<i>Did You Know</i>	
U.S. Deaths in 2002 ³	
Suicide:	31,655
Homicide:	17,638
HIV/AIDS	14,095

- Suicide is the third leading cause of death for 15 to 19 year-olds; and the second leading cause of death for college age young people;⁴
- Like the rest of the nation, the largest number of suicide deaths occurs among our workforce, primarily men ages 25– 64.;⁵
- And the highest rate (measured in number of suicides per 100,000 population) is among our oldest residents.⁶

There are many at-risk populations within Michigan and the nation. This plan is meant to encompass all of these populations and address suicide risk across the lifespan. However, it does not include specific objectives for each special population. We continue to seek new and emerging practices that have potential for inclusion in future versions of this plan. The focus of this initial version is on building the infrastructure necessary to support prevention efforts across the state and on assisting communities in developing and initiating their own action plans. Every effort was made to assure that the strategy is:

- prevention-focused
- public health focused
- built on data, research, and best practices
- appropriate for community-based mental and public health systems

As with any plan that puts community-based collaboration, coordination, and intervention at its heart, the following assumptions have been made concerning recommendations involving local efforts:

- much of the final planning and execution must occur at the local level;
- all tools and protocols must be appropriate for the local community and its diverse members;
- there should be uniform messages and language across all activities, across all locations, and across all priority groups;
- only the local communities themselves can establish what their priorities will be; and
- all prevention programs and interventions must be delivered in appropriate ways given the specific community and its diversity

In addition to effective implementation, it is essential that we systematically track and evaluate our progress toward goals. This will enable us to provide accurate feedback to government leaders, policy makers, organizations, advocates, and all those involved in implementation of the Michigan Plan for Suicide Prevention. It will also provide the information needed to revise objectives over time, enabling the Michigan Plan to evolve as goals are reached and new “best practices” information becomes available. Thus, in keeping with recommendations described in the National Strategy, all objectives in the Michigan Plan include measurable outcomes or targets that specifically identifying what is to be achieved. All objectives in the Michigan Plan indicate the “data source” for monitoring progress, and one set of objectives is dedicated solely to improving and expanding state surveillance systems related to suicide prevention, so the best possible data for the state is available.

The primary goals of the Michigan Plan for Suicide Prevention are to increase awareness across the state, to develop and implement best clinical and prevention practices, and to advance and disseminate knowledge about suicide and effective methods for prevention. There is full recognition that the goals and objectives overlap and contribute to a unified, integrated, and coordinated effort. Furthermore, given the ongoing research and evaluation of suicide prevention programs and strategies, we can expect this plan to change and evolve as knowledge is advanced and best practices emerge.

We Present ...

Michigan’s Suicide Prevention Plan reflects the input of dozens of people from across the state, and incorporates some of the work from the state’s first effort in the 1990s at developing a plan. It is based on the most valid information we now have about how to reduce suicide deaths and attempts using a community-based, public health approach.

SUICIDE AS A PUBLIC HEALTH PROBLEM IN THE UNITED STATES

Suicide has been one of the leading causes of death in the United States for decades. Rates of suicide have been relatively constant over the last sixty years, although the last decade shows some encouraging, but modest, decline in rates (see Table 1). Still, the nation experiences more than 30,000 suicide deaths each year, and an estimated 750,000 attempts⁷. The U.S. Centers for Disease Control and Prevention says that suicide is under-reported. The cost in terms of pain and suffering, loss of life, medical payouts and lost productivity, and the impact upon the survivors of suicide, is immeasurable.

Survivors

- *It is estimated that each suicide death intimately affects at least six other people.*
- *Based on the more than 745,000 suicides from 1978 through 2002, there are at least 4.47 million survivors in the U.S. (1 of every 64 Americans in 2001).*
- *In 2002 alone, that number grew by nearly 190,000.*
- *There is a suicide—and six new survivors created—every 16.6 minutes.*

• IMPACT

Suicide's impact in the nation and in our state is enormous, whether measured in numbers of deaths, attempts, economic and medical benefit costs, or the devastation to survivors—people who have lost someone close to them to suicide. Edwin Schneidman, founder of the American Association of Suicidology, has stated that the worst thing about suicide is the impact on loved ones, as the “suicidal person puts their psychological skeleton into the closet of the minds of survivors forever. It is a bitch to have there.”

• RISK FACTORS

While suicide is closely correlated with mental illnesses (studies indicate that in well over 90% of all suicide deaths, there is a diagnosable and treatable illness of the brain present^{8,9}), there

are other risk factors that contribute to suicide deaths and attempts as well. For example, elderly persons are the highest risk population age group for suicide, and frequency of suicide tends to increase with age (see Table 2). In general terms, the highest demographic risk group of non-institutionalized Americans is elderly white males, living alone, with a diagnosable and treatable mental illness and a substance abuse problem.

Those incarcerated in jails are one of the populations at highest risk for suicide in the United States with rates of 54 per 100,000^a (the national average is less than 12 per 100,000). Another very high risk group are gay, lesbian, and bisexual (GLB) youth. Studies have shown that GLB youth have suicide attempt rates of 3.6-7.1 times higher than their heterosexual peers^{10,11}. There are multiple other groups at elevated risk for suicide across the life span. Untreated or under-treated depression is highly correlated with suicide. Around a third of those who die by suicide have an identifiable diagnosis of clinical depression at the time of death. Other mental illnesses also are associated with increased risk including, among others, schizophrenia, bi-polar disorder,

^a Calculated from data available in: Stephan JJ. *Census of Jails, 1999* (NCJ 186633). Washington, D.C.: U.S. Dept. of Justice, Bureau of Justice Statistics, 2001.

Table 1. US Suicide Rates, 1993–2002
(rates per 100,000 population)

Age/Group	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
5-14	0.9	0.9	0.9	0.8	0.8	0.8	0.6	0.8	0.7	0.6
15-24	13.5	13.8	13.3	12.0	11.4	11.1	10.3	10.4	9.9	9.9
25-34	15.1	15.4	15.4	14.5	14.3	13.8	13.5	12.8	12.8	12.6
35-44	15.1	15.3	15.2	15.5	15.3	15.4	14.4	14.6	14.7	15.3
45-54	14.5	14.4	14.6	14.9	14.7	14.8	14.2	14.6	15.2	15.7
55-64	14.6	13.4	13.3	13.7	13.5	13.1	12.4	12.3	13.1	13.6
65-74	16.3	15.3	15.8	15.0	14.4	14.1	13.6	12.6	13.3	13.5
75-84	22.3	21.3	20.7	20.0	19.3	19.7	18.3	17.7	17.4	17.7
85+	22.8	23.0	21.6	20.2	20.8	21.0	19.2	19.4	17.5	18.0
Total	12.1	12.0	11.9	11.6	11.4	11.3	10.7	10.7	10.8	11.0
Men	19.9	19.8	19.8	19.3	18.7	18.6	17.6	17.5	17.6	17.9
Women	4.6	4.5	4.4	4.4	4.4	4.4	4.1	4.1	4.1	4.3
White	13.1	12.9	12.9	12.7	12.4	12.4	11.7	11.7	11.9	12.2
Non-white	7.1	7.2	6.9	6.7	6.5	6.2	6.0	5.9	5.6	5.5
Black	7.0	7.0	6.7	6.5	6.2	5.7	5.6	5.6	5.3	5.1

Table 2. Suicides in the United States, 2002

	<u>Number</u>	<u>Avg./day</u>	<u>Rate</u>	<u>% of all deaths</u>
<i>Nation</i>	31,655	86.7	11.0	1.3
<i>Males</i>	25,409	69.6	17.9	2.1
<i>Females</i>	6,246	17.1	4.3	0.5
<i>Whites</i>	28,731	78.7	12.2	1.4
<i>Non-whites</i>	2,924	8.0	5.5	0.9
<i>Blacks</i>	1,939	5.3	5.1	0.7
<i>Native Americans</i>	324	0.8	10.5	---
<i>Asians/Pacific Islanders</i>	661	1.8	5.2	---
<i>Elderly (65+ years)</i>	5,548	15.2	15.6	0.3
<i>Young (15-24 years)</i>	4,010	11.0	9.9	12.1

some anxiety disorders, and borderline personality disorder.^{8,9} Co-morbidity with other psychiatric diagnoses is known to increase risk for suicide.

While there are well demonstrated biological, psychological, and sociological factors that contribute to suicide, a very complex tapestry of factors lead up to death by suicide. Schneidman concludes that “regardless of biology, diagnosis, or demographics, the experience of those who suicide is that they are trying to solve problems that cause them intolerable psychological pain ... they don’t want to die, they want the pain they feel to stop.”

*Encompass'd with a thousand dangers,
Weary, faint, trembling with a thousand terrors ...
I ... In a fleshy tomb, am buried above ground*
William Cowper (1731-1800)

• PREVENTION

While there are few research based suicide prevention programs that are proven to reduce suicidal behaviors, several are worth noting. Approaches that utilize integrated suicide prevention efforts that include education, increased identification and referral, increased access to care, reduction of stigma, and the application of effective clinical interventions have been shown to reduce deaths and attempts and are promising for the future. A major United States Air Force study¹² and multiple school evaluations have demonstrated positive results at the community level. Other major studies are currently underway to evaluate and replicate programs with potential. One-time and isolated prevention efforts may have some value, but have not demonstrated sustainable positive impact on suicide behaviors. Recent evidence suggests that effective suicide prevention programs also reduce other violent behaviors. Some interventions have shown promise for the treatment of depressed, despondent or suicidal individuals; however, major efforts are necessary to implement quality care throughout the healthcare delivery system from general medical practice to professional mental health practices. Standards of care for the treatment of disorders with high suicide risk are not clearly defined, disseminated, or widely practiced across the nation.

*Thank you to that wonderful woman who kept me on the line long enough
to get help to me. If it had not been for her, I would not be here today.
She gave me back my life. There is no way to put into words when
Someone has saved your life.*
Anonymous – letter to a crisis line

• MEANS OF DEATH

In the U.S., the method used in more than 50% of suicide deaths is firearms. The 2002 data Table 3 is consistent with data over the past decade. Some studies have demonstrated that voluntary removal of firearms from homes of persons at risk has a positive impact on suicide rates and that substitution of methods does not necessarily occur.

Table 3. Suicide Methods, United States, 2002

<i>Suicide Method</i>	<i>No.</i>	<i>Rate</i>	<i>% of total</i>
Firearms	17,108	5.9	54.0
Suffocation/Hanging	6,462	2.2	20.4
Poisoning	5,486	1.9	17.3
Falls	740	0.3	2.3
Cut/Pierce	566	0.2	1.8
Drowning	368	0.1	1.2
Fire/burn	150	0.1	0.5
All other	775	0.3	2.5
Total	30,622		100.0

DRAFT

SUICIDE AS A PUBLIC HEALTH PROBLEM IN MICHIGAN

Did You Know?

At least 6,108 people became suicide survivors in Michigan in 2003

Did You Know?

Michigan Deaths In 2003¹³

Suicide 1,018

Homicide 644

HIV/AIDS 237

What is a public health problem? It is anything that affects or threatens to affect the overall health and well-being of the public. Compared to causes of death such as heart disease or cancer, suicide as a manner of death is a relatively rare event. And yet, on average, more than 1,000 Michigan residents take their lives each year (see Table 4). This makes suicide the tenth leading cause of death in the state for 2003. For some groups, such as white males ages 10-34 years, suicide is the second or third leading cause of death. In this state, suicide is among the top five leading causes of years of potential life lost below age 75^{b,14}.

Suicide rates, methods, risk factors and at-risk populations in Michigan closely parallel national trends and statistics (see Figure 1). Annual estimated economic costs^c associated with completed and attempted suicide in Michigan are over \$1.1 billion annually¹⁵.

The average annual suicide rate^d for the state has remained relatively flat for more than a decade. Men account for 81% of suicides deaths in Michigan. The highest average annual suicide rate per capita (38.5 per 100,000) is actually among white males ages 75 and older. Other groups of men with high rates are black males ages 30-34 (26.7/100,000), and white males ages 35-54 (24.9/100,000), 25-29 (23.7/100,000), 65-74 (23.7/100,000), and 30-34 (23.2/100,000). The lowest suicide rates are among black women, who have an average annual rate of 2.2 per 100,000 persons.

An analysis of the 2003 Michigan Youth Risk Behavior Survey data found that 18% of Michigan's 9th-12th graders seriously considered attempting suicide at some point during the 12 months preceding the survey¹⁶. More than one out of every ten students indicated they actually attempted suicide during that time. The number of young people in the state who die by suicide increases dramatically over the adolescent years (see Figure 2).

^b The number of years of potential life lost is calculated as the number of years between the age at death and 75 years of age for persons who die before age 75.

^c Estimated medical costs plus estimated costs of work loss.

^d Rates are the number of deaths per 100,000 persons in a specified group.

Table 4. Average Annual Number of Suicides By Age, Race, and Sex, Michigan Residents, 1999-2002⁵

Age	White			Black			Other			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
10-14	6	3	8	1	0	2	-	-	-	7	3	10
15-19	41	7	48	6	1	7	2	1	3	49	9	58
20-24	56	9	64	10	1	11	2	1	2	67	10	77
25-29	59	12	71	10	2	12	3	1	3	71	14	85
30-34	65	12	77	13	2	16	1	0	1	80	15	94
35-44	164	46	210	16	5	20	3	1	3	182	52	234
45-54	142	38	181	10	4	14	1	1	2	153	43	196
55-64	73	23	95	3	1	4	1	1	1	77	24	101
65-74	61	11	71	4	1	5	1	1	2	65	12	77
75+	73	14	87	2	1	3	0	0	1	75	15	90
Total	738	174	911	75	17	91	12	6	18	826	196	1,021

Decedents with unknown race (n=5) not illustrated but included in totals.

Numbers in columns and rows may not total exactly due to rounding.

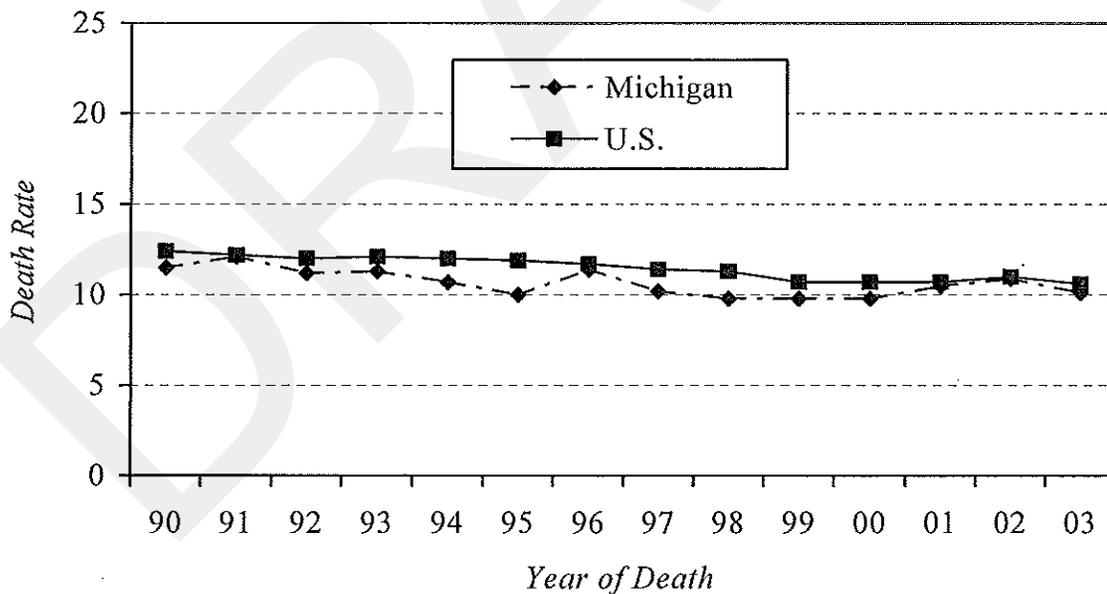


FIGURE 1. Suicide rates, Michigan and U.S. Residents, 1990-2003¹⁷

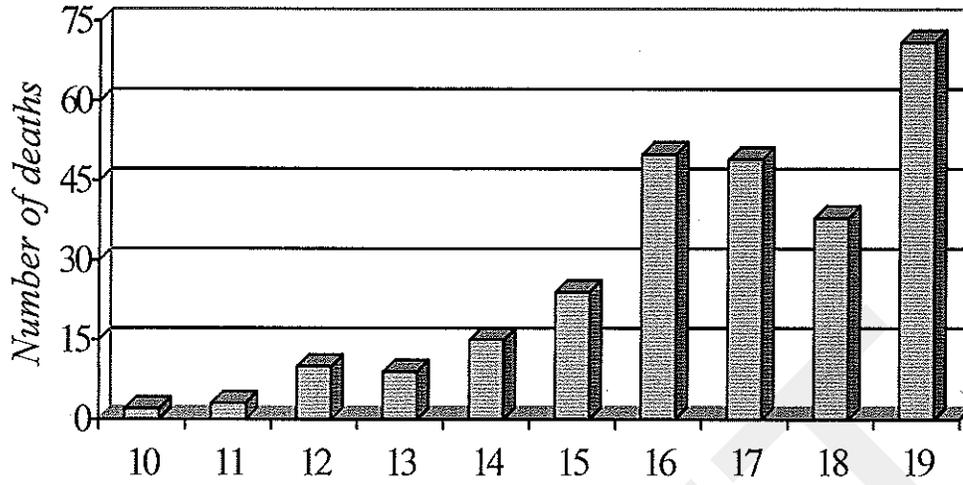


Figure 2. Adolescent suicide deaths, Michigan, 1999-2002¹⁸

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GOALS AND OBJECTIVES

The Michigan Plan addresses the problem of suicide with an integrated approach to suicide prevention over the lifespan. Based upon the preponderance of evidence in the suicide prevention field as well as that learned through other prevention activities, to be truly effective, any prevention program must be multi-modal, integrated, and widely accepted. By implementing this type of plan we will, over time, have an impact on the incidence of suicide in Michigan. The commitment of a wide diversity of organizations, government leaders at the state and local level, community leaders, private sector leaders and private citizens is needed to effectively implement this plan.

The plan's overarching goal (Goal #1) is to reduce the incidence of suicide attempts and death. The members of MiSPC feel that this will be best accomplished through increased awareness across the state, implementation of best clinical and prevention practices, and advancement and dissemination of knowledge about suicide and effective methods for prevention. Given the ongoing research and evaluation of suicide prevention programs, we can expect that this plan will change as knowledge is advanced and best practices emerge. The following categories are the general framework for planning and there is full recognition that the goals and objectives overlap and contribute to a unified, integrated and coordinated effort.

Goal #1

Reduce the Incidence of Suicide Attempts and Deaths Across the Lifespan

Objective 1.1 Reduce the number of suicide attempts among Michigan youth, a population for which we have baseline data

DATA SOURCE: Youth Risk Behavior Survey results and emergency services surveillance systems.

Objective 1.2 Reduce suicide deaths among Michigan populations, utilizing evidence-based best practices focused on the unique needs of each community.

DATA SOURCE: Michigan Department of Community Health vital records

AWARENESS

Broaden the Public Awareness of Suicide and its Risk Factors

Goal #2

Develop Broad Based Support for Suicide Prevention

- Objective 2.1** Identify and support a state-level management/leadership structure for oversight of the Michigan Suicide Prevention Plan.
- 2.1.1 Establish and staff an Office of Suicide Prevention (OSP) in Michigan. This Office should be embedded within the Michigan Department of Community Health with a reporting relationship to the Department Director in order to foster a collaborative, public/private partnership between the Department and the Michigan Suicide Prevention Coalition, as well as support collaboration across administrations and offices within MDCH.
 - 2.1.2 Within one year, establish a Michigan Suicide Prevention Advisory Council (Michigan SPAC) comprised of a broad coalition of public and private sector representatives to oversee the implementation of the Michigan Suicide Prevention Plan.

DATA SOURCES: State organizational chart, membership roster and record of meetings of the Michigan SPAC, record of MDCH and Michigan Suicide Prevention Coalition joint meetings. This objective will be evaluated jointly by the MDCH and the Michigan Suicide Prevention Coalition.

- Objective 2.2** Utilize the state's existing Community Collaboratives to take the lead to identify the appropriate leadership in each community to establish Local or Regional Suicide Prevention Coalitions and to seek broad and diverse participation at the local level. While the process can begin immediately, these coalitions should be established within 18 months.

DATA SOURCE: Membership rosters of Local or Regional Suicide Prevention Coalitions

- Objective 2.3** The OSP, in collaboration with local coalitions, will utilize broad based public-private support to blend resources of stakeholders in support of suicide prevention.

DATA SOURCE: Record of OSP initiatives involving public/private support for prevention strategies or programs

Objective 2.4 The OSP, in collaboration with local planning efforts, will utilize broad-based public-private support to seek additional funds for suicide prevention.

DATA SOURCE: Record of OSP collaborative initiatives that seek funding, and which result in funds for suicide prevention

Objective 2.5 The OSP will compile and make publicly available a Resource Directory that includes state and community reports referenced in the Plan.

DATA SOURCE: The Resource Directory and publicly available information on how it can be accessed.

Goal # 3

Promote Awareness and Reduce the Stigma

Objective 3.1 The OSP will develop, within its first year and by coordinating with public and private sectors and assisting in local efforts, a comprehensive plan to implement a state-wide campaign promoting awareness that suicide is a preventable public health problem that reaches all citizens in Michigan.

This would be followed in year two by implementation of at least one component of the comprehensive plan—a public awareness campaign that promotes the concept that suicide is preventable and that focuses on reducing the stigma of mental illness and improving help-seeking behaviors.

DATA SOURCES: Publicly available comprehensive state plan and Michigan SPAC report concerning the scope of the implemented public awareness component.

Objective 3.2 Within one year, the OSP, in partnership with the Michigan Association of Suicidology (MAS), the Michigan Chapter of the Suicide Prevention Action Network (SPAN), and other public and private entities, will expand participation in symposiums held within the state on suicide prevention.

DATA SOURCES: Number of symposiums throughout the state on suicide prevention, their geographic locations, attendance and program content.

Objective 3.3 The OSP, during year one, will assist with educating the media on their critical role in suicide prevention, including mental illnesses and substance abuse, and collaborate to ensure responsible media practices in the coverage of these topics. Use of the nationally recognized *Reporting on Suicide*:

Recommendations for the Media (U.S. Centers for Disease Control and Prevention) will be encouraged. OSP will assist with availability of curriculum for state journalism schools.

DATA SOURCE: Documentation of dissemination of media guidelines

Objective 3.4 Within one year, the Suicide Prevention Advisory Council will increase the awareness of policy makers by educating officials on the impact that suicide, mental illnesses, and substance abuse have on other policy areas, such as health care, law enforcement, and education.

DATA SOURCE: Documentation of dissemination of educational materials to policy makers.

Objective 3.5 Within two years, the OSP will identify and encourage the use of effective, best practices in prevention and awareness programs to mental health agencies, educational settings, law enforcement agencies, and other involved programs.

DATA SOURCE: Documentation of "best practices" information disseminated in regional and state conferences, workshops, etc.

Objective 3.6 Expand public awareness efforts that contribute to this goal and seek public and private partnerships to encourage help-seeking behaviors and to represent mental illnesses as diseases that are treatable.

DATA SOURCE: Reports from relevant state offices, the OSP, and the Michigan SPAC.

INTERVENTION

**Enhance Services and Programs, Both
Population Based and Clinical Care**

Goal #4

Develop and Implement Community-Based Suicide Prevention Programs

Objective 4.1 In each of the next five years, increase the number of local and/or regional suicide prevention collaboratives.

DATA SOURCE: Annual reports from OSP of Community Collaborative involvement.

Objective 4.2 Within the next two years, through collaboration and partnerships, increase the number of communities or counties that are implementing an evidence-based early intervention strategy for children who have experienced significant childhood trauma.

DATA SOURCE: Local and community data on program implementation gathered by Community Collaboratives and provided to OSP.

Objective 4.3 Encourage all communities to develop services for survivors of suicide and promote utilization of these services.

DATA SOURCES: Evidence that guidelines and technical assistance with provision of survivor services were made available to communities.

Objective 4.4 Within the next three years, the OSP and the Michigan Department of Education will partner to develop legislative proposals for state policy best practice guidelines that support schools in implementing and expanding evidence-based suicide prevention and response policies and programs.

4.4.1 Disseminate information to raise awareness among Michigan legislators, school administrators, educational associations, public and mental health advocacy groups, and parent groups regarding the impact of mental health on learning and lifelong health outcomes, and the role

of coordinated school health and safety programs in addressing mental health problems in schools.

- 4.4.2 Develop proposed policies for the State Board of Education that encourage coordinated, evidence-based suicide prevention and response policies and programs, identify the characteristics of effective suicide prevention and response strategies, and further the Board's existing policies on coordinated school health and safety programs.

DATA SOURCES: Documentation of stated policies, legislative proposals and outcomes; Michigan SPAC reports on each point.

Objective 4.5 Within two years, frame guidelines for evidence-based suicide prevention programming using a collaboration of school health partners, including the Michigan Departments of Education and Community Health, the Comprehensive School Health Coordinators Association, local school districts, community mental health agencies, Community Collaboratives, parent groups, suicide prevention advocacy groups, and others interested in the health and well-being of Michigan children and youth. The guidelines will be disseminated statewide to public and private education settings and will address objectives and resources for:

- Healthy environment and positive school climates that embrace the broad diversity of all youth and include sequential social-emotional skills curriculum addressing problem solving, help seeking, and decision making; physical and emotional safety for all students; proactive and positive school-wide discipline; and healthy and orderly physical environment
- Measures that decrease risk factors and enhance protective factors.
- Identification of students at-risk for suicide, including gatekeeper training for staff and students, screening, and peer support.
- Administrative issues, including policies and procedures, program support and maintenance, broad based diversity training, crisis response teams, evaluation of programs, duty, responsibility and liability
- Intervention strategies, involving school-community partnerships which facilitate referrals, 24 hour crisis response, and student re-entry support following a crisis
- Responding to a death by suicide, including to the needs of the school community and working with media – recommend using the CDC Guidelines for containment of suicide clusters and Guidelines for Media Coverage of Suicide.
- Family and community partnerships

- Dissemination to all Michigan Public and Private educational settings

DATA SOURCES: Record of collaboration (described above) in developing guidelines; and publicly available, comprehensive guidelines for evidence-based suicide prevention programming in schools

Goal #5

Promote Efforts to Reduce Access to Lethal Means and Methods of Suicide

- Objective 5.1** Within three years, the OSP working in collaboration with the appropriate professional organizations, will increase the proportion of primary care clinicians, other health care providers, and health and safety officials who routinely assess the presence of lethal means (including firearms, drugs, and poisons) in the home and educate about actions to reduce associated risks.

DATA SOURCE: Establish baseline data (OSP, the Michigan SPAC and/or Community Collaboratives) for at least one category of health provider, enabling an evaluation of outcomes for this group(s) within three years.

- Objective 5.2** Within three years, the OSP, in collaboration with local suicide prevention efforts, will assure that at least 50% of the households in the state are exposed to public information campaigns designed to reduce the accessibility of lethal means, including firearms, in the home.

DATA SOURCE: Record of penetration of public information campaigns

Goal #6

Improve the Recognition of and Response to High Risk Individuals Within Communities

- Objective 6.1** Utilize Community Collaboratives to identify the number of “gatekeepers” in their communities who are trained to recognize at-risk individuals and intervene.

- 6.1.1** Within three years, expand the number of gatekeepers.

DATA SOURCE: Community Collaborative reports about available gatekeepers in their areas.

As defined in the National Strategy for Suicide Prevention, key gatekeepers are those people who regularly come into contact with individuals or families in distress. They are professionals and others who must be trained to recognize behavioral patterns and other factors that place individuals at risk for suicide and be equipped with effective strategies to intervene before the behaviors and early signs of risk evolve further. Key gatekeepers include, but are certainly not limited to:

- Teachers and school staff
- School health personnel
- Clergy and others in faith-based organizations
- Law enforcement officers
- Correctional personnel
- Workplace supervisors
- Natural community helpers
- Hospice and nursing home volunteers
- Primary health care providers
- Victim advocates and service providers
- Mental health care and substance abuse treatment providers
- Emergency health care personnel
- Individuals and groups working with gay, lesbian, bi-sexual, and transgender populations
- Members of tribal councils and staff of health centers serving Native Americans in Michigan
- Persons working with isolated senior citizens
- Funeral directors

Objective 6.2 Within two years, the OSP and the Michigan SPAC will develop and disseminate a model for community “capacity assessment” for suicide prevention. This will include a template for resource identification. Its purpose will be to not only assist communities in identifying all available assets related to suicide prevention and intervention, but also any critical gaps and deficits.

DATA SOURCE: Documentation of dissemination of the model to communities.

Objective 6.3 Within one year the OSP and the Michigan SPAC will identify and distribute guidelines for suicide risk screening to primary care settings, emergency departments, mental health and substance abuse settings, senior programs, and the corrections system.

DATA SOURCE: Publicly available copies of materials and distribution lists

Objective 6.4 Within three years, the Michigan Department of Corrections will adopt and disseminate system wide policies and practices for suicide prevention in accordance with the American Correctional Association Standards for

Emergency Care and Training, or the National Commission on Correctional Health Care.

DATA SOURCE: Record of policies and practices for suicide prevention

Objective 6.5 Within three years, require that all state funded colleges and universities develop suicide prevention policies, and implement one or more prevention strategies patterned after evidence-based approaches

DATA SOURCE: Publicly available policy statement(s) and record of implemented strategies.

Objective 6.6 Within two years, require Community Mental Health programs to implement suicide prevention training for all direct service personnel. They will also adopt policies and practices for suicide prevention/intervention including identification, intervention, discharge, and tracking of outcomes.

DATA SOURCE: Record of training sessions and percentages of direct service personnel who participated; documentation of policies

Goal #7

Expand and Encourage Utilization of Evidence-based Approaches to Treatment

Objective 7.1 The OSP and the Michigan SPAC, in collaboration with the National Suicide Prevention Resource Center, will identify best practices for emergency departments and inpatient facilities that help ensure engagement in follow-up care upon a suicidal patient's discharge. The OSP and Michigan SPAC will disseminate this information.

DATA SOURCE: Provision of best practices documents and records of dissemination

Objective 7.2 Within 18 months, MDCH, in collaboration with the Michigan Association of Community Mental Health Boards, will assure that up-to-date evidence-based standards of care are distributed to the Public Mental Health/Substance Abuse system.

DATA SOURCE: Evidence of distribution

Objective 7.3 Within 18 months, MDCH, in collaboration with the Michigan Association of Community Mental Health Boards (MACMHB), will identify quality care/utilization management guidelines for effective response to suicidal risk or

behavior and assure that these guidelines are incorporated into the state managed care plan.

DATA SOURCE: Identification of guidelines and incorporation into the managed care plan

Goal # 8

Improve Access to and Community Linkages With Mental Health and Substance Abuse Services

Objective 8.1 MDCH, in collaboration with the Michigan Association of Community Mental Health Boards and the Community Collaboratives, will identify and disseminate model programs that address co-occurring disorders of mental health and substance abuse, as this combination of disorders significantly increases suicide risk.

DATA SOURCE: Publicly available document describing model programs; record of dissemination

Objective 8.2 Support policies and/or legislation that provide coverage for evaluation and treatment of mental illnesses and substance abuse that is equal with coverage of other illnesses and conditions.

DATA SOURCE: Policy and/or legislative outcomes

Objective 8.3 Within each of the next five years, increase the number of communities promoting the awareness and utilization of 24-hour crisis intervention services that provide full range crisis and referral services. These services may be locally based or linked to the national hotline. It is desirable that these services be AAS certified.

Once the baseline is established the annual cumulative goal increases will be as follows:

2006	20%
2007	30%
2008	40%
2009	50%
2010	60%

DATA SOURCE: MDCH mental health services audit

METHODOLOGY

Advance the Knowledge of Suicide and Best Practices for Prevention

Goal #9

Improve and Expand Surveillance Systems

Objective 9.1 The Michigan Department of Community Health will produce reports, not less than annually, that will include data on suicide and suicide attempts. This data will include demographics, trends, methods, locale, and other information. This data will serve as a key tool in the evaluation of the Michigan Suicide Prevention Plan.

DATA SOURCE: MDCH reports

Objective 9.2 Promote the use of standardized protocols for death scene investigations throughout Michigan.

DATA SOURCE: MDCH implementation report

Death scene investigation reports provide key information on circumstances and means of death. While use of a standardized protocol should improve the information available through Medical Examiner case files, the OSP and the Michigan SPAC should also examine how this information can be accessed and used through other systems.

Objective 9.3 Through an ongoing collaboration between the Michigan Departments of Education and Community Health and local public school districts, continue to conduct surveillance of youth risk behavior, including behavior related to suicide and depression, using the Youth Risk Behavior Survey developed by the Centers for Disease Control and Prevention and the Michigan Department of Education.

9.3.1 Biannually, within one year of data collection, fact sheets related to the results of the 2003 Michigan YRBS most pertinent to depression and suicide, by age, gender, and race, will be widely disseminated in printed format and on-line.

- 9.3.2 Within two years, disseminate fact sheets related to the results of the 2005 Michigan YRBS, adding rates for Native American youth, in printed format and on-line.

DATA SOURCE: Report of YRBS results and records of dissemination

- Objective 9.4** The results of the surveillance activities described above will be used to plan and evaluate state, regional, and local suicide prevention activities.

DATA SOURCE: Copies of written plans and evaluation reports.

Goal #10

Support and Promote Research on Suicide and Suicide Prevention

- Objective 10.1** The OSP and Michigan SPAC will encourage use of the national registry of evidence-based suicide prevention programs and clinical practices, located at the national Suicide Prevention Resource Center's website, www.sprc.org; and provide regular reports about evidence-based approaches.

DATA SOURCE: Evidence of regular distribution of information about the SPRC and its website; compilation of evidence-based approaches.

- Objective 10.2** Facilitate the development of public/private partnerships and community-based coalitions to build support for, and request funding for, suicide prevention research within the State of Michigan, including efforts to identify evidence-based strategies for various at-risk populations in the state.

DATA SOURCE: Evidence of collaborative efforts to seek funds

- Objective 10.3** Determine the social and economic costs of untreated mental illnesses and substance abuse, and support strategies for reducing these costs.

- Objective 10.3.1** Investigate, within three years, either statewide or in at least one defined region and/or for one defined at-risk population, the social and fiscal costs of untreated mental illness and alcohol/substance abuse to the State of Michigan.

DATA SOURCE: Publicly available report on social and economic costs

Objective 10.3.2 Based on the above investigation, consider the social and/or economic cost benefit(s) for parity in coverage of health benefits for mental illnesses and substance abuse.

DATA SOURCE: Publicly available cost benefit report

Objective 10.4 The OSP, with input from all community and state partners, will prepare and disseminate an annual progress report for the Michigan Suicide Prevention Plan.

DATA SOURCE: The OSP's annual reports

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RECOMMENDED RESOURCES

- The American Association of Suicidology: www.suicidology.org
- American Foundation for Suicide Prevention: <http://www.afsp.org/index-1.htm>
- The Canadian Association for Suicide Prevention: <http://www.suicideprevention.ca/>
- Centers for Disease Control and Prevention <http://cdc.gov/ncipc/factsheets/suicide-overview.htm>
- Children's Safety Network: <http://www.childrensafetynetwork.org/>
- Children's Safety Network, Economics & Data Analysis Resource Center: <http://www.edarc.org/>
- Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE (eds.). *Reducing Suicide: A National Imperative*. Washington, D.C.: The National Academies Press, 2002.
- Michigan Department of Community Health, Vital Records and Health Data Development Section: <http://www.mdch.state.mi.us/pha/osr/index.asp?Id=4>
- Michigan State University, School of Journalism. Victims and the Media Program: <http://victims.jrn.msu.edu/>
- National Strategy for Suicide Prevention: Goals and Objectives for Action*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 2001.
- U.S. Centers for Disease Control and Prevention. *Web-based Injury Statistics Query and Reporting System (WISQARS)*: <http://www.cdc.gov/ncipc/wisqars/default.htm>
- National Commission on Correctional Healthcare: <http://www.ncchc.org/index.html>
- American Foundation for Suicide Prevention, American Association of Suicidology, Annenberg Public Policy Center. *Reporting on Suicide: Recommendations for the Media*: <http://www.afsp.org/education/recommendations/5/1.htm>
- National Institute of Mental Health—Suicide Prevention: <http://www.nimh.nih.gov/suicideprevention/index.cfm>
- New Zealand Ministry of Youth Development—Youth Suicide Prevention: <http://www.myd.govt.nz/sec.cfm?i=21>
- Schneidman, Edwin. *The Suicidal Mind*. New York: Oxford University Press, 1996.
- Suicide Prevention Action Network: <http://www.spanusa.org/>
- Suicide Prevention Resource Center: <http://www.sprc.org/>
- World Health Organization. *SUPRE—the WHO worldwide initiative for the prevention of suicide*: http://www.who.int/mental_health/prevention/suicide/supresuicideprevent/en/

APPENDIX A: SENATE RESOLUTION NO. 77^e

A resolution to recognize suicide as a serious state and national problem and to encourage suicide prevention initiatives.

Whereas, Suicide is the ninth leading cause of all deaths in the state of Michigan and the third cause for young persons ages 15 through 24. In 1995, suicide claimed over 960 Michigan lives, a number greater than the number of homicides. In addition, suicide attempts adversely impact the lives of millions of family members across the country; and

Whereas, The suicide death rate has remained relatively stable over the past 40 years for the general population. However, the rate has nearly tripled for young persons. The suicide death rate is highest for adults over 65; and

Whereas, These deaths impose a huge unrecognized and unmeasured economic burden on the state of Michigan in terms of potential life lost, medical costs incurred, and the lasting impact on family and friends. This is a complex, multifaceted biological, sociological, and societal problem; and

Whereas, Even though many suicides are currently preventable, there is still a need for the development of more effective suicide prevention programs. Much more can be done, for example, to remove stigmas associated with seeking help for emotional problems. Prevention opportunities continue to increase due to advances in clinical research, in mental disorder treatments, in basic neuroscience, and in the development of new community-based initiatives. Suicide prevention efforts should be encouraged to the maximum extent possible; now, therefore, be it

Resolved by the Senate, That we

- (1) Recognize suicide as a statewide problem and declare suicide prevention to be a state priority;
- (2) Acknowledge that no single suicide prevention program or effort will be appropriate for all populations or communities;
- (3) Encourage initiatives dedicated to preventing suicide, helping people at risk for suicide and people who have attempted suicide, promoting safe and effective treatment for persons at risk, supporting people who have lost someone to suicide, and developing an effective strategy for the prevention of suicide; and
- (4) Encourage the development, promotion, and accessibility of mental health services to enable all persons at risk for suicide to obtain these services without fear of any stigma.

pg. 983 JOURNAL OF THE SENATE [June 25, 1997] [No. 56]

^e The wording of the resolution passed by the House of Representatives on September 22, 1998, was essentially the same as that used in the Senate resolution.

APPENDIX B: MICHIGAN SUICIDE PREVENTION COALITION

Ms. Karen Amon	Touchstone Services
Ms. Susan Andrus	ThumbResources.org
Ms. Ain Boone	Survivor; MAS
Ms. Robin Bell	Michigan Public Health Institute (MPHI)/Child Death Review Program (CDR)
Ms. Patricia Brown	Survivor; Michigan Association of Suicidology (MAS)
Ms. Bonnie Bucqueroux	Michigan State University, Victims in the Media Program
Mr. Michael Cummings	Joseph J. Laurencelle Foundation
Ms. Joan Durling	Shiawasee Community Mental Health Authority
Ms. Glenda Everett-Sznoluch	Survivor; MAS Youth Suicide Prevention
Ms. Cathy Goodell	Mental Illness Research Association (MIRA)
Mr. Eric Hipple	MIRA; Stop Suicide Alliance; Survivor
Dr. Hubert C. Huebl	NAMI (National Alliance for the Mentally Ill) Michigan
Ms. Peggy Kandulski	President, MAS; Survivor
Dr. Cheryl King	University of Michigan Department of Psychiatry
Dr. Alton Kirk	Associated Psychological Services
Mr. Sean Kosofsky	Triangle Foundation
Ms. Sabreena Lachainn	Survivor; Journey for Hope
Ms. Mary Leonhardi	Administrator, Detroit Waldorf School
Mr. Larry G. Lewis (MiSPC Chair)	Vice-President MAS; C.O. Suicide Prevention Action Network (SPAN) of Michigan
Ms. Vanessa Maria Lewis	Advanced Counseling Service; MAS
Ms. Mary Ludtke	Michigan Department of Community Health (MDCH), Mental Health Services to Children and Families
Ms. Karen Marshall	Stop Suicide Alliance; Community Education About Mental Illness and Suicide (CEMS) of Oakland County CMH; Survivor
Ms. Lynda Meade	MPHI/CDR
Ms. Marilyn Miller	MDCH, Office of Drug Control Policy
Ms. Lindsay Miller	MPHI/CDR
Mr. Micheal Mitchell	Emergency Telephone Service, Neighborhood Services Organization (NSO), Detroit
Mr. William Pell	Gryphon Place, Kalamazoo
Ms. Carol Pompey	Indiana Coalition, Miles, Michigan
Ms. Judi Rosen-Davis	MAS
Mr. Tony Rothschild	Common Ground Sanctuary
Ms. Patricia Smith	MDCH, Injury and Violence Prevention Section
Mrs. Elly Smyczynski	Survivor
Ms. Merry Stanford	MiSPC liaison from the Michigan Department of Education
Mr. Michael Swank	Bay-Arenac Behavioral Health
Mr. William Tennant	Mental Health Association in Michigan

MICHIGAN'S PLAN IS DEDICATED TO THOSE WHO HAVE LOST THEIR LIVES TO SUICIDE

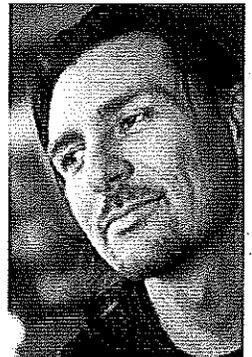
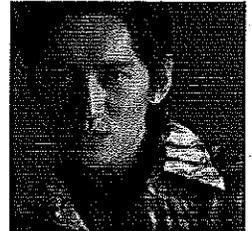
Mary Gallinagh Beghin	October 25 1967	Curtis Joseph Stucki	February 2 1998
Danny Sullivan	1970	Greg Pascoe	February 2 1998
Robert Taylor	1970	Jason Michael Harrold	June 27 1998
Laura LaCharite	February 25 1971	Todd Stackowicz	October 28 1998
Thomas J. Caldwell	April 15 1972	William Henry Hebert	October 8 1998
Joyce Hebert-Donaldson	May 12 1974	Joel Scott Serlin	September 22 1998
Tippy	1976	Deryl Roy Davis	September 7 1998
Beverly Taylor	January 28 1977	Chris Pace	September 9 1998
Brian Anthony Bucek	July 6 1978	Chuck Rowe	1999
Gregory Allan Florian	June 11 1980	Cody Burton	1999
Jeff Anderson	November 11 1982	Eric Byrd	1999
John Sevakis	February 1 1983	Robert Houck	April 5 1999
Herbert Derby	August 16 1986	Gerald Auth	August 22 1999
Robert John Buckner	May 2 1986	John Knowlton	August 28 1999
Michael G Fix	May 9 1986	Mark Eric Maxwell	August 7 1999
Lawrence M. Nortan	February 8 1987	David (DJ) Jones	December 8 1999
Nicole Marie Peterson	April 25 1989	Brian Walker	February 20 1999
Leonard K. West	May 11 1990	Jamie Lynn Jenkins	July 12 1999
Gerry Stephani	September 21 1990	Peggy Tinker Pijor	July 18 1999
Jason Ruppal	January 21 1991	Dwight Antcliff	June 6 1999
Helen Skarbowski	August 26 1992	Marcus Hodge	May 20 1999
Marcus John Codd	August 6 1992	Thomas Baker	November 1 1999
Mark Bogatay	December 15 1992	Thomas James Brundage	October 14 1999
Justin Oja	December 4 1992	Corey Hayslit	September 20 1999
Simran Nanda	January 12 1992	David Earnest Butcher	Apr-00
John Hookenbrock	1993	Anna Trola	April 4 2000
Theresa Boyce	April 17 1993	Jeffrey Daniel Hipple	April 9 2000
Jason Michael Briggs	February 23 1993	Tara McClelland	August 10 2000
Kenny Howard	1994	Carol Verlee Sommers	December 10 2000
Ethan Gilbert	April 4 1994	Richard Scott Hubar	January 26 2000
Nikki Freeman	April 9 1994	David A. Dill	January 3 2000
Rick Jackson	December 25 1994	Steve Clark	June 22 2000
Ted Tyson	January 10 1994	Brian Burnham	June 5 2000
Jeff Joiner	January 18 1994	Clayton James Rogers	June 7 2000
David Thompson	January 2 1994	Dennis New	May 13 2000
Muhammond Brown	March 10 1994	Kurt Liebetreu	May 13 2000
Peter VanHavermat	Jun-95	Kurt Liebetrev	May 13 2000
Robert James Toft	December 2 1995	Jeff Rey Reuter	May 18 2000
Scott Herald Stevenson	January 31 1995	Doris Zwicker	October 18 2000
Ken Bon	March 28 1995	Thomas W. Moxlow	September 19 2000
Bryce Green	August 28 1996	John Chris Pieron	September 23 2000
David Williamson	February 27 1996	Brian Tiziani	2001
Carl Hookana	January 17 1996	Heinz C. Prechter	July 6, 2001
Greg Erickson	July 20 1996	James Thomma Jr.	April 29 2001
Heather Mays	March 7 1996	Mark Manning	August 14 2001
Jesse Ross Everett	November 30 1996	Chad Baughey	August 15 2001
Shelley Dawn Markle	October 7 1996	Rhonda Roodland-Robinson	August 18 2001
Keith Ellison	July 17 1997	Susan Elizabeth Young	August 21 2001
Eric Robert Shafer	June 21 1997	Troy James Duperron	August 5 2001
Terry Lee Garner	November 19 1997	Gilbert Hernandez	February 11 2001
Terry Baksic	October 10 1997	William Aloysius Petrick	February 23 2001
Scott Mayer	December 1 1998	James David McDonald	January 15 2001

Brian Richard Triplet	January 7 2001	Jim Tuscany	21
Christopher Jay Spivey	July 13 2001	Matt Erber	23
Dennis W. Young	June 16 2001	Terri Marrison	25
Daryl Jernaine Jones Jr. Detective Sgt. Richard D. Irvin	June 18 2001 March 20 2001	Donna Niebraydowski	29
Matthew Richard Coy	March 23 2001	Bill Gibson	33
Larry Alan Thomas	May 6 2001	Alvan "Bud" Merriman	38
Philip "PJ" Heim Jr.	May 8 2001	Karen Edwards	52
Natricia Burray-Ciefiolka	November 11 2001	Thomas E. Robinson	54
Russell Meehan	September 7 2001	Charlie Vandervennet	1-Aug
Greg Grisham	September 9 2001	Chris Cozzi	
Brian Gearhart	April 6 2002	Colin McIntyre	
Kurt Vullard	August 29 2002	David Chase	
Amy Marie Powell	August 31 2002	Debbie Bogle	
Yale D. Mettetal	December 8 2002	Debbie DeMoss	
Christine Marie Klein	February 26 2002	Douglas Ray DeVine	
Bruce Ward	January 16 2002	Francisco Nuno II	
Thomas Kobrehel	July 7 2002	Ila Riddnour	
Ralph Patterson	June 17 2002	James Graham	
Reggie Williams	June 25 2002	Jeff McEwen	
Jennifer Sturtz	June 4 2002	Lee Harding	
Brent Lindstrom	March 5 2002	Mike Loft	
Gina Elizabeth Jackson	May 1 2002	Mike Sandell	
Michael Alan Aldelson	May 14 2002	Nakia Gordon	
George Bardon	November 18 2002	Randy Tochalowski	
Terri Bozyk	November 18 2002	Richard D. Irvin	
Martin Wilford Boone Jr.	November 4 2002	Samuel Mutschler	
Eric Daniel Dorbin "Big E"	October 14 2002	Steve R. Warner	
Danny "Amos" Taylor	2003		
Jimmy Glenn Farley	April 10 2003		
Russell Lee Bingham	April 22 2003		
Michael Loney	January 20 2003		
Chase Edwards	March 3 2003		
Fred Zaplitny	May 17 2003		
Jim Epperson	May 3 2003		
Robert O'Brien	November 13 2003		
Sharon Miller	October 14 2003		
Ryan Osterman	September 11 2003		
Corey Maslanka	September 17 2003		
Brittany Moore	April 17 2004		
Christopher James Ritter	April 23 2004		
Donna Harmenan	August 17 2004		
Joe Wolfe	August 8 2004		
Justin Turner	December 24 2004		
Ruth Wyatt	February 8 2004		
Shilpa	January 5 2004		
Mark Spengler	June 28 2004		
Bobby Rutledge	March 16 2004		
Raymond Lepage	March 18 2004		
Zachary Bentley	March 3 2004		
Brandon Goodreau	May 10 2004		
Ryan Currie	16		

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<i>Draft Committee:</i>	<i>Bill Pell</i> <i>Pat Smith</i>
<i>List Serve:</i>	<i>Karen Marshall</i> <i>Larry Lewis</i>
<i>Formatting:</i>	<i>Diane Rebori</i>
<i>Newsletter:</i>	<i>Michael Swank</i> <i>Karen Amon</i>
<i>Research:</i>	<i>Robin Bell</i>

DRAFT



Michigan Association for Suicide Prevention
Suicide Prevention Plan for Michigan Evaluation

May 1, 2012



The Michigan Association for Suicide Prevention

DRAFT

Developed in consultation with

ReFocus,
L.L.C.

September 2011 – May 2012

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Report cover designed by Joy M. Klingeman, Marketing Specialist – ReFocus, L.L.C.

Six years into the implementation of *The Suicide Prevention Plan for Michigan*, we had two statewide surveys completed and were attempting to assess the implementation successes, identify the gaps, and make recommendations for moving the plan forward. We realized after a period of time that our work was lacking concrete data with which to make our recommendations. In November 2011 the Michigan Association for Suicide Prevention commissioned ReFocus, L.L.C. to conduct a data based evaluation of the plan. This document is the result of this effort.

In 2011, Jack Calhoun of Refocus, L.L.C., worked with Cheryl King, PhD and Cindy Ewell Foster, PhD at the University of Michigan Depression Center to develop a plan for completing an evaluation of *The Suicide Prevention Plan for Michigan*. They also revised a brief internet survey that we used twice previously to obtain information on suicide prevention activities being conducted locally across the state. The survey was opened for responses for approximately two months and promoted to individuals in communities statewide. The evaluation team at ReFocus, L.L.C. also obtained data from the National Suicide Prevention Lifeline, a national crisis line that re-routes calls to the closest Crisis Center according to calls' area codes. In addition, the evaluation team was provided with suicide statistics from the Michigan Department of Community Health. The use of these data and more allowed the evaluation team to provide us with state maps showing us counties where suicide prevention was active and make recommendations to strengthen our efforts to address this important public health problem.

It will be up to all of us to look at this document and data to project the future of suicide prevention in Michigan. With the end of the state's federal grant for youth suicide prevention in the fall of 2012, we know that funding for state and local efforts is likely to be even more scarce than it has been in recent history. It will be up to all of us to make sure we do not lose the momentum to keep our plan on track. We hope this document will help us see where best to put our limited resources and will inspire you to join us in our forthcoming effort to update and revise *The Suicide Prevention Plan for Michigan*.

Sincerely,

Larry G. Lewis, MSW
Chairman Michigan Suicide Prevention Coalition
Michigan Association for Suicide Prevention

Acknowledgements

The Michigan Association for Suicide Prevention would like to acknowledge the support and contributions of two individuals and their respective agencies that have made to this effort, in not only the initial stages of forming our statewide coalition, but assisting with getting our state plan adopted as the official suicide prevention plan for Michigan.

Pat Smith, Violence Prevention Program Coordinator in the Injury & Violence Prevention Section of the Michigan Department of Community Health, wrote the state youth suicide prevention grant that was funded under the Garrett Lee Smith Memorial Act. This grant allowed us to provide resources for community suicide prevention programs, trainings, media, and community coalitions.

Mary Ludtke, Consultant in the Mental Health Services to Children and Families Division of the Michigan Department of Community Health, is the state-level person who supports the coordinators of Michigan's Community Collaboratives. The Collaboratives provided an already existing structure at the grassroots level on which to build and focus our efforts. Additionally, we would like to thank all the original members of the Michigan Coalition for Suicide Prevention (listed in the appendix), many of whom worked diligently on and gave many hours to the development of the state plan. Our thanks also go out to the many individuals and organizations in communities across the state that have joined with us to reduce the attempts and suicides in Michigan.

Our hearts go out to all survivors and Michiganians touched by suicide—we pledge to continue our efforts.

Goal of the Suicide Prevention Plan for Michigan: It is the primary goal of the Suicide Prevention Plan for Michigan to increase awareness across the state, to develop and implement best clinical and prevention practices, and to advance and disseminate knowledge about suicide and effective methods for prevention.

Introduction: In 2005 the Michigan Suicide Prevention Coalition completed a suicide prevention plan that was modeled after the National Strategy for Suicide Prevention. That plan was accepted by the Michigan Department of Community Health as the suicide prevention plan for the state. Through the emphasis of ten goals and related objectives, the plan was designed to encompass all of the many at-risk populations and “address suicide risk across the lifespan.” The focus of the plan was “on building the infrastructure necessary to support prevention efforts across the state and on assisting communities in developing and initiating their own action plans,” and based on a set of assumptions concerning recommendations involving local efforts:

1. Much of the final planning and execution must occur at the local level;
2. All tools and protocols must be appropriate for the local community and its diverse members;
3. There should be uniform messages and language across all activities, across all locations, and across all priority groups;
4. Only the local communities themselves can establish what their priorities will be; and
5. All prevention programs and interventions must be delivered in appropriate ways given the specific community and its diversity.

In April, 2011, the Michigan Association for Suicide Prevention produced the “Status of the State Plan” report, which was intended to present a progress report on the implementation of the state’s suicide prevention plan. The document reviewed the plan on a goal by goal basis, identifying some relevant successes and gaps in achieving the respective goals. It is the intention of this evaluation to augment that status report and quantifiably evaluate the plan.

According to the “Status of the State Plan” report, when the “plan was formulated it set many objectives to be accomplished within 18 months to 3 years. With dwindling human resources available for implementation the timelines for many of the objectives were unrealistic.” Thus, it is not the intention of this evaluation to assess, by each objective, whether the specific action was completed on time or completed at all. Rather this evaluation addresses each goal and seeks to assess the degree to which progress has been made over the five-year life of the plan.

Evaluation Methodology: The purpose of this evaluation is four-fold:

1. To determine the degree to which the Suicide Prevention Plan for Michigan goals have been achieved.
2. To identify and recommend actions to improve the plan.
3. To maintain accountability to funding sources and other stakeholders.
4. To demonstrate the program’s value and increase support among Michigan communities.

Therefore, this evaluation uses a Behavioral-Objectives approach, focusing primarily on the degree to which the goals of the plan have been achieved. The evaluation is structured in order to answer the following questions:

1. To what degree has Michigan’s suicide prevention plan been implemented?

In addition to the statewide survey, the evaluation team gathered information from other sources to perform this evaluation, including the National Suicide Prevention Lifeline (SAMHSA), the Michigan Profile for Healthy Youth (MiPHY), local Health Departments, the Centers for Disease Control and Prevention, the United States Census Bureau, the Transforming Youth Suicide Prevention in Michigan program, and the Suicide Prevention Resource Center.

The Michigan Association for Suicide Prevention obtained the services of ReFocus, L.L.C. to perform this evaluation. Prior to forming the organization in 2005, the ReFocus, L.L.C. partners worked for more than thirty-six combined years within local community mental health systems in the State of Michigan as both clinicians and administrators. ReFocus, L.L.C. provides strategic planning and program evaluation services, focusing primarily on not-for-profit and governmental entities, including mental health agencies, Substance Abuse Coordinating Agencies, community coalitions, school districts and circuit and family courts. Thus, Refocus, L.L.C. was uniquely positioned to evaluate the Suicide Prevention Plan for Michigan's scope and impact across the state from a community collaboration perspective.

Goal #1: Reduce the incidence of suicide attempts and deaths across the lifespan

According to the "Status of the State Plan" report, goal #1 represents the "first and foremost" impact the framers of the State Suicide Prevention Plan wished to have: to ultimately "help reduce the rates" of suicide across the state. Objectives under the goal address the number of suicide attempts among Michigan youth and to reduce suicide deaths among all Michigan populations utilizing evidence based best practices.

In order to evaluate the incidence of suicide attempts among youth, this evaluation looked at the Michigan Profile for Healthy Youth (MiPHY), which was developed by the Michigan Department of Education in collaboration with the Michigan Department of Community Health. The MiPHY is an online, anonymous student survey available to all Michigan schools on a biennial basis to assess risk behaviors, risk factors, and protective factors in Grades 7, 9, and 11. The evaluation team obtained county-level MiPHY data published for 2007 and 2009 (the two survey administrations that have occurred since the State Suicide Prevention Plan was implemented.¹) Three items are important to remember when reviewing the MiPHY data. First, there is not one hundred percent participation across the state. Not all counties are represented in the datasets nor are all school districts within counties for which data are reported represented. For purposes of this evaluation the MiPHY information should be considered a sample of youth across the state of Michigan. Second, MiPHY data have not been published for the State of Michigan in aggregate. Thus, the data presented here represents the sum of county-level data published by the State of Michigan (See Attachments A and B for MiPHY data by county for 2007 and 2009). Third, these data represent participating students' self-report and are not verified as to accuracy.

As figure 2 displays, the MiPHY questions are based on an understanding of the progression of suicidal behavior, from feelings of depression to taking action to end one's own life.

¹ For county-level MiPHY results see Appendix A (2007) and Appendix B (2009).

Figure 2. Progression of suicidal behavior

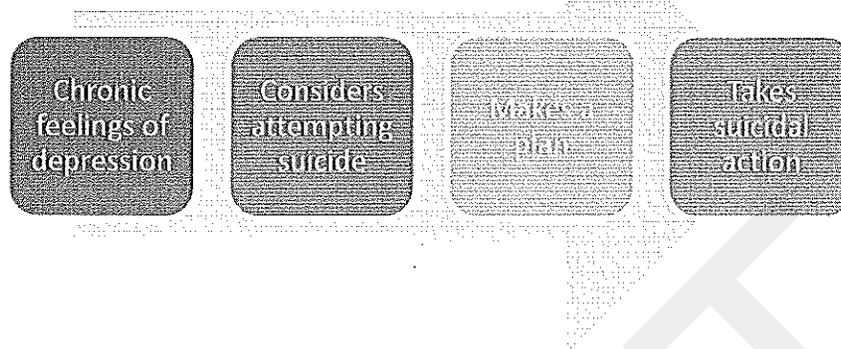


Figure 3 compares 2007 and 2009 MiPHY results for questions that address suicidal behavior. It shows a large increase from 2007 to 2009 in the number of Middle and High School students that took the MiPHY survey. It also shows a slight decrease in the percent of Middle School students who ever seriously considered attempting suicide (from 21.59% to 21.3%) as well as a slightly larger decrease in the percent of High School students who made a plan about how they would attempt suicide during the past 12 months. It shows that the percent of High School students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months increased in 2009 from the 2007 results. Overall, this analysis would indicate that the percent of students considering suicide to the point of making a plan has remained stable.

Figure 3. 2007 and 2009 MiPHY results: suicidal behavior

	Middle School Number MiPHY Respondents	High School Number MiPHY Respondents	Percent of Middle School respondents who ever seriously considered attempting suicide	Percent of Middle School respondents who ever made a plan about how they would attempt suicide	Percent of High School respondents who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	Percent of High respondents who seriously considered attempting suicide during the past 12 months	Percent of High School respondents who made a plan about how they would attempt suicide during the past 12 months
2007	18933	34911	21.59%	13.22%	29.14%	14.60%	12.93%
2009	34430	61231	21.30%	13.36%	32.33%	16.24%	12.00%
+/-	15497	26320	-0.003	0.001	0.032	0.016	-0.009

Figure 4 compares 2007 and 2009 MiPHY results for questions that address student reported suicide attempts. It shows slight increases in the percent of Middle and High School students reporting that they had attempted suicide. (Note the variation between the questions asked to Middle and High School students. While Middle School students are asked if they *ever* tried to kill themselves, High School students were asked if they had attempted suicide *during the past 12 months.*)

Figure 4: 2007 and 2009 MiPHY results: suicide attempts

	Middle School Number MiPHY Respondents	High School Number MiPHY Respondents	Percent of Middle School respondents who ever tried to kill themselves	Percent of High School respondents who actually attempted suicide one or more times during the past 12 months	Percent of High School respondents whose suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse during the past 12 months
2007	18933	34911	7.44%	9.03%	3.60%
2009	34430	61231	7.86%	9.39%	3.90%
+/-	15497	26320	0.004	0.004	0.003

These data should be compared to the results of the 2011 MiPHY administration, which is due for public release in June 2012; however, based upon the analysis above there does not appear to have been significant shifts (positively or negatively) in the percent of youth considering, planning, nor taking suicidal action between the 2007 and 2009 survey administrations.

According to state vital records data, there were 1,265 suicides in the state of Michigan in 2010 (the most recent year for which data have been published). Figure 5, below, displays the counts of suicides in Michigan by year and age grouping between 2005 and 2010. Figure 6 displays the distribution of persons by age grouping who died by suicide between 2005 and 2010. It shows that 38.0% of persons that died by suicide in the time period were between the ages of 45 and 64 and 12.5% were among persons age 24 and under. There were no suicides by persons under the age of 5 years during the period under review.

Figure 5. Counts of suicides in Michigan by year and age grouping²

Michigan	Total Count of Suicides	5-14	15-24	25-44	45-64	65 and Older
2005	1,103	6	136	423	378	160
2006	1,132	8	114	414	437	159
2007	1,123	7	129	380	437	170
2008	1,173	7	138	431	431	166
2009	1,164	10	131	360	472	191
2010	1,265	11	171	411	490	182
Totals	6,960	49	819	2,419	2,645	1,028

² Michigan Department of Community Health, <http://www.mdch.state.mi.us/pha/osr/chi/FATAL/DX09LTN4.ASP>.

Figure 6. Distribution of age groupings of persons committing suicide between 2005 and 2010

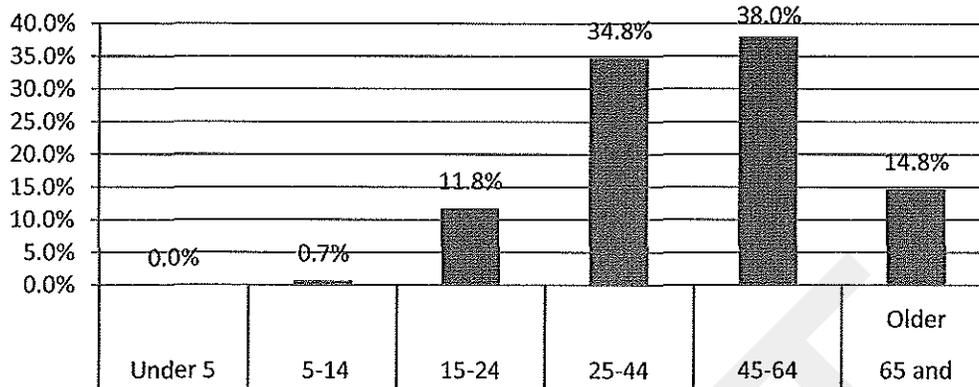


Figure 7 displays the suicide trends of persons in Michigan by age grouping between 2005 and 2010 using state vital records data (shown above). It shows that while the count of suicides among adults ages 25 to 44 is stable; the count of suicides among adults ages 45 to 64 and adults age 65 and older are increasing. The count of suicides among youth between ages 15 and 24 has remained stable throughout the five years.

Figure 7. Suicide Trends by Age Grouping 2005 - 2010

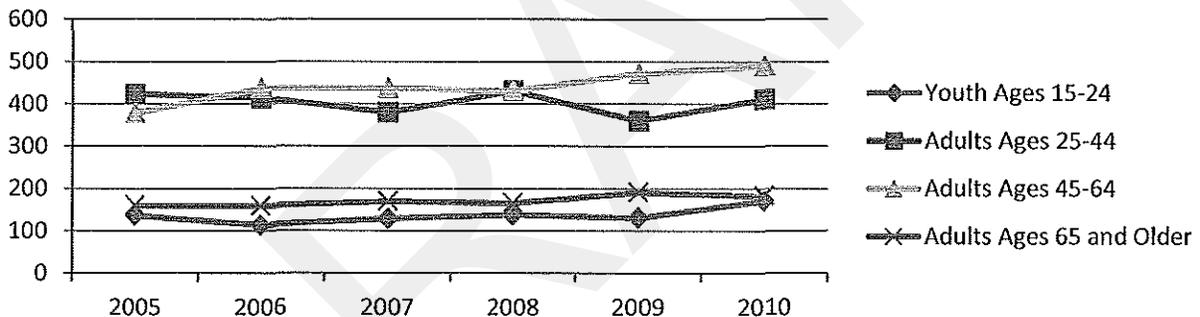
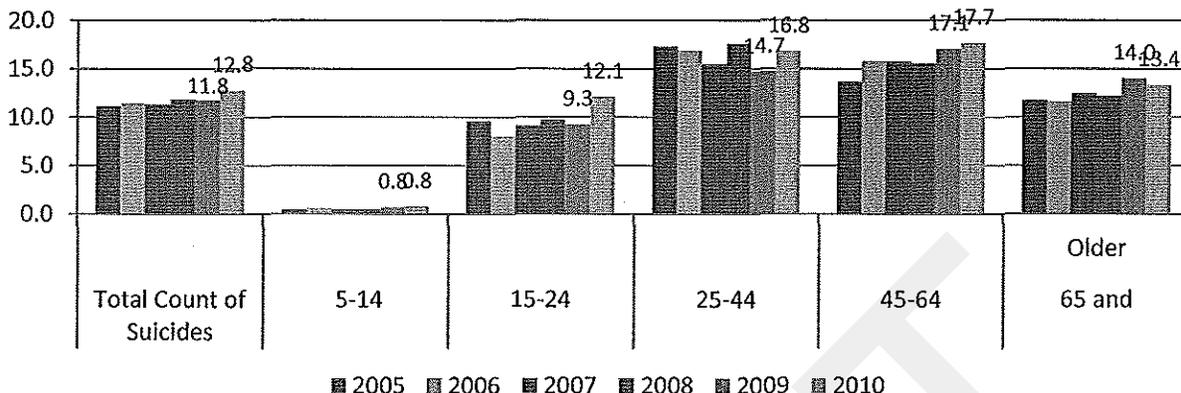


Figure 8, below, displays suicides in Michigan per 100,000 residents for each year between 2005 and 2010.³ This analysis is used to account for variations in the sizes of age groupings relative to the other age groupings and the population of the state as a whole. For example, if there are twice as many persons over the age of 65 in the State of Michigan than there are children between ages 5 and 14, one would expect the number of suicides to be twice as high for the more aged group than for the children. By accounting for the size of each age demographic, one can more easily identify variations in the rates of suicides between the age groupings. Figure 8 displays that in 2010 there were 17.7 suicides per 100,000 persons age 45-64 and 13.4 suicides per 100,000 persons age 65 and older. Suicides per 100,000 residents increased in 2010 for all age groupings between ages 15 and 64 as well as for the state as a whole. When evaluated per 100,000 Michigan residents, there has been a steady increase in the annual rate of suicides since 2005.

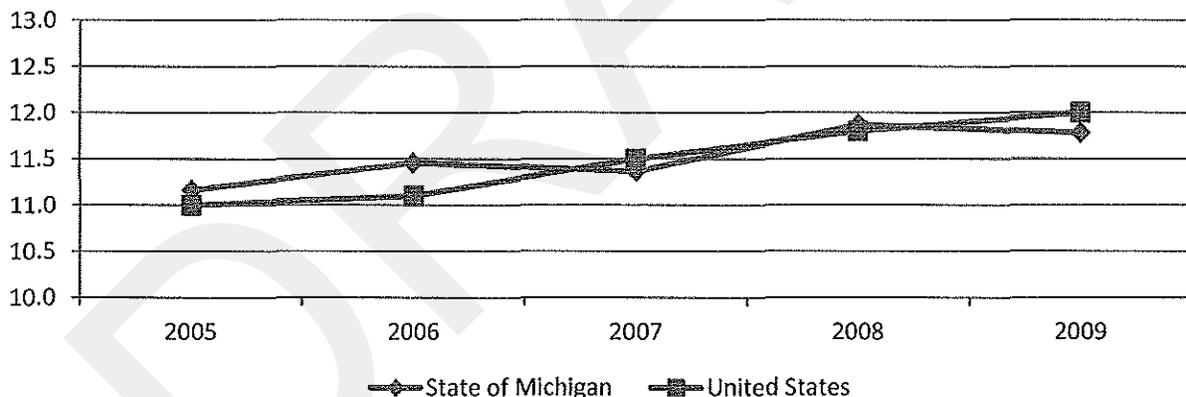
³ Census data used in this analysis is taken from the 2010 United States Census, published by the U.S. Census Bureau.

Figure 8. Michigan Deaths by Suicide per 100,000 residents by year



One must ask, then, how does Michigan compare to the United States as a whole. The last year for which national statistics are available from the Centers for Disease Control and Prevention is 2009⁴. In that year suicides per 100,000 residents in the United States was 12.0; the rate in Michigan was comparable at 11.8. Figure 9, below, displays the suicide rates per 100,000 residents for Michigan and the United States, trended between 2005 and 2009. It shows that the suicide rates for both the United States and Michigan have been increasing at a comparable rate. In 2009 Michigan's rate was slightly lower than that of the United States as a whole.

Figure 9. U.S. & MI Suicides per 100,000 residents, trended over time



Based on the fact that the age grouping with the highest rate of suicide in Michigan is adults between the ages of 45 and 64, Figure 10, below, compares deaths by suicide per 100,000 residents in Michigan to the United States as a whole in 2008.⁵ It shows that in that year deaths from suicide in Michigan for persons aged 45 -64 per 100,000 residents was well below the rate for the same age grouping across the country. Based upon the increase of suicides within this age grouping in Michigan in 2009, however, the rate within the state may be catching up to the national rate (assuming it has not significantly shifted).

⁴ National Vital Statistics Reports, 60(3). 5 January 2012.

⁵ 2008 figures are used in this analysis because it is the most recent year for which U.S. statistics for the comparable age grouping can be obtained. U.S. Suicide data is from the Centers for Disease Control and Prevention. According to the CDC, "the suicide death rate for persons aged 45 – 64 years increased overall (from 13.2 [in 1999] to 17.6 per 100,000 population)" National Vital Statistics System. CDC Health Data.

Figure 10. Deaths from Suicide Among Persons Aged 45 - 64/per 100,000 (Michigan vs. United States)

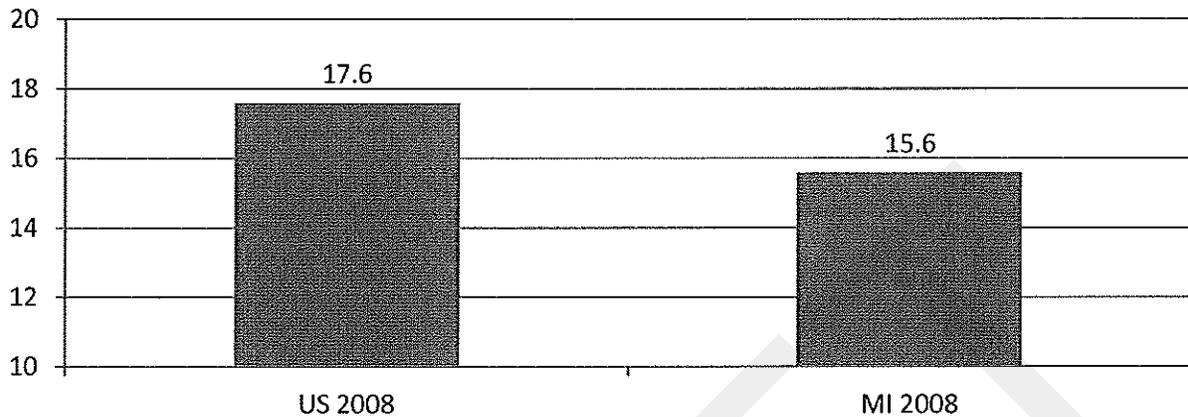
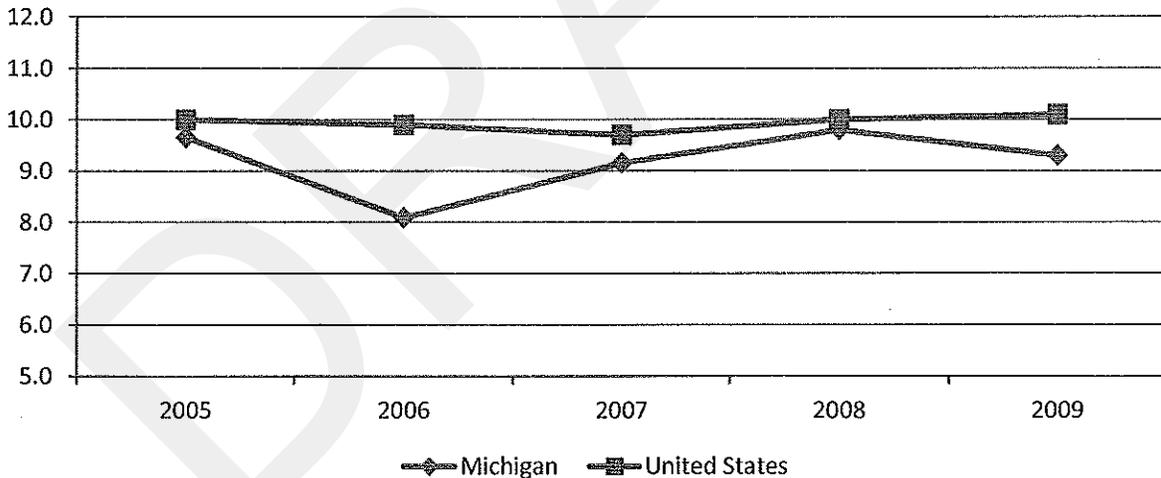


Figure 11, below, displays suicide rates per 100,000 residents between ages 15 and 24, trended between 2005 and 2009 for both the United States and Michigan. It shows that Michigan's suicide rate among this age group has consistently trended below the United States as a whole and that there was a positive downward shift in 2009.

Figure 11. US & MI Suicides per 100,000 residents between ages 15 & 24, trended over time



It is difficult to evaluate suicides and suicidal ideation and behaviors due to two factors. First, it is difficult to obtain recent suicide data. Thus, the impact of current interventions may not be statistically noted for several years. The Michigan Department of Community Health has implemented the Michigan Violent Death Reporting System, which collects data about violent deaths that occur in the State of Michigan, including suicide. This system is new and the first year's data (2010) may be released this year. This will be a significant step in facilitating the evaluation of the state suicide prevention plan and the impact local coalitions are having upon their communities. Second, while the MiPHY data suggests that

significantly more youth think about and develop suicide plans than actually attempt or die by suicide, similar data are not yet available regarding suicidal behaviors in adults. Through local coalitions, some communities in Michigan are working to address this issue through the implementation of surveillance systems, however, these systems are new and there are relatively few across the state (surveillance systems development will be discussed in greater detail later in this evaluation). *It is recommended that the Michigan Association for Suicide Prevention should, with the assistance of the Michigan Department of Community Health, continue to support the implementation of local surveillance systems across the state and promote the development of a process that facilitates the reporting of all surveillance data collected to a central data repository. It is further recommended that the Michigan Association for Suicide Prevention update the portion of this evaluation after the 2012 MiPHY data is released.*

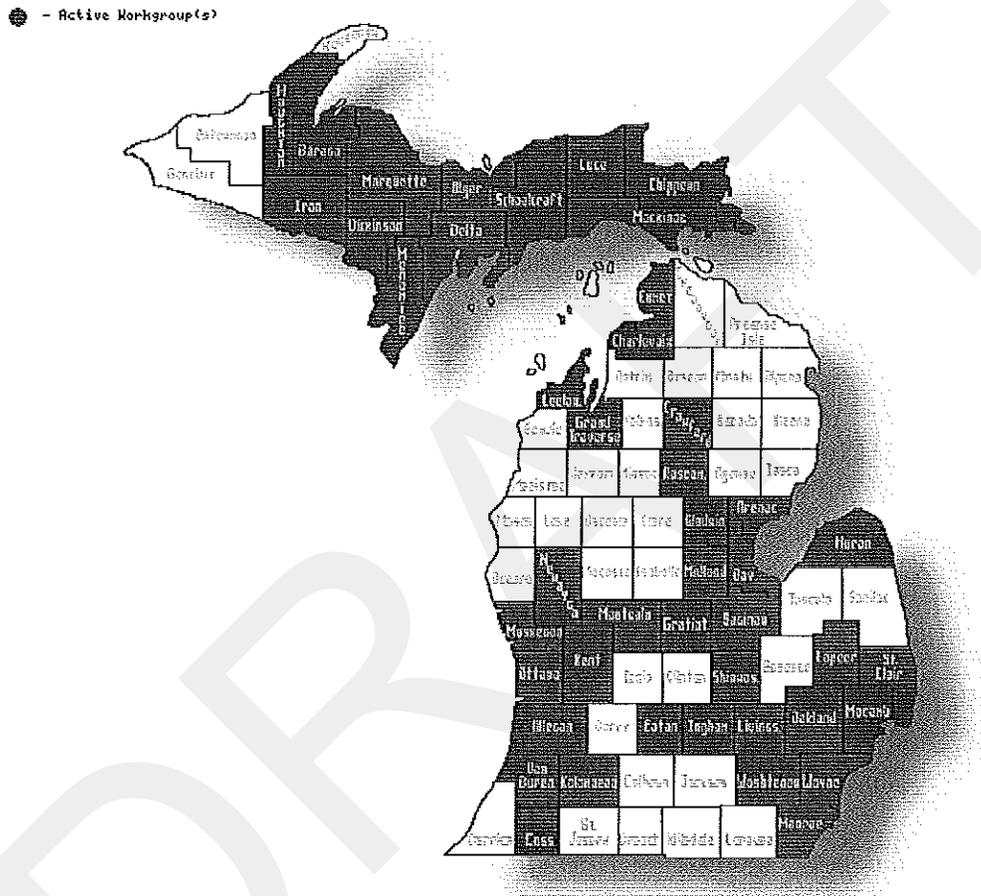
Goal #2: Develop broad-based support for suicide prevention.

According to the *State of the State Plan* document, “the state plan was developed with the knowledge that the State of Michigan would have little or no money to contribute toward the implementation of a broad-based state-level support for suicide prevention. However, plan developers felt very strongly that there needed to be strong leadership at the state level to effectively and efficiently coordinate the implementation effort.” Goal #2 in the state plan includes five objectives, one of which calls for the establishment of an Office of Suicide Prevention (OSP) within the Michigan Department of Community Health. Economic conditions within the state over recent years have prohibited the realization of this objective. As the *State of the State Plan* document identifies, however, there is an MDCH staff member who works predominantly within the area of suicide prevention. *It is recommended that the Suicide Prevention Plan for Michigan be revised to identify and plan for implementation of a sustainable method for state-level support of local suicide prevention efforts that is feasible based upon the current economic environment.*

While the OSP was not developed, the remaining four objectives under goal #2 focus on the support of local coalitions in Michigan communities. As noted earlier, this evaluation was based, in part, on survey responses from across the state. Several questions from that survey are used to measure the use of coalitions to lead the suicide prevention efforts. The first of those questions was, “does your community have a formal group working on suicide prevention activities?” Figure 12, below, displays the counties in Michigan that have at least one formal workgroup that is currently active. It shows that at least one suicide prevention workgroup is active in 45 out of the 83 Michigan counties (54.2%). Following the close of the survey the evaluation team learned of three additional counties that have active suicide prevention coalitions that did not complete the survey as requested. Thus, there are currently active suicide prevention workgroups in at least 48 of Michigan’s 83 counties (57.83%). It is noteworthy that all counties that include larger metropolitan areas in the state are known to have at least one suicide prevention workgroup with the exception of Genesee County (Flint) and Calhoun County (Battle Creek).

It is also interesting to note that 80% (12 of 15) of counties in the Upper Peninsula are known to have at least one active workgroup, while only 33% (11 of 33) of counties in the northern half of the Lower Peninsula are known to have active workgroups.

Figure 12. Michigan Counties with formal suicide prevention workgroups



With the exception of three, all respondents who indicated there was a suicide prevention workgroup within their county identified a broad coalition of community representatives including hospitals, substance abuse coordinating agencies and providers, Community Mental Health (and mental health services practitioners), schools (including Intermediate School Districts), law enforcement, human services agencies (including the Department of Human Services), universities and colleges, the National Guard, local Health Departments, women’s services providers, survivors of suicide, the faith community, Youth focused organizations, Tribal services, courts, the United Way, community businesses, media, Area Agencies on Aging, Veterans’ service providers, and bereavement support services. Respondents to the 2011 survey also indicated that community assessments have been completed in 28 counties (see Figure 13, right). Thus, of the 45 counties represented in the survey that currently have an active Suicide Prevention Coalition, 62.2% have completed a community assessment. Likewise, of the 40 counties

most Health Systems), much of the coalitions' work has already been completed and may require only some limited analysis. *It is recommended that the Michigan Association for Suicide Prevention develop (or adopt) a resource guide or method to provide technical assistance that will help coalitions systematically implement a community assessment as a part of suicide prevention planning which includes establishment of baseline information, quantifies the problem, identifies gaps and evaluates plan effectiveness.*

The survey process through which the evaluation team collected data for this strategic plan evaluation revealed another area of weakness where the Michigan Association for Suicide Prevention can have a significant, positive impact. The survey process made clear that in many areas of the state the lack of information sharing is a barrier to addressing suicide prevention in an effective, coordinated manner. Several counties in the state were represented by several survey respondents. There were several instances where respondents from the same county would provide opposing answers. For example, one respondent in County X would indicate that there was an active suicide prevention plan in place, while another respondent from that same county would indicate that no plan existed. In several of these instances it was clear that the active suicide plan addressed a single system (e.g. a public school system) or population group. It appears that suicide prevention plans may not be publicized and/or coordinated as broadly within a county as they should be. Even when plans are developed to address only a portion of a county's geography and/or population, persons who are sufficiently involved within the suicide prevention system to be invited to respond to the evaluation survey should minimally have knowledge of that plan's existence. *It is recommended that the Michigan Association for Suicide Prevention provide technical assistance to groups that have implemented a suicide prevention plan to assist them in marketing their plans to community leaders and social service organizations to encourage understanding and assistance with its success.*

In order to measure objective 2.4 (The OSP, in collaboration with local planning efforts, will utilize broad-based public-private support to seek additional funds for suicide prevention), the evaluation survey asked the question, "What resources is your community currently using to support suicide prevention efforts?" Figure 14, below, displays the count and percent of valid responses from across the state. It shows that the highest percentage of resources used by local coalitions and workgroups is in the form of in-kind donations (predominantly agency staff time and printed materials). This is followed by grants from local agencies and state departments (12.3% respectively).

Figure 14. Resources	Count of Responses	Percent of Responses
Private Donations	3	4.6%
Community Agencies (CMH, CA)	8	12.3%
In-Kind Donations	22	33.8%
Community Businesses	1	1.5%
Local Grant Making Organizations (United Way, Community Foundations)	5	7.7%
Grants from State Departments (DHS, MDCH [Excluding Garrett Lee Smith])	8	12.3%

Figure 14. Resources	Count of Responses	Percent of Responses
Fundraising	5	7.7%
SAMSHA (Free Materials)	2	3.1%
Garrett Lee Smith Youth Suicide Prevention Grant	3	4.6%
Lifeline partnership	2	3.1%
Survivors' Support Groups	1	1.5%
Suicide Prevention Resource Center	1	1.5%
Suicide Prevention Fund	2	3.1%
Training Registration fees	1	1.5%
Local Schools and Universities	1	1.5%

Because of the way this question was asked (and respondents answered), it is difficult to evaluate what effect any potential reduction in state grant funding might have on coalitions' sustainability. The scope of resources identified suggests, however, that most local coalitions have broad local community support.

Goal #3: Promote awareness and reduce the stigma.

Six objectives were organized under goal #3 of the Suicide Prevention Plan for Michigan, all addressing various facets of promoting awareness among the general public and public policy makers about issues related to suicide prevention. Among these objectives was a state-wide "campaign promoting awareness that suicide is a preventable public health problem that reaches all citizens in Michigan." A media campaign was implemented during Mental Health Awareness Week in September 2007. The campaign was initiated to "help young adults learn what to do when confronted with suicidality – refer those in need to trained crisis intervention professionals."⁶ Figure 15, below, displays the reach of the ads aired. It shows that the paid radio spots and public service radio announcements (total = 5232) provided good (although time limited) coverage across most areas of the lower half of the lower peninsula. The radio spots were aired during the same week in September 2008.

Figure 15.

Market	Total Paid Spots	Total PSAs	Sponsorships	Reach/Frequency	Gross Rating Points	Net Impressions	Gross Impressions
Lansing	530	511	0	58.6%/11.0	761	43800	481800
Grand Rapids	438	320	0	67.3%/10.5	711.2	62200	653100
Kalamazoo	138	138	0	51.9%/11.7	713.4	19000	222300
Battle Creek	67	64	0	19.9%/14.4	327.3	3200	46080

⁶ Transforming Youth Suicide Prevention in Michigan – Campaign Evaluation.

Market	Total Paid Spots	Total PSAs	Sponsorships	Reach/Frequency	Gross Rating Points	Net Impressions	Gross Impressions
Berrien County	80	80	0				
Detroit	428	155	41	51.6%/8.0	533.4	278800	22300400
Ann Arbor	44	30	0	12.0%/4.3	75.6	8700	37410
Flint	361	327	0	60.4%/10.3	750.3	31200	321360
Saginaw	262	234	0	58.7%/9.3	670.9	28500	265050
Northern Michigan	589	436	0	36%/18.5	894.4	9800	181300
Total	2937	2295	41		5437.5	485200	24508800

Although this media campaign was time limited and did not have the geographic reach apparently envisioned in the strategic plan, the goal was, in part, to advertise a crisis intervention hotline. Figure 16, displays the total number of calls to the crisis intervention hotline, the National Suicide Prevention Lifeline, per 1,000 Michigan residents. It shows significant growth in the number of calls from Michigan residents between 2006 and 2008, with continued annual increases through 2010. While there cannot be a direct correlation drawn between the media campaign and the growth in the use of Lifeline around the state, along with the promotion efforts of local coalitions, the goal to increase public awareness of the crisis intervention hotline among Michigan residents was clearly achieved.

Figure 16. Lifeline Calls per 1,000 residents in Michigan, trended over time

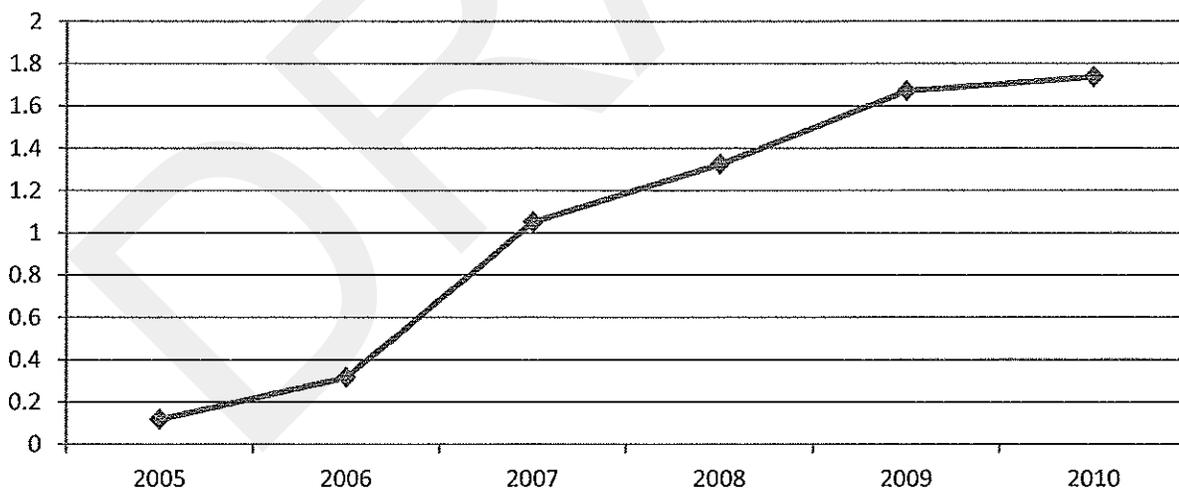
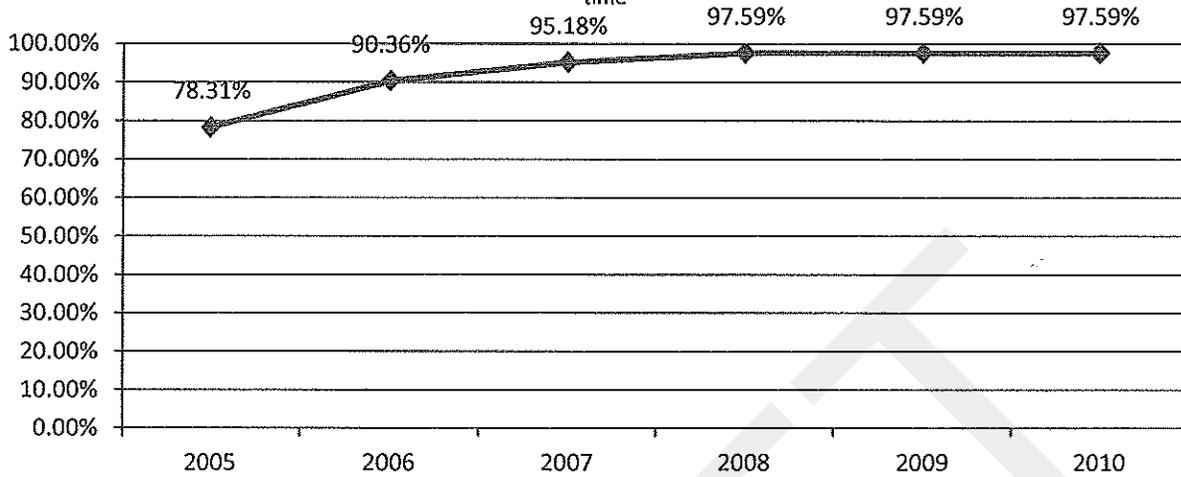


Figure 17 displays the percent of Michigan counties from which at least one Lifeline call was originated by year since 2005. It shows the same positive increase between 2006 and 2008 that was noted above. By 2008, at least one lifeline call was generated from nearly 98% of Michigan counties. (See Attachment C for Lifeline call data by Michigan County.)

Figure 17. Percent of Michigan Counties where at least one Lifeline call originated, trended over time



Figures 18 and 19, below, display Lifeline call data on calls from Michigan veterans, trended over time. Like calls from Michigan residents in general, calls from veterans have increased significantly since July 2007. Figure 19 shows that more than 20% of Lifeline calls from Michigan were from veterans during 2011.

Figure 18. Lifeline Calls from Veterans

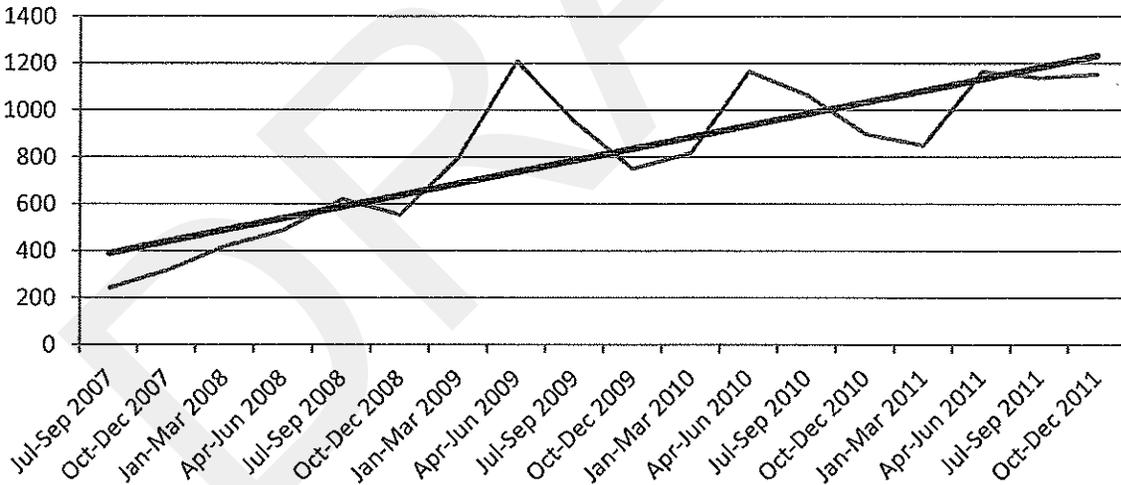
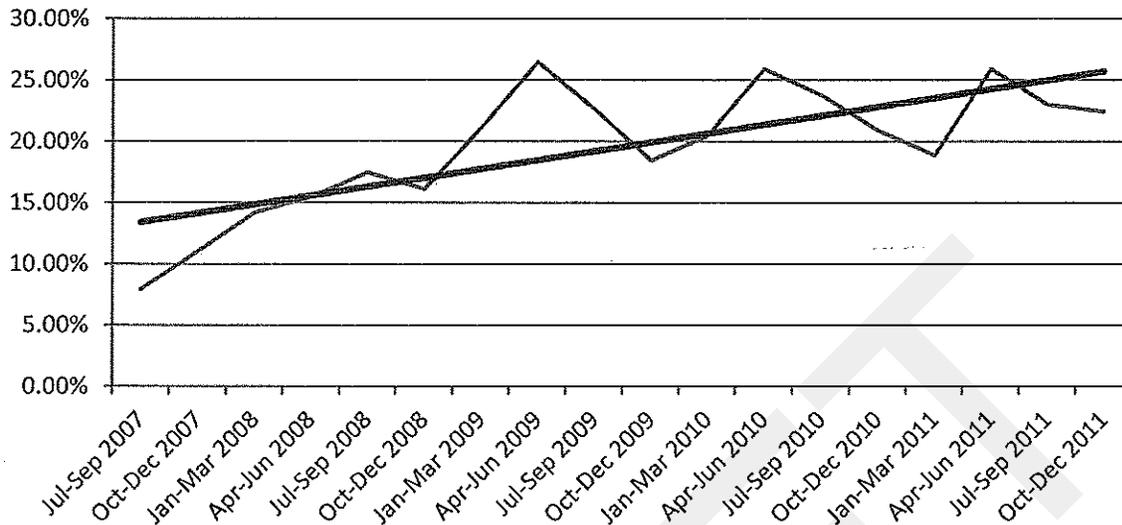


Figure 19. Percent of Michigan Lifeline calls that are from Veterans



These data suggest that Veterans may be an emerging area of focus for local suicide prevention coalitions. *It is recommended that the Suicide Prevention Plan for Michigan be revised to include a focus on soldiers returning from active combat as well as veterans in general.*

As a part of the evaluation survey, respondents were asked, "what, if any, public awareness activities related to suicide prevention have been conducted in your community in the last 12 months?" Figure 20, below, displays an analysis of the answers to that question based upon the current status of coalitions' Suicide Prevention Plans. Two points are noteworthy based upon this information. First, the largest percentage of public awareness activities among respondents was through the use of individual speakers (22.7% of all activities reported), followed by newspaper articles (21.1%) and suicide prevention week activities (12.4%). More passive public awareness activities, such as distribution of brochures, and purchase of billboard space were reported less often than these more active and time intensive methods.

Figure 20.

	Active Plan	Inactive Plan	Plan Under Development	Plan Not Stated	Status of Plan Not Indicated	Totals	Percent of Activities
Count of Respondents	33	3	13	12	9	70	
Public service announcements on TV and/or radio	11	1	0	2	2	16	8.6%
Billboards	5	0	3	0	0	8	4.3%
Newspaper Articles	22	1	9	3	4	39	21.1%
Individual Speaker(s)	27	2	7	5	1	42	22.7%
Suicide Prevention Week activities	16	2	3	2	0	23	12.4%
Suicide Prevention Conference/Symposium	9	1	6	1	0	17	9.2%

	Active Plan	Inactive Plan	Plan Under Development	Plan Not Stated	Status of Plan Not Indicated	Totals	Percent of Activities
Provide education for local elected officials (and/or other policy makers) on the impact of suicide, mental illness and substance abuse	13	1	2	2	1	19	10.3%
Distributed brochures or information handouts	5	0	1	0	0	6	3.2%
Training Events	4	0	3	1	0	8	4.3%
Awareness Events	3	1	1	1	0	6	3.2%
Email & other forms of communication	0	0	0	0	1	1	0.5%
Average Count of Promotional Activities	3.5	3.0	2.7	1.4	1.0	2.6	

Second, the focus provided by a Suicide Prevention Plan is clearly noted. Coalitions that have an active Suicide Prevention Plan engage in public awareness activities nearly three times more often than coalitions that do not have a plan. Even coalitions that are in the process of developing their Suicide Prevention Plan or had a plan previously engage in public awareness activities twice as often as coalitions that have not begun plan development.

Goal #4: Develop and implement community-based suicide prevention programs

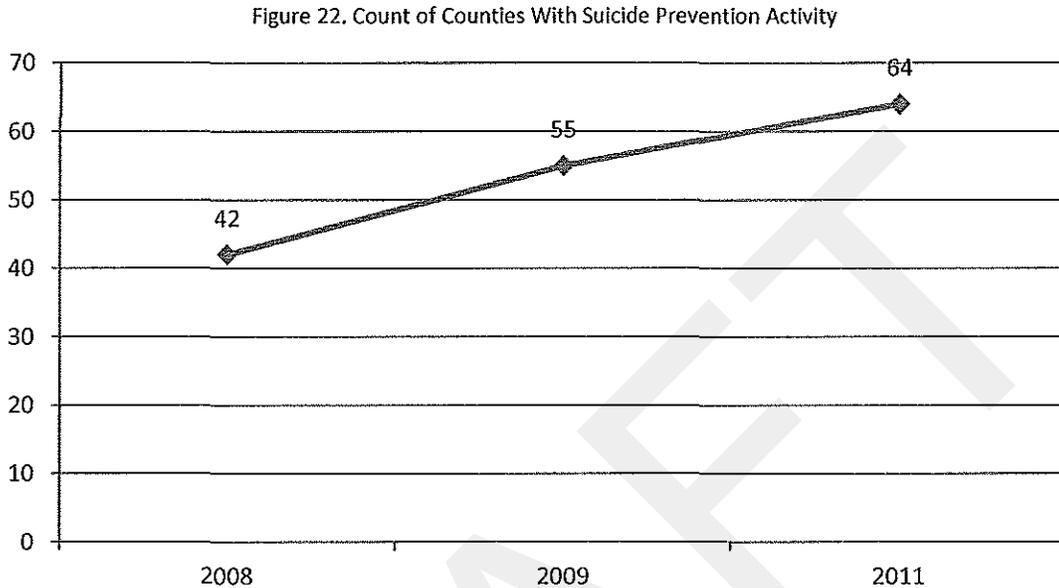
Goal #6: Improve the recognition of and response to high risk individuals within communities.

Goal #7: Expand and encourage utilization of evidence-based approaches to treatment.

Goal #10: Support and promote research on suicide and suicide prevention.

This section of the evaluation addresses three goals in the Suicide Prevention Plan for Michigan. Five objectives are organized under goal #4 of the plan. These objectives address methods for supporting the expansion and strengthening of suicide prevention activity in communities across the state. Primary among the activities the plan seeks to expand are early intervention strategies for children, services to survivors of suicide, development of state policies that support schools in implementing and expanding suicide prevention policies and programs, and collaboration of school health partnerships. Goal #6 includes six objectives, addressing identification of and increasing the number of gatekeepers, capacity assessment, suicide risk screening in primary care settings, suicide prevention policies development and suicide prevention training for community mental health direct service personnel. Goal #7 includes three objectives addressing the identification and distribution of evidenced based approaches to treatment. Goal #10 includes four objectives addressing supporting use of the National Suicide

Figure 22, below, displays the growth in suicide prevention activity across the three survey administrations. It shows that over the three year period between 2008 and 2011 the percent of counties known to have suicide prevention activities increased from 50.6% in 2008 to 77.1% in 2011.



To gain a deeper understanding of the types of suicide prevention activities occurring across the state, survey respondents were asked the question “*what services does your community have available specifically for survivors of suicide?*” Survey respondents of 36 out of 54 counties (66.7%) represented in the cohort identified at least one service available in their county for survivors of suicide. Figures 23 and 24, below, display responses to that question.

Figure 23 Answer Key Description:
Support Groups Only – the only service identified by the respondent was support groups
Sup Groups/Outreach – respondent identified support groups as well as Individual and Group Outreach programs (such as CISM)
Sup Groups/Emerg Rsp – respondent identified support groups as well as individuals/groups going with police when responding to potential suicide
Emergency Response – Individual/groups going with police when responding to potential suicide
Sup Groups/Resp Plan – respondent identified support groups as well as a school district response plans
Outreach/Emerg Rsp – respondent identified individual and group outreach programs (such as CISM) as well as individuals/groups going with police when responding to potential suicide

Sixty-three percent of counties represented by a survey respondent reported that support groups were available within their county. The second most common service to survivors of suicide identified was individual or group outreach programs such as CISM (Critical Incident Stress Management).

As a part of the suicide prevention coalition survey, respondents were asked to indicate the number of persons served in the past twelve months using evidence-based practices. Evidence-based practices were taken from the registry published by the Suicide Prevention Resource Center.⁷ This registry is an online resource that fulfills the intent of objective 7.1. Figure 25, below, displays the best practices that have been implemented around the state (among counties represented by respondents), including the name of the best practice, an estimate of the number of persons trained or materials distributed, and the number (and percent) of counties where the best practice is being implemented. These data should be used with caution. The counts of persons trained/materials distributed are presented as estimates for several reasons. First, because multiple survey respondents may have represented the same coalition, some counts may be duplicates. The evaluation team was careful to evaluate and clean duplication from the data set and it occurs minimally, if at all. However, it is important to note that duplication may still exist. Second, most respondents reported “ballpark” figures rather than actual counts of persons trained/materials distributed. Third, the survey did not proscribe a methodology for counting persons and materials and, therefore, it is likely that the various respondents used different methods to establish the counts reported. For example, it is possible with reporting materials distributed to schools that some respondents reported the number of students that received the materials while other respondents reported the number of schools. Therefore, this information is best used to, first, evaluate the breadth of best practices being implemented across the State of Michigan and, second, to evaluate those best practices which are most commonly being implemented. Finally, it should be noted that the counts reported by survey respondents are not representative of all suicide prevention activities which have occurred in the state over the last twelve months. For example, according to statistics reported by the Suicide Prevention Resource Center, 417 persons received Assessing and Managing Suicide Risk: Core Competencies (AMSR) training in Michigan in the twelve month period for which the survey requested data. Survey respondents identified a total of 254 persons trained.⁸

Based upon this analysis, nearly forty-three percent of counties represented among survey respondents have used the ASIST program in the last twelve months, with an estimated count of 629 persons receiving the training. While used in just under fifteen percent (14.8%) of counties reporting, the Ask 4 Help program has been received by more than twelve thousand persons in eight counties.

⁷ www.sprc.org/bpr

⁸ According to the Suicide Prevention Resource Center, 1733 persons have received AMSR Training in Michigan between September 30, 2008 and July 23, 2012. Likewise, 144 ASIST workshops have occurred since 2004, having reached 3024 persons in Michigan.

Figure 25. Evidence-Based Practice	Estimate Number of Persons Receiving/ Materials Distributed in most recent 12 months	Number of Counties Reporting Use/Distribution in most recent 12 months	% of Michigan Counties
After a Suicide: A Toolkit for Schools	113	14	25.9%
After an Attempt: A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt Survivors	383	10	18.5%
After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department	460	11	20.4%
After an Attempt: A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department	445	10	18.5%
American Indian Life Skills Development/ Zuni Life Skills Development	23	9	16.7%
Applied Suicide Intervention Skills Training (ASIST)	629	23	42.6%
Ask 4 Help Suicide Prevention for Youth	12,214	8	14.8%
Assessing and Managing Suicide Risk: Core Competencies (AMSR)	254	10	18.5%
At-Risk for High School Educators	70	4	7.4%
At-Risk for University and College Faculty: Identifying and Referring Students in Mental Distress	28	1	1.9%
At-Risk for University and College Students	250	4	7.4%
Be A Link Suicide Prevention Gatekeeper Training	430	4	7.4%
Gryphon Place Gatekeeper Suicide Prevention Program-A Middle School Curriculum	2393	1	1.9%
High School Gatekeeper Curriculum	2560	2	3.7%
How Not To Keep A Secret	*	1	1.9%
Late Life Suicide Prevention Toolkit	24	1	1.9%
LifeSavers Training	80	1	1.9%
More Than Sad: Suicide Prevention Education for Teachers and Other School Personnel	32	2	3.7%
More Than Sad: Teen Depression	247*	5	9.3%
Preventing Transgender Suicide: An Introduction for Providers	90	1	1.9%
QPRT Suicide Risk Assessment and Management Training	12	1	1.9%

Figure 25. Evidence-Based Practice	Estimate Number of Persons Receiving/ Materials Distributed in most recent 12 months	Number of Counties Reporting Use/Distribution in most recent 12 months	% of Michigan Counties
Question, Persuade, Refer (QPR) Gatekeeper Training for Suicide Prevention	1207	8	14.8%
School Suicide Prevention Accreditation	8	2	3.7%
SOS: Signs of Suicide	324	9	16.7%
SOS Signs of Suicide Middle School Program	47	4	7.4%
Suicide Alertness for Everyone (safeTALK)	375*	7	13.0%
Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)	50	1	1.9%
Supporting Survivors of Suicide Loss: A Guide for Funeral Directors	42	4	7.4%
What Is Depression? How to Treat It and What to Do--A Suicide Prevention Guide for Young People	*	1	1.9%
Working Minds: Suicide Prevention in the Workplace	*	2	3.7%
Youth Suicide Prevention School-based Guide Checklists	39	1	1.9%
Youth Suicide Prevention, Intervention, and Postvention Guidelines: A Resource for School Personnel	39	1	1.9%

*Indicates that one or more respondent did not indicate a number but wrote the word "many" or some other non-quantifiable indicator.

Utilizing these data helps to evaluate progress under plan goal #6: Improve the recognition of and response to high risk individuals within communities. Based on the counts reported through this survey process, 6590 persons received training to be gatekeepers during the past twelve months. The Question, Persuade, Refer (QPR) gatekeeper training program was the curriculum reported as being used most broadly across the state (1207 persons trained in eight counties). However, the highest number of gatekeepers was trained using the Gryphon Place Gatekeeper curriculum (4953 persons trained in two counties). While this information cannot be extrapolated across the six year life of the Suicide Prevention Plan, it can provide a one year snap-shot.

While not an exhaustive list, figure 26, below, displays additional activities that respondents reported that were not included on the best practices list.

Figure 26. Other Programs Implemented (not included on best practices list)	Estimate Number of Persons Receiving/ Materials Distributed in most recent 12 months	Number of Counties Reporting Use/ Distribution in most recent 12 months	% of Michigan Counties
Survivor Support Group		4	7.4%
Minds Program	60	1	1.9%
Suicide Awareness Presentations		3	5.6%
Yellow Ribbon Clubs/Campaigns	800*	6	11.1%
Military Family Support Outreach		1	1.9%
Educational programs/forums	1000	8	14.8%
Out of Darkness/Suicide Awareness Walk	1200	2	3.7%
TeenScreen	60	2	3.7%
Means Restriction Education	4	1	1.9%
Local Outreach to Suicide Survivors (LOSS)	6	1	1.9%
Suicide Prevention Among LGBT Youth: A Workshop for Professional Who Serve Youth	90	1	1.9%

*Indicates that one or more respondent did not indicate a number but wrote the word "many" or some other non-quantifiable indicator.

Goal #5: Promote efforts to reduce access to lethal means and methods of suicide.

Two objectives are organized under goal #5 of the Suicide Prevention Plan for Michigan. These objectives address primary and other healthcare providers routinely assessing the presence of lethal means and exposing households across the state to public information campaigns designed to reduce accessibility of lethal means. Evaluation survey respondents were asked the question, "what, if anything, has your community done to reduce access by suicidal individuals to lethal means?" Respondents representing thirty-five counties (64.8% of counties represented among survey respondents) indicated that they were engaging in at least one activity to reduce access to lethal means of suicide. Figure 27, right, displays the distribution of counties across the state where these activities are taking place. Among the thirty-five counties reporting activities to reduce access to lethal means, sixty percent (N=21) reported engaging in two or more activities.

Figure 27. Counties addressing access to lethal means

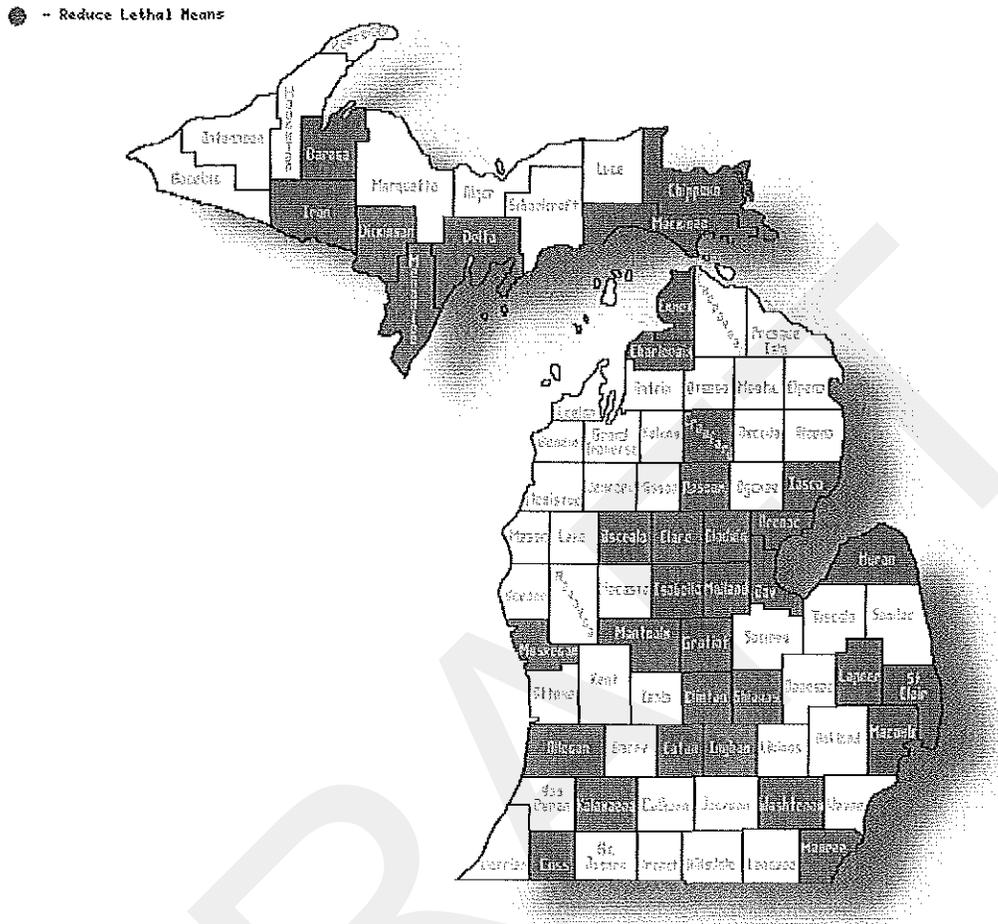
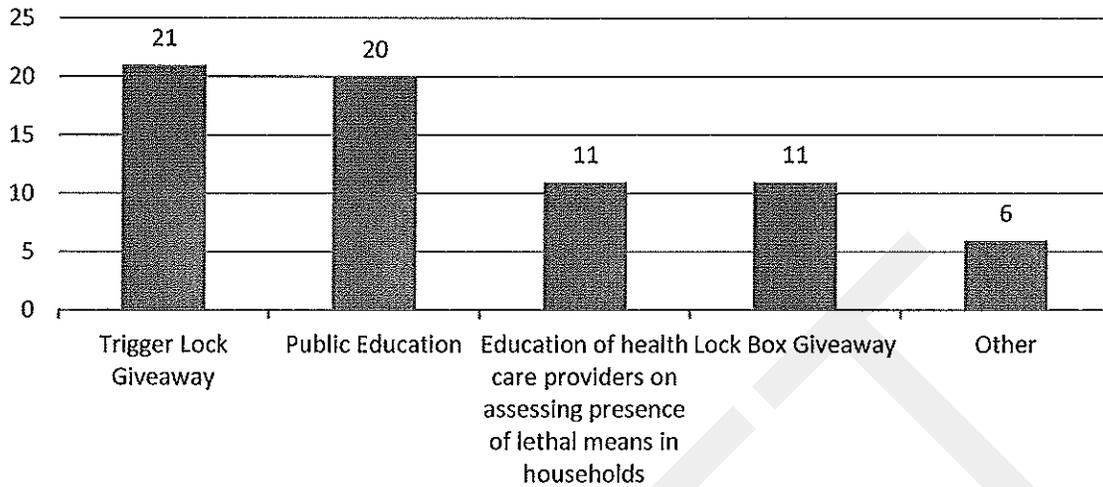


Figure 28, below, shows the number of counties where activities are taking place, by activity type. It shows that the most common activities are trigger lock giveaway programs and public education campaigns. Respondents from six counties identified activities other than those specifically identified on the survey. Respondents from two of those counties identified linking their efforts to limit access to lethal means to efforts to reduce access to prescription medications. Respondents representing four counties identified planning to address access to lethal means as the activity they have engaged in to date.

Figure 28. Count of Counties Acting to Reduce Access to Lethal Means, by activity



Goal #8: Improve access to and community linkages with mental health and substance abuse services.

Goal #8 includes three objectives addressing linkages with mental health and substance abuse services. Those objectives address the identification and dissemination of model programs that address co-occurring disorders, mental health and substance abuse treatment parity, and increasing the number of communities promoting the awareness and utilization of 24-hour crisis intervention services. Related to increasing utilization of 24-hour crisis intervention services, the plan established annual, cumulative goal increases that established the goal of a sixty percent increase over the baseline number of communities where 24-hour crisis intervention services are promoted and utilized. As was discussed earlier in this evaluation document, at least one call to the Lifeline crisis hotline was made in 2010 from nearly ninety-nine percent (98.8%) of Michigan counties. No calls originated from just one county (Keweenaw). In addition to the state wide promotion of the Lifeline crisis hotline, several coalitions promote locally based crisis intervention hotline programs. Call volume to the various local hotline programs was not included as a part of this evaluation; thus Lifeline call data is not indicative of all crisis line calls made in the state.

Evaluation survey respondents were asked the question, "Do people living in your community have access to 24-hour crisis intervention services?" Of the sixty-eight respondents that answered that question, more than eighty-eight percent (88.2%, N=60) responded in the affirmative. Seven of the counties represented by respondents answering this question "no" or "I don't know" were identified by other respondents as having 24-hour crisis intervention services and all of them are counties where Lifeline calls originated in 2010. Thus, while the baseline does not appear to have been established when the Suicide Prevention Plan for Michigan was written, this plan objective has clearly been met.

Although the objective was met, this analysis as well as 2010 Lifeline data suggests that there is still work to be done in this area. First, as has been noted earlier in this evaluation, respondents from the same counties are not always aware of the activities of their coalition or other coalitions operating within that county. Perhaps more importantly, however, twelve counties originated less than ten calls to Lifeline in 2010, which may suggest the need for additional public awareness activities. Several of these counties are sparsely populated and the number of calls per 1,000 residents is within the average range for Michigan as a whole. Figure 29, below, shows the counties where less than ten calls to Lifeline were originated in 2010 and the number of calls per 1,000 residents is well below the average for Michigan as a whole. Two items are noteworthy here. First, just two of these counties have an active Suicide Prevention Coalition or workgroup; three more had a Suicide Prevention Coalition or workgroup that is now inactive. Second, all of the counties identified in Figure 29 are rural, relatively sparsely populated counties. *It is recommended that the Michigan Association for Suicide Prevention market or support local or state-level marketing efforts of the Lifeline system to rural areas of the state.*

Figure 29.

County	Population	Lifeline Calls 2010	Lifeline Calls per 1,000 residents 2010
Arenac	15899	6	0.377
Keweenaw	2156	0	0.000
Leelanau	21708	1	0.046
Missaukee	14849	4	0.269
Montmorency	9765	2	0.205
Oceana	26570	7	0.263
Oscoda	8640	2	0.231

Goal #9: Improve and expand surveillance systems.

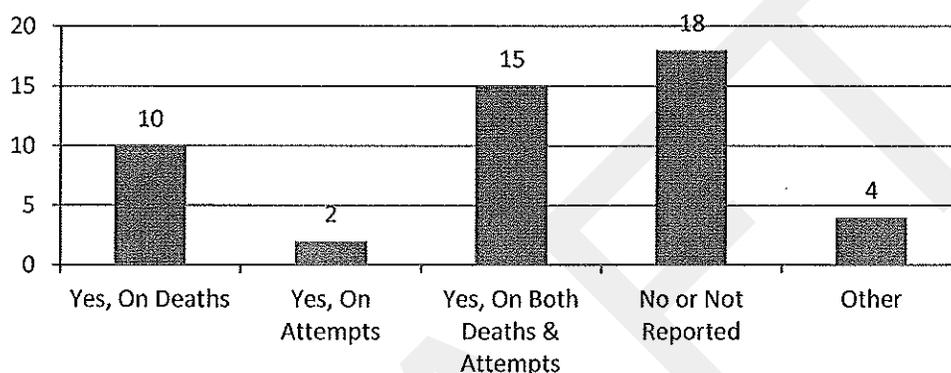
Four objectives are organized under goal #9. These objectives address annual reporting regarding suicides and suicide attempts by the Michigan Department of Community Health, standardized protocols for death scene investigations, surveillance of youth risk behavior, and use of surveillance data in future planning efforts.

The Michigan Department of Community Health has implemented the statewide collection of data regarding violent deaths, including suicides. The Michigan Violent Death Reporting System has reportedly collected a full dataset for 2010. *It is recommended that these data be published in a timely manner and technical assistance provided to local coalitions regarding its interpretation and use at the local level.*

Figure 30, below, displays an analysis of 2011 evaluation survey responses to the question asking whether local coalitions are collecting surveillance data. It shows that at least one respondent from

more than fifty-five percent (55.1%) of local coalitions indicated that their workgroup was collecting surveillance data regarding suicides, attempts, or both. Again, it is interesting to note that respondents from within the same counties did not always answer the same way. This may indicate one of two issues. First, surveillance data collected may not be shared as broadly as it should be and, thus, some members of a coalition may not be aware that surveillance data is being collected. Second, in counties where more than one coalition may be active, surveillance efforts might not be shared between coalitions. This may cause duplication of efforts and may limit the efficacy of both coalitions' efforts.

Figure 30. Coalitions' Local Surveillance Data Collection



Between January 1, 2008 and December 31, 2009 the Center for Disease Control and Prevention conducted a study of *Suicidal Thoughts and Behaviors Among Adults Aged >+18 Years*⁹. This study surveyed a representative sample of the civilian, non-institutionalized U.S. population aged 12 and older. Figure 31, below, displays the results of that study for the United States in general and Michigan specifically (N=118). It shows that, among survey respondents, the percent of Michigan residents that thought about, planned, and/or attempted suicide during the study period was greater than the percent of U.S. residents that thought about, planned and/or attempted suicide. However, the sample gathered in Michigan is small and cannot be considered representative of Michigan.

Figure 31.

Thought	Total	Male	Female	White, Non-Hispanic	Black, non-Hispanic	Hispanic	Asian, non-Hispanic
U.S.	3.7%	3.5%	3.9%	3.9%	3.5%	3.0%	2.1%
MI	4.4%	4.3%	4.6%	4.8%	3.0%	2.5%	3.8%

⁹ Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, Vol. 60, No. 13. October 21, 2011.

<i>Plan</i>	Total	Male	Female	White, Non-Hispanic	Black, non-Hispanic	Hispanic	Asian, non-Hispanic
U.S.	1.0%	1.0%	1.0%	1.0%	1.0%	0.9%	0.4%
MI	1.6%	1.4%	1.7%	1.6%	1.5%	0.7%	--
<i>Attempt</i>	Total	Male	Female	White, Non-Hispanic	Black, non-Hispanic	Hispanic	Asian, non-Hispanic
U.S.	0.5%	0.4%	0.5%	0.4%	0.7%	0.5%	0.2%
MI	0.8%	0.9%	0.7%	0.8%	1.0%	0.5%	0.3%

Recommendation: While the MiPHY survey collects self-reported data from Middle and High School students regarding suicide ideation and attempts, this system is limited by its voluntary nature. The breadth of administration allows a snapshot at the state level, but due to the fact that it is not a randomized sample, it cannot be interpreted as representative of Michigan youth in general. In addition, there is no system to collect information about suicidal ideation or attempts among Michigan adults. As the county survey data reported above shows, several suicide prevention coalitions across the state are collecting data regarding attempts, but methods vary from coalition to coalition (based on local design) and are not broad enough to provide state-level information. MASP should work with local coalitions and the MDCH to establish a standardized data collection methodology that coalitions may utilize as a first step to gathering ideation and attempt data.

Additional Considerations: The Suicide Prevention Plan for Michigan does an excellent job identifying and constructing a framework for organizing the state’s priorities when addressing suicide prevention efforts. It provides initial, supporting data and presents an excellent argument for why suicide prevention is important. Additionally, real or potential data sources are identified under each objective throughout the plan for future measurement of success. The plan, however, has some limitations that, if addressed, may produce greater results. First, while goals and objectives are clearly stated, they are not supported by specific, measurable action steps that will produce the desired results. For example, objective 1.1 states, “reduce the number of suicide attempts among Michigan youth, a population for which we have baseline data.” In order for the plan to effectively lead prevention efforts for Michigan youth, it should provide methods to be employed to achieve the desired reduction. Further, it would be beneficial for the baseline data mentioned in the objective to be specifically stated. Second, while data sources are suggested under each objective, the Michigan Association for Suicide Prevention would have served itself well to periodically obtain data updates from those sources or, when the potential sources proved fruitless or non-existent, seek alternative data sources that could be used to measure progress. When action plans are written in a measurable manner, data collection can generally occur with little effort and cost, enabling ongoing measurement to occur. Third, *it is recommended that the Michigan Association for Suicide Prevention develop a revised plan, addressing the limitations noted above as well as revising the direction of several goals that have not been addressed in the manner intended.*

Conclusion: The Suicide Prevention Plan for Michigan was implemented six years ago and has provided a framework for local and state suicide prevention efforts. Each of the areas measured as a part of this evaluation has demonstrated positive results, although it is difficult to draw a direct correlation between the plan and the results. Local suicide prevention activity has expanded across the state, with most metropolitan areas in the state and many rural areas covered by a suicide prevention plan, and some communities have more than one plan (addressing specific populations such as youth, school districts, and Tribal entities). There is some concern that coalitions that have implemented plans and have been successful in addressing suicide prevention issues in the communities they were designed to serve are no longer active, predominantly due to funding issues. *It is recommended that the Michigan Association for Suicide Prevention support local coalitions with methods for post-grant funding sustainability planning that begins in the first year of grant funding and builds throughout the life of the grant.* Additionally, efficiencies could be realized, and efforts better sustained if coalitions with plans addressing populations within the same county—or even in neighboring counties—were to share resources and build upon one another’s strengths.

DRAFT

Appendix A: County-level MiPHY data 2007

County	Population	2007: MS # MiPHY Respondents	2007: HS # MiPHY Respondents	2007: Percent of MS students who ever seriously considered attempting suicide	2007: Percent of MS students who ever made a plan about how they would attempt suicide	2007: Percent of MS students who ever tried to kill themselves	2007: Percent of HS students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	2007: Percent of HS students who seriously considered attempting suicide during the past 12 months	2007: HS % of students who made a plan about how they would attempt suicide during the past 12 months	2007: HS % of students who actually attempted suicide one or more times during the past 12 months	2007: HS % of students whose suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse during the past 12 months.
Antrim	23580	181	279	22.30%	12.60%	8.20%	31.40%	17.70%	17.00%	9.40%	3.00%
Arenac	15899		359	-	-	-	30.10%	17.90%	16.30%	16.20%	6.90%
Baraga	8860	92	194	20.70%	7.60%	2.20%	28.40%	16.20%	16.20%	8.10%	1.40%
Bay	107771	867	1491	36.70%	13.30%	17.20%	40.00%	30.00%	10.00%	20.80%	23.30%
Berrien	156813	124	230	25.00%	16.70%	6.00%	33.00%	20.20%	15.60%	9.10%	4.20%
Branch	45248										
Calhoun	136146	408	774	22.50%	13.90%	7.90%	27.20%	14.10%	11.30%	9.50%	3.60%
Cass	52293										
Charlevoix	25949	183	215	17.10%	14.30%	6.90%	22.50%	14.70%	11.40%	8.40%	3.80%
Cheboygan	26152	0	162				31.00%	14.70%	17.10%	8.60%	0.70%
Clinton	75382	709	672	17.00%	11.90%	5.40%	28.40%	14.60%	13.00%	12.10%	5.10%
Eaton	107759	927	1155	22.20%	14.50%	6.90%	28.90%	14.30%	13.40%	8.50%	14.10%
Gogebic	16427	124	291	15.90%	6.20%	1.80%	30.50%	16.10%	13.60%	7.60%	3.20%
Grand Traverse	86986	125	224	26.40%	14.10%	8.80%	30.40%	15.70%	13.40%	10.30%	2.60%
Gratiot	42476	52	0	38.50%	21.20%	7.70%					
Hillsdale	46688	203	483	27.70%	16.10%	9.10%	25.40%	12.00%	12.60%	8.30%	4.40%
Houghton	36628		535				16.00%	4.00%	4.00%	4.50%	0.00%
Huron	33118	329	680	16.80%	9.20%	5.30%	23.90%	12.10%	10.40%	6.70%	2.50%
Ingham	280895	561	699	17.70%	11.50%	5.80%	32.30%	15.60%	15.50%	9.60%	2.20%
Iosco	25887	384	667	29.80%	18.50%	13.70%	29.70%	15.40%	16.70%	10.50%	3.30%
Isabella	70311		205				26.10%	13.40%	9.90%	6.60%	2.50%
Jackson	160248	1612	2864	24.80%	14.90%	9.00%	31.70%	16.80%	15.10%	10.60%	3.70%

County	Population	2007: MS # MIPHY Respondents	2007: HS # MIPHY Respondents	2007: Percent of MS students who ever seriously considered attempting suicide	2007: Percent of MS students who ever made a plan about how they would attempt suicide	2007: Percent of MS students who ever tried to kill themselves	2007: Percent of HS students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	2007: Percent of HS students who seriously considered attempting suicide during the past 12 months	2007: HS % of students who made a plan about how they would attempt suicide during the past 12 months	2007: HS % of students who actually attempted suicide one or more times during the past 12 months	2007: HS % of students whose suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse during the past 12 months.
Kalkaska	17153	208	208				30.50%	16.70%	13.40%	10.30%	2.00%
Kent	602622	669	1433	17.90%	10.50%	5.50%	28.10%	14.10%	11.20%	8.90%	4.40%
Leelanau	21708	185	185				24.50%	14.40%	10.80%	13.70%	4.40%
Macomb	840978	2599	3882	19.50%	13.30%	6.90%	28.50%	13.60%	13.10%	10.30%	4.30%
Midland	83629	951	951				27.60%	13.70%	14.10%	8.00%	3.10%
Montcalm	63342	380	1511	23.40%	15.50%	11.30%	29.60%	14.20%	12.70%	7.70%	2.70%
Muskegon	172188	445	1090	17.20%	6.90%	4.80%	26.40%	15.40%	12.40%	7.90%	2.90%
Oakland	1202362	3533	6156	19.60%	10.40%	5.30%	27.80%	12.20%	10.90%	6.60%	2.70%
Ontonagon	6780	103	103				17.50%	7.50%	10.00%	0.00%	0.00%
Saginaw	200169	830	1849	20.00%	12.90%	6.30%	30.20%	14.70%	12.80%	7.90%	3.00%
Sanilac	43114	292	292				35.40%	20.30%	14.20%	11.80%	5.00%
Tuscola	55729	470	1007	29.00%	18.60%	10.20%	29.40%	15.90%	14.00%	8.60%	3.70%
Wayne	1820584	3126	4065	24.20%	15.60%	10.40%	31.10%	15.50%	13.60%	10.70%	3.60%

Appendix B: County-level MiPHY data 2009

County	Suicide Prevention Plan Active 2009	Suicide Prevention Plan Previously Active	2009: MS # MiPHY Respondents	2009: HS # MiPHY Respondents	2009: MS % of students who ever seriously considered attempting suicide	2009: MS % of students who ever made a plan about how they would attempt suicide	2009: MS % of students who ever tried to kill themselves	2009: HS % of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	2009: HS % of students who seriously considered attempting suicide during the past 12 months	2009: HS % of students who made a plan about how they would attempt suicide during the past 12 months	2009: HS % of students who actually attempted suicide one or more times during the past 12 months	2009: HS % of students whose suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse during the past 12 months.
Aipena, Montmorency, Alcona			443	661	20.70%	12.70%	6.90%	36.00%	14.10%	8.00%	6.00%	0.00%
Allegan	Y		379	459	17.60%	11.90%	5.20%	32.80%	15.00%	12.70%	9.40%	4.10%
Antrim			225	218	25.50%	17.10%	8.60%	31.70%	14.30%	10.70%	5.60%	2.30%
Arenac	Y		151	311	11.60%	4.70%	4.90%	32.20%	17.30%	12.50%	12.70%	6.00%
Baraga	Y		92	172	23.10%	14.30%	6.60%	25.00%	12.60%	9.00%	5.00%	1.20%
Barry			498	875	12.80%	7.30%	3.90%	28.60%	14.90%	9.40%	7.00%	2.80%
Bay	Y		950	1443	18.40%	8.90%	5.90%	33.60%	18.10%	13.10%	8.90%	2.60%
Berrien				401				30.70%	14.30%	9.90%	8.00%	3.60%
Branch			348	597	21.20%	10.80%	5.00%	31.60%	15.50%	12.30%	9.50%	4.50%
Calhoun			1315	1934	22.30%	14.30%	8.80%	34.20%	16.50%	14.00%	11.20%	4.50%
Charlevoix	Y		255	340	19.20%	14.90%	6.10%	34.10%	20.10%	15.60%	9.20%	6.10%
Chippewa, Luce & Mackinac	Y		314	585	16.70%	9.90%	4.60%	30.30%	15.70%	11.50%	8.50%	3.60%
Clinton		Y	467	684	13.50%	8.70%	5.00%	29.40%	16.20%	13.40%	12.50%	5.80%
Crawford, Ogemaw, Oscoda, Roscommon	Y		262	446	23.20%	13.80%	8.70%	36.80%	19.10%	14.50%	9.90%	4.20%
Eaton	Y		779	1832	25.30%	13.90%	8.60%	33.00%	15.50%	12.80%	9.10%	5.20%
Emmet	Y		328	662	21.60%	13.70%	8.00%	25.30%	15.80%	17.60%	9.50%	0.00%
Genesee				578				30.20%	14.10%	10.60%	7.40%	3.60%

County	Suicide Prevention Plan Active 2009	Suicide Prevention Plan Previously Active	2009: MS # MIPHY Respondents	2009: HS # MIPHY Respondents	2009: MS % of students who ever seriously considered attempting suicide	2009: MS % of students who ever made a plan about how they would attempt suicide	2009: MS % of students who ever tried to kill themselves	2009: HS % of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	2009: HS % of students who seriously considered attempting suicide during the past 12 months	2009: HS % of students who made a plan about how they would attempt suicide during the past 12 months	2009: HS % of students who actually attempted suicide one or more times during the past 12 months	2009: HS % of students whose suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse during the past 12 months.
Gogebic			69	116	27.80%	16.70%	11.10%	38.90%	16.70%	11.80%	25.00%	5.90%
Grand Traverse	Y		629	1233				29.80%	13.50%	10.00%	8.50%	3.70%
Hillsdale			262	480	24.20%	16.30%	8.80%	36.30%	17.90%	13.60%	7.80%	4.20%
Houghton	Y		272	343				29.90%	16.50%	5.70%	7.00%	3.20%
Huron	Y		293	707	21.20%	12.30%	8.00%	29.10%	15.20%	13.10%	7.10%	2.60%
Ingham	Y		1198	1922	25.70%	17.80%	12.70%	34.20%	16.30%	13.90%	11.50%	5.10%
Iosco		Y	295	522	21.20%	6.10%	3.10%	34.60%	19.50%	5.60%	10.70%	5.00%
Jackson			1610	2945	21.80%	13.00%	7.90%	33.40%	17.30%	13.20%	10.10%	4.00%
Kalamazoo	Y		1602	3624	17.60%	11.20%	5.40%	28.90%	14.40%	10.40%	8.80%	4.00%
Kent	Y		1509	2952	19.40%	12.30%	4.70%	31.80%	15.60%	10.50%	7.80%	3.70%
Leelanau	Y		92	287				25.40%	10.50%	8.80%	6.30%	2.20%
Lenawee			308	218	15.40%	8.60%	2.70%	30.80%	18.60%	12.20%	9.60%	3.90%
Macomb	Y		3949	6671	21.20%	12.90%	8.30%	32.70%	17.20%	10.70%	9.60%	3.30%
Mason & Lake			107	71	29.10%	24.30%	12.60%	22.20%	7.90%	7.90%	7.30%	3.20%
Midland	Y		842	1732				37.60%	17.10%	21.10%	7.20%	70.00%
Missaukee			145	309	39.20%	25.70%	14.90%	34.40%	22.20%	16.00%	11.80%	3.90%
Newaygo	Y		357	789	32.20%	19.20%	9.60%	33.00%	17.10%	12.70%	10.20%	3.60%
Oakland	Y		5000	8307	19.00%	12.70%	7.50%	32.00%	16.20%	12.00%	9.00%	3.70%
Oceana			129	120	14.80%	9.30%	3.90%	24.50%	10.80%	6.40%	7.30%	1.90%
Ontonagon			46	114	21.40%	7.70%	7.10%	40.50%	18.90%	16.20%	5.90%	0.00%
Osceola			189		28.30%	20.80%	8.40%					
Saginaw	Y		928	1637	21.00%	11.10%	7.20%	32.80%	15.40%	12.40%	8.30%	2.70%
St. Joseph			581	1008	23.10%	13.70%	9.00%	30.10%	13.20%	10.10%	6.30%	2.70%
Sanilac			102	217	14.30%	10.70%	3.60%	39.60%	19.80%	14.30%	10.80%	7.20%

County	Suicide Prevention Plan Active 2009	Suicide Prevention Plan Previously Active	2009: MS # MIPHY Respondents	2009: HS # MIPHY Respondents	2009: MS % of students who ever seriously considered attempting suicide	2009: MS % of students who ever made a plan about how they would attempt suicide	2009: MS % of students who ever tried to kill themselves	2009: HS % of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	2009: HS % of students who seriously considered attempting suicide during the past 12 months	2009: HS % of students who made a plan about how they would attempt suicide during the past 12 months	2009: HS % of students who actually attempted suicide one or more times during the past 12 months	2009: HS % of students whose suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse during the past 12 months.
Tuscola			431	1008	19.40%	11.70%	5.80%	35.70%	20.80%	13.90%	8.00%	4.20%
Washtenaw	Y		549	1026	16.20%	10.40%	4.60%	25.30%	11.20%	9.50%	4.80%	1.90%
Wayne	Y		5840	10036	24.10%	15.40%	10.20%	35.30%	17.50%	13.20%	11.90%	4.40%
Westford			289	639	22.90%	17.80%	7.10%	36.90%	22.80%	19.00%	11.10%	3.70%

Attachment C: Lifeline calls by Michigan county

County	Population	Lifeline Calls 2005	Lifeline Calls per 1,000 residents 2005	Lifeline Calls 2006	Lifeline Calls per 1,000 residents 2006	Lifeline Calls 2007	Lifeline Calls per 1,000 residents 2007	Lifeline Calls 2008	Lifeline Calls per 1,000 residents 2008	Lifeline Calls 2009	Lifeline Calls per 1,000 residents 2009	Lifeline Calls 2010	Lifeline Calls per 1,000 residents 2010
Alcona	10942	0	0.000	1	0.091	5	0.457	3	0.274	3	0.274	7	0.640
Alger	9601	0	0.000	5	0.521	2	0.208	2	0.208	6	0.625	20	2.083
Allegan	111408	5	0.045	25	0.224	44	0.395	57	0.512	60	0.539	64	0.574
Alpena	29598	4	0.135	10	0.338	46	1.554	66	2.230	52	1.757	332	11.217
Antrim	23580	2	0.085	2	0.085	23	0.975	19	0.806	32	1.357	23	0.975
Arenac	15899	1	0.063	1	0.063	16	1.006	19	1.195	22	1.384	6	0.377
Baraga	8860	0	0.000	1	0.113	3	0.339	9	1.016	24	2.709	14	1.580
Barry	59173	1	0.017	13	0.220	34	0.575	36	0.608	67	1.132	31	0.524
Bay	107771	11	0.102	29	0.269	147	1.364	220	2.041	214	1.986	156	1.448
Benzie	17525	2	0.114	8	0.456	13	0.742	13	0.742	20	1.141	15	0.856
Berrien	156813	17	0.108	78	0.497	158	1.008	200	1.275	211	1.346	301	1.919
Branch	45248	2	0.044	9	0.199	40	0.884	28	0.619	73	1.613	46	1.017
Calhoun	136146	15	0.110	25	0.184	129	0.948	211	1.550	341	2.505	365	2.681
Cass	52293	3	0.057	11	0.210	21	0.402	54	1.033	32	0.612	19	0.363
Charlevoix	25949	1	0.039	3	0.116	17	0.655	16	0.617	10	0.385	16	0.617
Cheboygan	26152	0	0.000	5	0.191	38	1.453	24	0.918	31	1.185	43	1.644
Chippewa	38520	6	0.156	9	0.234	38	0.987	68	1.765	58	1.506	79	2.051
Clare	30926	1	0.032	8	0.259	29	0.938	24	0.776	43	1.390	26	0.841
Clinton	75382	1	0.013	6	0.080	29	0.385	21	0.279	22	0.292	29	0.385
Crawford	14074	0	0.000	0	0.000	22	1.563	32	2.274	33	2.345	32	2.274
Delta	37069	10	0.270	16	0.432	44	1.187	38	1.025	42	1.133	45	1.214
Dickinson	26168	3	0.115	5	0.191	29	1.108	51	1.949	69	2.637	52	1.987
Eaton	107759	10	0.093	10	0.093	78	0.724	76	0.705	65	0.603	65	0.603
Emmet	32694	1	0.031	11	0.336	25	0.765	85	2.600	50	1.529	50	1.529

County	Population	Lifeline Calls 2005	Lifeline Calls per 1,000 residents 2005	Lifeline Calls 2006	Lifeline Calls per 1,000 residents 2006	Lifeline Calls 2007	Lifeline Calls per 1,000 residents 2007	Lifeline Calls 2008	Lifeline Calls per 1,000 residents 2008	Lifeline Calls 2009	Lifeline Calls per 1,000 residents 2009	Lifeline Calls 2010	Lifeline Calls per 1,000 residents 2010
Genesee	425790	40	0.094	162	0.380	507	1.191	659	1.548	721	1.693	921	2.163
Gladwin	25692	2	0.078	0	0.000	12	0.467	14	0.545	25	0.973	24	0.934
Gogebic	16427	3	0.183	5	0.304	12	0.731	10	0.609	29	1.765	20	1.218
Grand Traverse	86986	10	0.115	54	0.621	65	0.747	165	1.897	184	2.115	157	1.805
Gratiot	42476	0	0.000	7	0.165	25	0.589	49	1.154	35	0.824	49	1.154
Hillsdale	46688	3	0.064	3	0.064	46	0.985	47	1.007	47	1.007	52	1.114
Houghton	36628	4	0.109	20	0.546	22	0.601	64	1.747	46	1.256	44	1.201
Huron	33118	5	0.151	0	0.000	13	0.393	33	0.996	33	0.996	35	1.057
Ingham	280895	53	0.189	119	0.424	387	1.378	478	1.702	807	2.873	726	2.585
Ionia	63905	0	0.000	4	0.063	27	0.423	15	0.235	51	0.798	51	0.798
Iosco	25887	1	0.039	5	0.193	15	0.579	52	2.009	61	2.356	92	3.554
Iron	11817	2	0.169	1	0.085	5	0.423	3	0.254	16	1.354	14	1.185
Isabella	70311	0	0.000	16	0.228	38	0.540	37	0.526	28	0.398	45	0.640
Jackson	160248	8	0.050	33	0.206	219	1.367	217	1.354	164	1.023	255	1.591
Kalamazoo	250331	34	0.136	79	0.316	233	0.931	196	0.783	322	1.286	370	1.478
Kalkaska	17153	1	0.058	1	0.058	16	0.933	19	1.108	17	0.991	17	0.991
Kent	602622	31	0.051	66	0.110	399	0.662	629	1.044	763	1.266	981	1.628
Keweenaw	2156	0	0.000	0	0.000	0	0.000	0	0.000	0	0.000	0	0.000
Lake	11539	0	0.000	3	0.260	2	0.173	5	0.433	6	0.520	9	0.780
Lapeer	88319	4	0.045	14	0.159	34	0.385	84	0.951	59	0.668	84	0.951
Leelanau	21708	1	0.046	2	0.092	5	0.230	12	0.553	8	0.369	1	0.046
Lenawee	99892	5	0.050	11	0.110	87	0.871	86	0.861	134	1.341	185	1.852
Livingston	180967	10	0.055	44	0.243	120	0.663	181	1.000	181	1.000	188	1.039
Luce	6631	0	0.000	0	0.000	0	0.000	4	0.603	6	0.905	8	1.206
Mackinac	11113	0	0.000	5	0.450	8	0.720	10	0.900	7	0.630	25	2.250
Macomb	840978	110	0.131	282	0.335	1017	1.209	1199	1.426	1937	2.303	1398	1.662

County	Population	Lifeline Calls 2005	Lifeline Calls per 1,000 residents 2005	Lifeline Calls 2006	Lifeline Calls per 1,000 residents 2006	Lifeline Calls 2007	Lifeline Calls per 1,000 residents 2007	Lifeline Calls 2008	Lifeline Calls per 1,000 residents 2008	Lifeline Calls 2009	Lifeline Calls per 1,000 residents 2009	Lifeline Calls 2010	Lifeline Calls per 1,000 residents 2010
Manistee	24733	0	0.000	21	0.849	41	1.658	30	1.213	20	0.809	15	0.606
Marquette	67077	3	0.045	21	0.313	35	0.522	88	1.312	152	2.266	166	2.475
Mason	28705	1	0.035	5	0.174	24	0.836	51	1.777	41	1.428	80	2.787
Macosta	42798	3	0.070	13	0.304	35	0.818	40	0.935	29	0.678	85	1.986
Menominee	24029	1	0.042	5	0.208	17	0.707	48	1.998	53	2.206	49	2.039
Midland	83629	8	0.096	16	0.191	56	0.670	92	1.100	90	1.076	96	1.148
Missaukee	14849	2	0.135	3	0.202	2	0.135	7	0.471	7	0.471	4	0.269
Monroe	152021	11	0.072	20	0.132	162	1.066	269	1.769	424	2.789	267	1.756
Montcalm	63342	2	0.032	15	0.237	59	0.931	45	0.710	45	0.710	86	1.358
Montmorency	9765	0	0.000	1	0.102	6	0.614	8	0.819	9	0.922	2	0.205
Muskegon	172188	18	0.105	42	0.244	111	0.645	173	1.005	162	0.941	249	1.446
Newaygo	48460	6	0.124	13	0.268	47	0.970	45	0.929	30	0.619	26	0.537
Oakland	1202362	148	0.123	317	0.264	1344	1.118	1642	1.366	2293	1.907	2168	1.803
Oceana	26570	4	0.151	6	0.226	8	0.301	9	0.339	13	0.489	7	0.263
Ogemaw	21699	8	0.369	10	0.461	14	0.645	24	1.106	17	0.783	24	1.106
Ontonagon	6780	0	0.000	1	0.147	0	0.000	3	0.442	6	0.885	8	1.180
Osceola	23528	3	0.128	6	0.255	21	0.893	14	0.595	18	0.765	26	1.105
Oscoda	8640	0	0.000	0	0.000	5	0.579	5	0.579	10	1.157	2	0.231
Otsego	24164	1	0.041	1	0.041	25	1.035	41	1.697	32	1.324	26	1.076
Ottawa	263801	104	0.394	332	1.259	296	1.122	185	0.701	214	0.811	334	1.266
Presque Isle	13376	0	0.000	1	0.075	16	1.196	10	0.748	5	0.374	7	0.523
Roscommon	24449	1	0.041	6	0.245	20	0.818	39	1.595	29	1.186	35	1.432
Saginaw	200169	27	0.135	36	0.180	228	1.139	268	1.339	273	1.364	333	1.664
St. Clair	163040	29	0.178	41	0.251	142	0.871	197	1.208	145	0.889	218	1.337
St. Joseph	61295	0	0.000	10	0.163	60	0.979	128	2.088	80	1.305	164	2.676
Sanilac	43114	2	0.046	11	0.255	36	0.835	21	0.487	61	1.415	87	2.018

County	Population	Lifeline Calls 2005	Lifeline Calls per 1,000 residents 2005	Lifeline Calls 2006	Lifeline Calls per 1,000 residents 2006	Lifeline Calls 2007	Lifeline Calls per 1,000 residents 2007	Lifeline Calls 2008	Lifeline Calls per 1,000 residents 2008	Lifeline Calls 2009	Lifeline Calls per 1,000 residents 2009	Lifeline Calls 2010	Lifeline Calls per 1,000 residents 2010
Schoolcraft	8485	2	0.236	0	0.000	9	1.061	11	1.296	13	1.532	28	3.300
Shiawassee	70648	4	0.057	14	0.198	111	1.571	113	1.599	104	1.472	102	1.444
Tuscola	55729	2	0.036	11	0.197	45	0.807	54	0.969	44	0.790	40	0.718
Van Buren	76258	2	0.026	17	0.223	102	1.338	62	0.813	82	1.075	76	0.997
Washtenaw	344791	27	0.078	105	0.305	499	1.447	609	1.766	639	1.853	708	2.053
Wayne	1820584	322	0.177	778	0.427	2430	1.335	3076	1.690	4082	2.242	4024	2.210
Wexford	32735	1	0.031	19	0.580	36	1.100	48	1.466	40	1.222	47	1.436
Michigan	9883640	1165	0.118	3124	0.316	10386	1.051	13095	1.325	16529	1.672	17176	1.738

DRAFT

Michigan Suicide Prevention Coalition—2005

Ms. Ain Boone	Survivor; MAS
Ms. Robin Bell	Michigan Public Health Institute (MPHI)/Child Death Review Program (CDR)
Ms. Patricia Brown	Survivor; Michigan Association of Suicidology (MAS)
Ms. Bonnie Bucqueroux	Michigan State University, Victims in the Media Program
Mr. Michael Cummings	Joseph J. Laurencelle Foundation
Ms. Joan Durling	Shiawasee Community Mental Health Authority
Ms. Glenda Everett-Sznoluch	Survivor; MAS Youth Suicide Prevention
Ms. Cathy Goodell	Mental Illness Research Association (MIRA)
Mr. Eric Hipple	MIRA; Stop Suicide Alliance; Survivor
Dr. Hubert C. Huebl	NAMI (National Alliance for the Mentally Ill) Michigan
Ms. Peggy Kandulski	President, MAS; Survivor
Dr. Cheryl King	University of Michigan Department of Psychiatry
Dr. Alton Kirk	Associated Psychological Services
Mr. Sean Kosofsky	Triangle Foundation
Ms. Sabreena Lachainn	Survivor; Journey for Hope
Ms. Mary Leonhardi	Administrator, Detroit Waldorf School
Mr. Larry G. Lewis (MiSPC Chair)	Vice-President MAS; C.O. Suicide Prevention Action Network (SPAN) of Michigan
Ms. Vanessa Maria Lewis	Advanced Counseling Service; MAS
Ms. Mary Ludtke	Michigan Department of Community Health (MDCH), Mental Health Services to Children and Families
Ms. Karen Marshall	Stop Suicide Alliance; Community Education About Mental Illness and Suicide (CEMS) of Oakland County CMH; Survivor
Ms. Lynda Meade	MPHI/CDR
Ms. Marilyn Miller	MDCH, Office of Drug Control Policy
Ms. Lindsay Miller	MPHI/CDR
Mr. Micheal Mitchell	Emergency Telephone Service, Neighborhood Services Organization (NSO), Detroit
Mr. William Pell	Gryphon Place, Kalamazoo
Ms. Carol Pompey	Indiana Coalition, Miles, Michigan
Ms. Judi Rosen-Davis	MAS
Mr. Tony Rothschild	Common Ground Sanctuary
Ms. Patricia Smith	MDCH, Injury and Violence Prevention Section
Mrs. Elly Smyczynski	Survivor
Ms. Merry Stanford	MiSPC liaison from the Michigan Department of Education
Mr. Michael Swank	Bay-Arenac Behavioral Health
Mr. William Tennant	Mental Health Association in Michigan

IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

U. Technical Assistance Needs

1. What areas of technical assistance is the state currently receiving?

MDCH is receiving technical assistance through the National Council on Behavioral Health, University of Michigan School of Social Work and PIHP staff experienced in advanced integrated health fieldwork development. This assistance benefits MDCH staff and Michigan Association of Community Mental Health Board Staff through an innovative collaborative effort, which in turn benefits Prepaid Inpatient Health Plan Staff and direct providers. Information and resources are shared, and made available to the field for implementation.

During the first year and a half to two years of Michigan's transformation to a recovery oriented system of care, the state expended a significant amount of money to engage consultants to educate and assist with the needs and directions for transformation. This type of support is costly and the number of groups and types of individuals who need this training is significant. The state has supported this to the best of their ability but their resources are limited. Additionally, training needs to happen at each level of engagement with in the system including: state, regional, and local. Michigan did not have the depth of resources (financially or in personnel) to provide the depth and breadth of education and training needed. And now with the additional demands of primary health care integration and the Affordable Care Act, the state finds itself in even greater need of funding and technical assistance.

2. What are the sources of technical assistance?

In FY13, the National Council on Behavioral Health began providing guidance, technical assistance and individual support as Michigan continues to encourage and enhance PIHP health integration activities with physical healthcare. Activities that include a comprehensive evaluation of both qualitative and quantitative data for the Learning Community are provided through the University of Michigan, School of Social Work. Other assistance to the field comes from MDCH program staff, from the Integrated Health Project Manager and state leaders from the field.

3. What technical assistance is needed by state staff?

There are 12 federally recognized tribes in the state of Michigan, of which 11 are members of the Inter-Tribal Council of Michigan. The state is seeking technical assistance with regard to engagement in tribal consultation and collaboration.

Technical assistance related to understanding the interface of integrated health and the affordable care act would assist state staff greatly.

The state needs training and education to the substance use disorder staff and their state partners on the importance of collaboration around recovery services.

A national view of states progress that includes thorough understanding of integrated health models, the benefits and challenges faced by rural and urban providers with up-to-date information and the opportunity to observe and learn from them.

Assistance to clearly envision the desired outcomes (such as SAMHSA's recovery outcomes) and developed infrastructure to achieve integration would strengthen current efforts to move forward. Assistance addressing the reality that all efforts for truly integrated care must include the ability for providers to use the Medicaid encounter codes and be reimbursed for integrated services. Until such time, even the best efforts are only cooperative.

Recovery to people with working in or substance use disorders means something different than recovery for people with or working with a person with a psychiatric illness; people with co-occurring disorders are caught in between. Assistance in understanding and restructuring to one system that centers on each person's individual needs to recovery is to some degree a change in treatment philosophy. Common definitions and beliefs are different.

4. What technical assistance is most needed by behavioral health providers?

How to utilize, incorporate and manage peer recovery support services at the local levels and how to supervise peer recovery personnel are needed. Transition funding from currently supported services to the new culture and vision of substance use disorder recovery oriented services is also needed. It is difficult to manage change during the transition to ROSC and have the funds to support "new and expanded" types of services while gradually letting go of the "old" types of services.

Behavioral health providers are learning and implementing integrated health on all levels. Understanding case to care management, including integrated goals in behavioral health plans, supporting and modeling healthy behaviors at drop-in centers, clubhouses, FQHCs and Community Mental Health Services Programs/Substance Abuse Coordinating Agencies is in various developmental stages. Technical assistance, resources, training, supervision/coaching, and continued structural building is still needed.

IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Footnotes:



Behavioral Health Advisory Council

State of Michigan

July 24, 2013

James Haveman, Director
Michigan Department of Community Health
201 Townsend Street
Lansing, MI 48913

Dear Mr. Haveman:

The state's Behavioral Health Advisory Council (BHAC) met on June 28th 2013, to review and discuss Michigan's fiscal year 2014 Behavioral Health Services Block Grant Application.

The BHAC is comprised of behavioral health stakeholders including consumers, family members, advocates, service providers, and representatives of state departments from both the mental illness and substance abuse sectors of MDCH.

We appreciate the opportunity to provide advisement to you on the federal Block Grant Application. As a council we value that Michigan is taking a step ahead in creating a combined council to address these often overlapping concerns.

The council looks forward to developing our advisory role relating to the state's behavioral health activities. As our first step in that process we have been given the opportunity to review, make suggestions, and approve with the content of the information to be submitted for the FY14 Block Grant application. We are optimistic that this submission will be met with favorably by the federal government.

Sincerely,

Marcia Probst, Chair
Behavioral Health Advisory Council
Telephone: (269) 343-6725
E-mail: mprobst@recoverymi.org

IV: Narrative Plan

Behavioral Health Advisory Council Members

Start Year:
 End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Amy Allen	State Employees	Department of Community Health - Medicaid	400 South Pine Street Lansing, MI 48933 PH: 517-241-8704	allena7@michigan.gov
Rebecca Cienki	Others (Not State employees or providers)	Michigan Primary Care Association	7215 Westshire Drive Lansing, MI 48917 PH: 517-827-0474	rcienki@mpca.net
Mary Beth Evans	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		101 Vienna Court Houghton Lake, MI 48629 PH: 231-394-1873	maibie_twins_two@yahoo.com
Benjamin Jones	Others (Not State employees or providers)	National Council on Alcoholism and Drug Dependence	2400 E. McNichols Detroit, MI 48212 PH: 313-868-1340	president@ncadd-detroit.org
Chris O'Droski	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3800 Packard, Suite 210 Ann Arbor, MI 48108 PH: 734-975-1602	hnv_chris75@yahoo.com
Linda Burghardt	Others (Not State employees or providers)	NAMI - Michigan	921 N. Washington Avenue Lansing, MI 48906 PH: 517-485-4049	lburghardt@namimi.org
Elmer Cerano	Others (Not State employees or providers)	Michigan Protection and Advocacy Services	4095 Legacy Parkway, Suite 500 Lansing, MI 48911 PH: 517-487-1755	ecerano@mpas.org
Elizabeth Evans	Federally Recognized Tribe Representatives	Saginaw Indian Chippewa Tribe	2800 S. Shepherd Road Mt. Pleasant, MI 48858 PH: 989-775-4893	eevans@sagship.org
Michael Davis	State Employees	Department of Corrections	9036 East M-36 Whitmore Lake, MI 48189 PH: 734-449-3897	davism24@michigan.gov
Grady Wilkinson	Providers	Sacred Heart Rehabilitation Center, Inc.	400 Stoddard Road Memphis, MI 48041 PH: 810-392-2167	gwilkinson@sacredheartcenter.com
Jeffery Wieferich	State Employees	Department of Community Health - Substance Abuse	320 S. Walnut, 5th Floor Lansing, MI 48913 PH: 517-335-0499	wieferichj@michigan.gov
Joelene Beckett	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		31900 Utica Road Fraser, MI 48026 PH: 586-218-5283	joeli44@wowway.com
Julie Barron	Family Members of Individuals in Recovery (to include family members of adults with SMI)		812 E. Jolly Road, G-10 Lansing, MI 48910 PH: 517-346-9600	barron@ceicmh.org
Kevin McLaughlin	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		P.O. Box 105 Caledonia, MI 49316 PH: 616-262-8531	irenicoaching@gmail.com

Kevin O'Hare	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2763 22nd Street Wyandotte, MI 48192 PH: 734-309-3091	commdrkev@yahoo.com
Kristie Schmiege	Providers	Genesee County CMH	420 W. 5th Avenue Flint, MI 48503 PH: 810-496-5541	kschmiege@gencmh.org
Lauren Kazee	State Employees	Department of Education	608 W. Allegan Street, 2nd Floor Hannah Building Lansing, MI 48933 PH: 517-241-1500	kazeel@michigan.gov
Shareen McBride	Others (Not State employees or providers)	Association for Children's Mental Health	5938 W. Fourth Street Ludington, MI 49431 PH: 231-499-3333	shareenmm@yahoo.com
Lonnetta Albright	Others (Not State employees or providers)	Great Lakes Addiction Technology Transfer Center	1640 W. Roosevelt Road, Suite 511 Chicago, IL 60608 PH: 312-996-4450	lalbrigh@uic.edu
Lori Ryland	Providers	Venture Behavioral Health	100 Country Pine Lane Battle Creek, MI 49015 PH: 269-979-9132	lar@summitpointe.org
Marcia Probst	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		326 W. Kalamazoo Avenue #312 Kalamazoo, MI 49007 PH: 269-343-6725	mprobst@recoverymi.org
Marlene Lawrence	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		120 Grove Street Battle Creek, MI 49037 PH: 269-209-9748	marlenelawrence2000@yahoo.com
Jeff Patton	Providers	Kalamazoo CMH & Substance Abuse Services	3299 Gull Road, P.O. Box 63 Nazareth, MI 49074 PH: 269-553-8000	jpatton@kazooemh.org
Mary Chaliman	State Employees	Department of Human Services	Grand Tower, Suite 1514 Lansing, MI 48909 PH: 517-335-4151	chalimanm2@michigan.gov
Neicey Pennell	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		130 S. Clinton Street Charlotte, MI 48813 PH: 517-745-2531	jpennell00@yahoo.com
Norm DeLisle	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		780 West Lake Lansing Road, Suite 200 East Lansing, MI 48823 PH: 517-333-2477	ndelisle@mymdrc.org
Jamie Pennell	Parents of children with SED		211 Butler Leslie, MI 49251 PH: 517-589-9074	jpennell00@yahoo.com
Patricia Smith	State Employees	Department of Community Health - Public Health	P.O. Box 30195 Lansing, MI 48909 PH: 517-335-9703	smithp40@michigan.gov
Sonia Acosta	Providers	Centro Multicultural La Familia, Inc.	35 W. Huron, Suite 500 Pontiac, MI 48342 PH: 248-858-7800	sacosta@centromulticultural.org
Stephanie Oles	State Employees	Michigan State Housing Development Authority	735 E. Michigan Avenue, P.O. Box 30044 Lansing, MI 48912 PH: 517-241-8591	oles@michigan.gov

30233 Southfield

Mark Reinstein	Others (Not State employees or providers)	Mental Health Association in Michigan	Road, Suite 220 Southfield, MI 48076 PH: 248-647-1811	mstrmha@aol.com
Ben Robinson	Others (Not State employees or providers)	Rose Hill Center	300 E. Michigan Avenue Holly, MI 48442 PH: 248-634-5530	brobinson@rosehillcenter.org
Sally Steiner	State Employees	Department of Community Health - Aging	300 E. Michigan Avenue, P.O. Box 30676 Lansing, MI 48909 PH: 517-373-8810	steiners@michigan.gov
Brian Wellwood	Family Members of Individuals in Recovery (to include family members of adults with SMI)		520 Cherry Street Lansing, MI 48933 PH: 517-371-2221	brwellwood@yahoo.com
Karen Cashen	State Employees	Department of Community Health - Mental Health	320 S. Walnut Street, 5th Floor Lansing, MI 48913 PH: 517-335-5934	cashenk@michigan.gov
Cynthia Wright	State Employees	Michigan Rehabilitation Services	201 N. Washington Square, P.O. Box 30010 Lansing, MI 48909 PH: 517-241-3957	wrightc1@michigan.gov

Footnotes:

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IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Start Year:
 End Year:

Type of Membership	Number	Percentage
Total Membership	36	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	9	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED*	1	
Vacancies (Individuals and Family Members)	<input type="text" value="0"/>	
Others (Not State employees or providers)	8	
Total Individuals in Recovery, Family Members & Others	20	55.56%
State Employees	10	
Providers	5	
Federally Recognized Tribe Representatives	1	
Vacancies	<input type="text" value="0"/>	
Total State Employees & Providers	16	44.44%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="3"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="5"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	8	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="12"/>	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Michigan's Behavioral Health Advisory Council (BHAC) met on March 22, 2013, and June 28, 2013, to review the draft combined FY14-15 Block Grant Application. Several questions were asked regarding specific sections of the application, feedback was provided, and the BHAC voted to submit a letter of support (attached in Section W). Several BHAC members also submitted language for inclusion in varying sections of the application.

Footnotes:

IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Footnotes:

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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.