I: State Information

State Information

Plan Year

Start Year:

End Year:

State DUNS Number

Number
113704139

Extension

I. State Agency to be the Grantee for the Block Grant

Agency Name
Michigan Department of Community Health

Organizational Unit
Behavioral Health & Developmental Disabilities Administration

Mailing Address
320 S. Walnut Street

City
Lansing, MI

Zip Code
48913

II. Contact Person for the Grantee of the Block Grant

First Name
Elizabeth

Last Name
Knisely

Agency Name
Michigan Department of Community Health

Mailing Address
320 S. Walnut Street

City
Lansing, MI

Zip Code
48913

Telephone
517-335-5100

Fax
517-241-7283

Email Address
kniselye@michigan.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From
10/1/2009

To
9/30/2010

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name
Karen

Last Name
Cashen

Telephone
517-335-5934

Fax
517-335-6775

Email Address
cashenk@michigan.gov

Footnotes:

I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

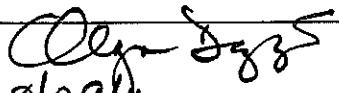
Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Olga Dazzo
Title	Director
Organization	Michigan Department of Community Health

Signature 

Date 8/29/11

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

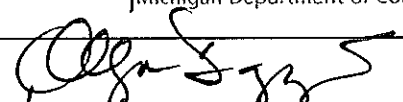
Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Olga Dazzo
Title	Director
Organization	Michigan Department of Community Health

Signature 

Date 8/29/11

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3)

Community Mental Health Services Block Grant Funding Agreements
FISCAL YEAR 2012

I hereby certify that Michigan agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:
i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”)
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

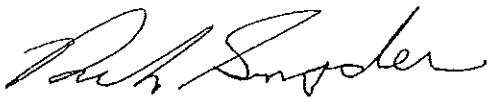
Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	Rick Snyder
Title	Governor
Organization	State of Michigan

Signature

Date



Footnotes:

I: State Information

Disclosure of Lobbying Activities (SF-LLL)

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Footnotes:

II: Planning Steps

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

Page 22 of the Application Guidance

Narrative Question:

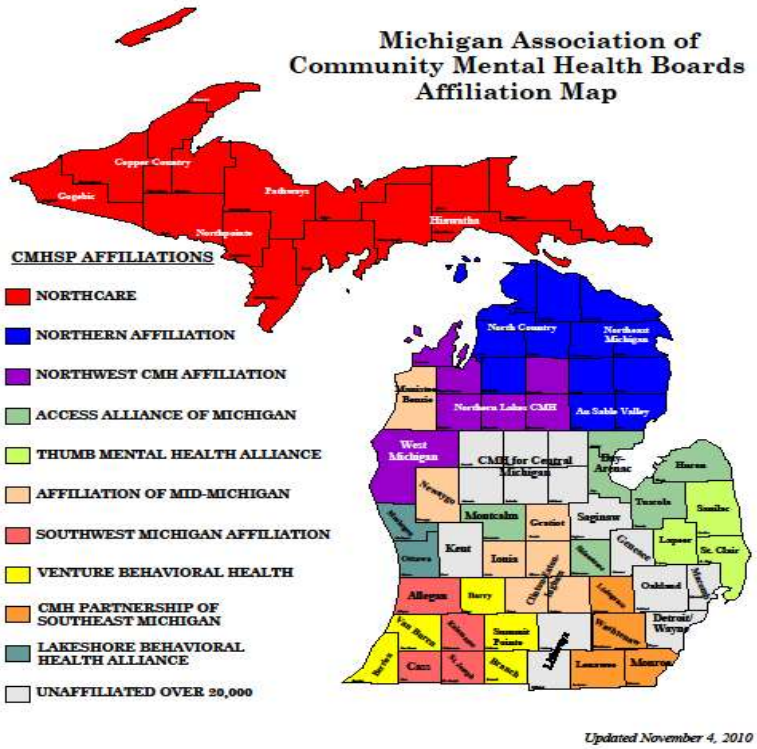
Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description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

Footnotes:

OVERVIEW

In Michigan, the State's behavioral health prevention, early identification, treatment, and recovery support systems are the primary responsibility of the State's mental health and substance abuse services authorities, collectively known as the Behavioral Health and Developmental Disabilities Administration (BHDDA), and located within the Michigan Department of Community Health (MDCH). MDCH, one of the largest of the 18 departments in Michigan's State government, is responsible for health policy and management of the State's publicly-funded health service systems. About 2 million Michigan residents will receive services in 2011 that are provided with total or partial support from MDCH. The department was created in 1996 by consolidating the Department of Public Health (now the Public Health Administration), the Department of Mental Health (now BHDDA), and the Medical Services Administration (MSA-the state's Medicaid agency). The Office of Drug Control Policy (which is now the Bureau of Substance Abuse and Addiction Services) and the Office of Services to the Aging were later consolidated with MDCH.

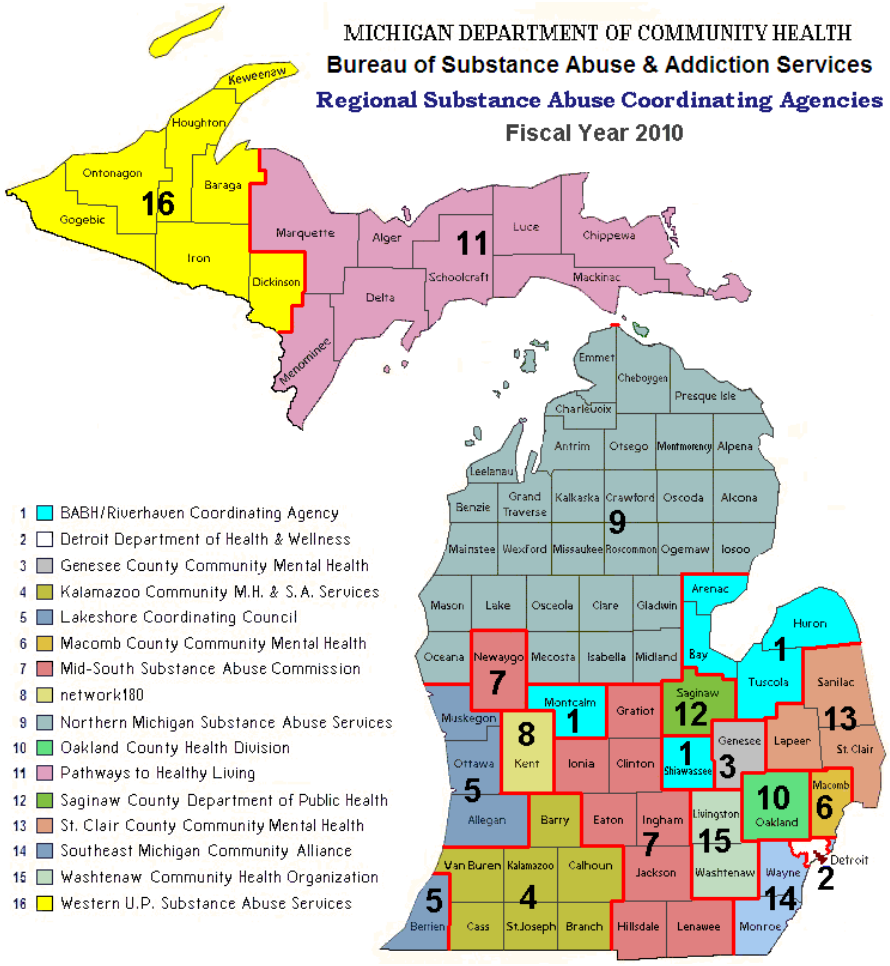
MDCH contracts with 18 Prepaid Inpatient Health Plans (PIHPs), which are comprised of single or multiple Community Mental Health Services Programs (CMHSPs), for Medicaid services to children with serious emotional disturbance (SED), to adults with serious mental illness (SMI), and to children and adults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



MDCH also contracts with the 46 CMHSPs for delivery of non-Medicaid funded services (including federal mental health block grant). The public mental health service delivery system also contains a small outpatient mental health benefit (20 visits) within the Medicaid Health Plans, which are contracted with MDCH through the Medical Services Administration to provide health and dental care to Medicaid beneficiaries. There is also a small fee-for-service mental health benefit for Medicaid beneficiaries (up to 10 visits) with a physician or psychiatrist. The array of Medicaid mental health specialty services and supports provided through PIHPs under Michigan's 1915b/c capitated managed care waiver includes: Applied Behavioral Services, Assertive Community Treatment, Assessments, Case Management, Child Therapy, Clubhouse Rehabilitation Programs, Crisis Interventions, Crisis Residential Services, Family Therapy, Health Services, Home-Based Services, Individual/Group Therapy, Intensive Crisis Stabilization Services, Medication Administration, Medication Review, Nursing Facility Mental Health Monitoring, Occupational Therapy, Personal Care in Specialized Settings, Physical Therapy, Speech, Hearing and Language, Substance Abuse, Treatment Planning, Transportation, Partial Hospitalization, and Inpatient Psychiatric Hospitalization. The specialty services and supports known as "b.3" services which are included in the MDCH contract include: Community Inclusion and Integration Services, Family Support and Training (including Parent-to-Parent Support), Respite Care, Housing Assistance, Peer-Delivered or -Operated Support Services, Prevention and Consultation Services (e.g. School Success Program, Childcare Expulsion Prevention Program, Infant Mental Health, Family Skills Training) and Wraparound Services. Additionally, in July of 2011, some of the services included as "b.3" for individuals over the age of 21 are now included in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program covered by Medicaid for individuals under 21 only. These include: Community Living Supports, Family Training (e.g. Parent Education, Programs for children of parents with mental illness) Peer-Directed and -Operated Support Services, Prevention-Services Direct Model, Skill Building Assistance, Supported Employment, Supports Coordination, and Wraparound Services.

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

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



BSAAS requires that the regional CAs make available to the public outpatient services (including intensive outpatient), residential services, medication-assisted treatment, case management, early intervention, peer recovery and recovery support, and integrated treatment for co-occurring mental health and substance use disorders. As a part of the service requirements that will be supported, BSAAS has been expanding and improving integrated treatment for persons with co-occurring mental health and substance use disorders. This has been a focus of improvement over the last several years and it has been done in partnership with the public mental health system. This process is overseen at the state level through the Practice Improvement Steering Committee and its Co-occurring Change Agent Leaders work group, comprised of state mental health and substance abuse staff, CA and PIHP representatives, stakeholders from local agencies and persons in recovery.

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

CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (SED)

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

There has been increased interagency collaboration in the state, especially in recent years, which has led to a more comprehensive SOC for children in a number of communities. In responding to Requests for Proposals (RFP) for the children's portion of the federal mental health block grant over 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 to propose projects in their RFP submissions that would fill identified gaps in the local SOC. 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, in order to maximize the effective use of funds.

In June of 2011, MDCH applied for a federal SOC Statewide Expansion Planning Grant through the Substance Abuse and Mental Health Services Administration (SAMHSA) and, if awarded, hopes that this focused attention on statewide SOC planning will provide the opportunity to develop a blueprint for expanding SOC for children with SED consistently across the state. The application alone was a tremendous collaborative effort that included multiple State agencies, local communities and families and the MDCH is optimistic about the progress that can be made through participation in this opportunity. Throughout this process as well, MDCH identified that there is definite need for additional focus and attention on providing culturally and linguistically competent services across the State. Michigan hopes to obtain technical assistance through this grant to identify ways to improve services to members of minority populations, including those of various racial, ethnic, gender and sexual orientation groups.

Historically in Michigan, efforts have been made to move children into communities from more restrictive out-of-home placements, while still providing beneficial and helpful treatment interventions. This movement has continued and is supported with mental health block grant funding. The development and implementation of evidence–based practices (EBPs) and 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. A formal family-driven and youth-guided policy and practice guideline was developed and has been included as an attachment to the MDCH contract with PIHPs/CMHSPs for Fiscal Year (FY) 12. (The family-driven and youth guided policy document is included in section L. of this application.)

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.

In addition Michigan has two new Substance Abuse and Mental Health Services Administration (SAMHSA) SOC grants which were awarded in 2011, one in Kent County and one in Saginaw County. These two sites, along with three former grant sites in Southwest Detroit, Ingham, and Kalamazoo counties provide leadership in collaborative efforts to develop SOC in their communities, and to impact State-level efforts. 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 various community representatives.

The system change initiative Michigan adopted requires systems to develop integrated treatment capacity at every level of care for both adults and children. Individuals with co-occurring disorders face issues that are complex in nature. These complexities cut across various health and human service agencies. The initial system change approach Michigan adopted is to develop a comprehensive model that addresses the needs of every individual who seeks help. To that effect, PIHPs are encouraged to develop consensus documents along with other systems that delineate the expectations of the individuals who have co-occurring disorders (COD) including both adults and children. Most of the CMHSPs are at varying degrees of implementation.

Some PIHPs have placed a specific focus on training on COD for children and these include Oakland and Central Michigan. Oakland County PIHP has held training in Motivational Interviewing in order to increase engagement of families in PMTO, as well as addressing the mental health and substance use issues of adolescents and family members. CMH for Central Michigan also includes a specific COD focus on children/adolescents to assist with meeting goals around their substance use. Several other PIHPs use Multi-Systemic Therapy (MST) as a strategy for addressing co-occurring disorders. There is a need for additional cross-agency cooperation between mental health and substance abuse services with regard to serving youth with co-occurring disorders. Michigan has for the first time included funding for statewide co-occurring treatment training for mental health professionals who treat children and youth with SED in the public mental health system in the children's mental health block grant spending plan. State and PIHP/CMHSP staff that have extensive experience with the implementation of integrated mental health and substance use disorder services for adults will be a great resource to access as the plan for this training is developed.

Michigan has achieved some success in creating the foundation for a statewide SOC for children with SED. All public mental health providers in Michigan utilize a standard definition of SED and uniform access standards, as outlined in an attachment to the MDCH contract with the PIHPs and with the CMHSPs. A standardized, validated and reliable outcome measure, the Child and Adolescent

Functional Assessment Scale (CAFAS) (Hodges, 1989)[1] is used to assess treatment effectiveness for children/youth, ages 7-17. MDCH has received national recognition for our work with Kay Hodges, PhD to implement the use of the CAFAS as an outcome measure in the public mental health system statewide. 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)[2] and Trauma-Focused Cognitive Behavioral Therapy (TFCBT) (Cohen, Mannarino, Deblinger, 2006)[3]. 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 for children with developmental disabilities and their families. MDCH is working individually with PIHPs to provide technical assistance regarding progressing to more comprehensive SOCs. CMHSPs were also required to utilize a SOC planning process to prepare their applications for funding through the children's portion of the mental health block grant and/or in implementing the 1915(c) Waiver for children with SED (SEDW). MDCH has been particularly interested in increasing access to specialty mental health services and supports for Medicaid eligible children/youth with SED in child welfare (i.e., abuse/neglect, foster care, and/or adopted children/youth) and juvenile justice.

MDCH has continued to work with the developer of the PMTO model to customize its use to the population served by the public mental health system in Michigan. Regional training, coaching, and fidelity monitoring for PMTO has been, and will continue to be, supported by children's mental health block grant funds. MDCH continues to implement a process for tracking the services provided by PMTO-certified therapists in the public mental health system through an encounter code modifier in hopes of getting a more accurate picture of how much of this EBP is actually being provided statewide. This has been an extremely challenging undertaking, and MDCH continues to work with regional trainers and consultants to refine and improve the process of expanding the training of clinicians in this EBP. Also, the introduction of a group format for PMTO was an exciting development in 2010. After several years of implementing the individual model, it became clear that Michigan needed a way to make PMTO available to more families at a lower cost to providers with the same positive outcomes. Through the existing long-term relationship with the PMTO developers, the development of a group format for PMTO as well as a two-day skill-based training for clinicians that teaches specific pieces of the PMTO model were created and implemented in 2010 to meet that need. Feedback on the group format and the two-day trainings has been overwhelmingly positive and training in this format has continued to grow statewide.

MDCH will also continue to support the Trauma Informed Initiative that began in 2008 with the first training cohorts in Trauma-Focused Cognitive Behavior Therapy (TFCBT). Supervisors, clinicians, intake staff and parent partners all participate at different levels in the training provided to create a comprehensive trauma-informed approach to services for children and families. MDCH is also training trainers and coaches in this EBP in order to create a sustained structure within Michigan. This initiative has been and will continue to be funded by children's mental health block grant funds. There continues to be a high level of interest expressed by CMHSPs wanting to participate in this initiative to be able to

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

[2] 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.

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

add TFCBT to the services they can offer to children with SED, especially those who have experienced abuse and/or neglect. The training being offered includes an adaptation of TFCBT for use in home-based services in addition to the traditional outpatient version of TFCBT. A few of the CMHSPs have also adapted the curriculum to provide training in trauma and its impact on children to juvenile justice providers (court staff, facility staff, etc.), educators, mental health staff (non-treatment staff), child welfare staff, and community members. This use of the curriculum assists in building a trauma-informed community where a child's behaviors will be understood, not as willful or delinquent, but as a result of the trauma(s) they have experienced in their young lives. With this foundation in place, Michigan needs to further this work across all communities to ensure adequate screening, assessment and treatment is available to children with SED as well as to continue to build trauma-informed communities.

Michigan continues to support the development of a SOC for children/youth with SED and their families by using block grant funding to support evidence-based and promising practices identified by local communities as necessary to fill gaps in their local service array. These projects are focused on particular sub-populations of children with SED, like young children and youth involved in the juvenile justice system, and provide opportunities for mental health providers to collaborate with system partners and families to develop, evaluate and plan for sustaining these projects. It is very important to note that implementing both PMTO and TFCBT on a statewide scale and supporting other EBP development in local communities would be impossible without the support of mental health block grant funding.

Additional 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 Policy Academy on Transforming Children's Mental Health through Family-Driven Strategies of the National Federation of Families for Children's Mental Health (and the continuing work of that team), an official MDCH policy on Family-Driven and Youth-Guided Practice has been released to assist 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, continued in 2011 and will be supported by children's mental health block grant funding to continue in 2012 and 2013. Parent Support Partners provide Medicaid reimbursable peer-to-peer support and training to parents and caregivers who have a child currently served through the public mental health system. The goal is to have authentic peer-to-peer support and training as a viable option for all eligible families in Michigan. The child welfare and judicial systems have also begun including family-driven and youth-guided concepts in their routine operations. Also as a result of the partnerships forged through this policy academy, State-level support correspondence was sent from the Department leadership in Mental Health, Child Welfare and Education, and from the State Court Administrator's Office, to their respective local offices and judges requesting their participation in local SOC planning efforts. The policy academy team still meets and has an active work plan to move forward with family-driven and youth-guided strategies across child-serving systems.

Another key component of SOC that has been addressed in the past two years is cross-system funding. MDCH and MDHS have committed to a collaborative partnership to implement the SEDW pilot in eight communities, including all four current and one former SAMHSA SOC grantee sites in Michigan. The waiver sites provide comprehensive mental health services, including wraparound, to children in MDHS foster care. This initiative provided the impetus for further collaboration between MDCH and MDHS to provide services to additional children in the foster care system who may not meet the criteria for the SEDW but who still require specialized mental health services. MDHS provides the State match to

Medicaid for both these projects in order to increase access to mental health services through CMHSPs/PIHPs for children in MDHS foster care. Also, an SEDW Access position, located at each local MDHS office, was funded by MDCH in each of the participating SEDW sites to provide a mental health assessment and connection for the MDHS staff locally. This partnership has been integral in assisting MDHS in responding to the consent decree that was the result of the Dwayne B. v. Granholm (2006) lawsuit and the revised consent decree (that requires, among other things, MDHS to provide improved screening and access to mental health services for children in foster care), and will continue to assist in the response to the revised consent decree Dwayne B. v. Snyder (2011) that requires that the SEDW be expanded to additional communities. Mental health block grant dollars are used to support this partnership by providing funding for mental health access clinician positions in local DHS offices in the pilot site communities. These positions act as a resource for DHS staff, provide mental health screens and assessments, facilitate referrals to appropriate services, and identify children appropriate for the SEDW. This has been a valuable component in the successful implementation of the SEDW as demonstrated in the MDCH/MDHS SEDW Pilot Preliminary Evaluation Report from February of 2011. MDCH and MDHS also provide joint funding for wraparound training statewide. These trainings are made available to participants, including providers and families, free of charge and are provided in various locations across the state. This has been a long standing and beneficial collaborative project that will continue to be supported in part by mental health block grant dollars.

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

BHDDA staff and PHA staff have closely collaborated on several projects focusing on young children, both integrating behavioral health and physical health for children and families and including screening for social and emotional issues in the pediatric office setting. These collaborative projects have allowed Michigan to utilize the expertise of both the mental health and public heath fields to address the very pressing issues of early identification of mental health problems and coordination of care for families with young children. Project LAUNCH (Linking Actions for Unmet Needs in Child Health) in particular, funded by SAMHSA and active in Saginaw County, is using evidence-based practice to improve collaboration among child-serving organizations and to integrate physical and mental health services and supports for children and their families. The project promotes the wellness of young children from birth to eight years of age by addressing the physical, emotional, social, cognitive, and behavioral aspects of their development. Another effort along these same lines, is the Screening Kids in Primary Care Plus (SKIPP) project. The SKIPP project is a collaborative proposal developed by MDCH (BHDDA, MSA and PHA) in partnership with MDHS which has been submitted to the Flinn Foundation for funding. The SKIPP project would provide for standardized developmental, social-

emotional and mental health screening, assessment, referral and follow-up for Medicaid children in Wayne County who are newly placed in foster care homes. SKIPP would provide mental health assessment and linkages to mental health services through the use of Mental Health Consultants at six selected pediatric practices Wayne County. Both of these projects can serve as resources and examples of how Michigan can develop a comprehensive system of care for its youngest citizens.

Another area where BHDDA and PHA staff have worked collaboratively to meet the needs of children and families is in the area of suicide prevention. The Suicide Prevention Program for Children and Youth program focuses on reducing both completed and attempted suicide among 10-24 year-olds in Michigan. The program provides grants, technical assistance and training to local communities, builds State-level capacity across departments, and conducts comprehensive evaluations. This program is housed in the PHA, but BHDDA staff, in addition to other state agency personnel, service providers and other stakeholders, participate on committees that contribute to the development and monitoring of programs like this, and to the statewide suicide prevention plan (which is included in this application in section J.). Because Michigan has accessed other funding sources for suicide prevention activities, children's mental health block grant funds have not been used for these types of programs to avoid duplication of efforts.

Finally, Michigan is very focused on outcome measures and evaluating the effectiveness and efficiency of the services provided by the public mental health system to children and youth with SED and their families and will continue to use mental health block grant dollars to support these essential projects. The block grant funded Michigan Level of Functioning (LOF) Project, which is a collaborative effort between MDCH, the PIHP/CMHSPs, Kay Hodges, PhD and Eastern Michigan University, collects and analyzes statewide CAFAS data to assess SED children's functioning in several life domains upon entry into services through CMHSPs, and then quarterly and at exit from services to determine if treatment is effective. MDCH receives aggregate reports and the CMHSPs are given provider specific reports that can help to monitor progress for programs, services and even individual children and their families. This information can be used with families in making decisions about treatment through family-driven/youth-guided practice. Training for clinicians on how to effectively use CAFAS information in treatment has been formalized and is available to CMHSPs. The data collected has led to improved outcomes management for children and youth with SED and their families, as well as identification of areas that could be improved in the SOC. In FY10, the transition to a web-based CAFAS system available to all CMHSPs was implemented and supported by a MDCH block grant contract with the developer. This web-based CAFAS makes it easier for sites to report data and to generate reports for their own internal use. Having immediate access to CAFAS data assists local mental health staff and supervisors in assessing effectiveness of treatment and in planning for future treatment. MDCH will also continue to utilize this data for planning and reporting purposes. Feedback about the ease of use and value of the web-based CAFAS has been very positive. Also, MDCH is continually forming and continuing partnerships with researchers and local universities, like eastern Michigan University and Michigan State University, to conduct evaluations of specific services (like home-based and wraparound) to inform policy, practice, and professional development statewide. Evaluation projects will continue to be supported with block grant funds to make sure that MDCH has the data it needs to provide to the public mental health system to inform clinically sound and efficient practice, and to the State legislature and federal funders when the need arises to demonstrate the effectiveness of the services and supports provided by Michigan's publicly funded mental health services to children and youth with SED and their families.

ADULTS WITH SERIOUS MENTAL ILLNESS (SMI)

Please reference the significant description of Michigan's public sector system serving the needs of adults with SMI contained in the OVERVIEW section above.

As early as 2001, the National Institute of Medicine's report brief entitled, Crossing the Quality Chasm – A New Health System for the 21st Century highlighted the finding that, *"Scientific knowledge about best care is not applied systematically or expeditiously to clinical practice. It now takes an average of 17 years for new knowledge generated by randomized controlled trails to be incorporated into practice, and even then application is highly uneven. The committee therefore recommends that the Department of Health and Human Services establish a comprehensive program aimed at making scientific evidence more useful and more accessible to clinicians and patients."*[4]

Additional calls for systems transformation came in 2003 with the President's New Freedom Commission on Mental Health report, in 2004 with the State of Michigan's Mental Health Commission final report, and in 2006 with another National Institute of Medicine report on Improving the Quality of Care for Mental and Substance-Use Conditions. As recently as 2009, Proctor et al noted that, *"One of the most critical issues in mental health services research is the gap between what is known about effective treatment and what is provided to and experienced by consumers in routine care in community practice settings."*[5]

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

Assisted by available block grant resources, Michigan has made great strides in improving our system of care to include the availability and delivery of many of these recommended practices. Among the strengths demonstrated across our State, efforts have continued to progress in the development and implementation of a range of SAMHSA-endorsed evidence-based practices (EBPs) and cross-cutting initiatives across our CMH provider system, including block grant-supported projects targeting the following adult service practice areas. As many of these practices are only partially implemented and/or are encountering sustainability challenges, they also continue to represent ongoing needs for the coming FY12 grant cycle:

- **Assertive Community Treatment** (ACT)
    - Every PIHP region in Michigan has one or more ACT teams delivering services at this highest level of intensity for outpatient mental health care.

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

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

- Ongoing core and refresher training has continued to be made available, along with the use of a State-developed ACT Field Guide and technical assistance to support provider teams in developing and maintaining high-fidelity service quality.
- Needs moving forward include supporting ongoing effective service quality, with better outcome tracking and analysis to substantiate progress and cost/benefit value.

- **Family Psychoeducation** (FPE)
  - The overwhelming majority of PIHP regions in Michigan feature one or more available FPE group services.
  - Ongoing training has continued to be made available to promote quality, high-fidelity provision and sustainability of this EBP.
  - Needs moving forward include supporting ongoing effective service quality, with better outcome tracking and analysis to substantiate progress and cost/benefit value.

- **Integrated Dual Disorders Treatment** (IDDT) and other **Co-occurring Disorders (COD) Treatment** services
  - Every PIHP regions in Michigan features more than one IDDT team, with several new teams launching during this past year, including four in the Upper Peninsula area.
  - Ongoing core and refresher training to establish and advance provider competencies was provided, including Michigan's 3rd Annual two-day Statewide COD Conference which drew 550 participants. Additionally, site review IDDT team evaluations and subsequent coaching / technical assistance also continued to be available across the State, contributing to the launch of several new teams.
  - Needs moving forward include supporting ongoing effective service quality, with better outcome tracking and analysis to substantiate progress and cost/benefit value. Also needed is greater integration between the traditionally bifurcated mental health and substance abuse service sectors.

- **Motivational Interventions**
  - Staff in every PIHP region in Michigan has had some level of training on Motivational Interviewing.
  - Ongoing refresher training was provided to a cadre of train-the-trainer graduates, and evaluation of the effectiveness of current training approaches took place, leading to a proposed redesign for FY12 to increase penetration of this cross-cutting practice across adult services staffing groups.
  - Needs include supporting ongoing effective service quality, with outcome tracking and analysis to substantiate progress and cost/benefit value.

- **Dialectical Behavior Therapy** (DBT)
  - The overwhelming majority of Michigan's PIHP regions feature one or more available DBT teams providing this evidence-based treatment to service recipients with Borderline Personality Disorder, a population that when untreated/undertreated tends to drive up emergency service/crisis service and psychiatric hospitalization costs.
  - Ongoing core and refresher training was provided, along with evaluation of the effectiveness of the current training approach took place, leading to a redesign for FY12 to increase cost-effectiveness and sustainability.
  - Needs moving forward include supporting ongoing effective service quality, with better outcome tracking and analysis to substantiate progress and cost/benefit value.

- **Supported Employment** (SE)
  - Newly prioritized core training was established and offered this past year in order to advance provider competencies. Additionally, site review SE team evaluation and subsequent coaching / technical assistance were offered across the State.
  - Needs moving forward include building and supporting ongoing effective service quality, with outcome tracking and analysis to substantiate progress and cost/benefit value.

- **Recovery-oriented care**
  - Transformation of the adult services system to a more complete recovery orientation, including but not limited to the greater establishment of peer support services availability.
  - Ongoing establishment of the Michigan Recovery Center of Excellence website resource (http://www.mirecovery.org), and quarterly meetings of the statewide Recovery Council to continue to inform movement of the State's mental health care provider network toward greater recovery-oriented transformation.

- **Peer Support Services**
  - Ongoing Certified Peer Support Services (CPSS) provider training and efforts to support the establishment of available peer support services in multiple CMH service settings, from Emergency Departments and Access Centers, to Integrated Health settings, and CMH outpatient clinics.
  - Needs moving forward include building and supporting ongoing effective service provision, ability to capture and bill for Peer Support Services that are delivered, and outcome tracking and analysis to substantiate service quality and cost/benefit value.

- **Integrated Physical & Behavioral Health** initiatives
  - Multiple efforts to better integrate mental health and substance use disorder treatment services with physical health services, in a variety of settings including Federally Qualified Health Clinics (FQHCs), in other traditional physical health clinics, and in CMH and other traditional mental health care settings.
  - Needs moving forward include continuing to learn and apply lessons from pilot projects, to inform ongoing efforts to be optimally positioned to develop and utilize healthcare home models and accountable care approaches that are part of ongoing healthcare reform.

- **Trauma-specific and Trauma-informed Services**
  - Increasing recognition of the high prevalence of historical trauma among many adult services populations, with support for developing and implementing Seeking Safety and Trauma Recovery and Empowerment Model services as part of Co-occurring Disorders treatment, as well as addressing trauma within the context of advanced Dialectical Behavior Therapy for borderline personality disorder with prolonged exposure approaches. Additional attention is being given to moving systems of care to becoming more trauma-informed.
  - Needs moving forward include building and supporting ongoing effective service quality, with outcome tracking and analysis to substantiate progress and cost/benefit value.

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

Michigan's economic difficulties of the past few years have also continued to pose financial challenges, in the form of a decreased amount of available General Fund resources with which to provide adult services to those needful recipients that are not covered by Medicaid or other health insurances. The needs of service recipients have also been exacerbated by the associated increase in the stressors of poverty and unemployment, as referenced in the next section (II – Step 2). Block grant resources have played a critical role in supporting the development, implementation, sustainability, and delivery of effective mental health services to Michigan recipients that otherwise would suffer from the lack of other available funding.

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

II: Planning Steps

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

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Narrative Question:

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

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

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

Footnotes:

OVERVIEW

The State Epidemiological Outcomes Workgroup (SEOW) in Michigan is chaired by the State Epidemiologist of MDCH. Other active members include Prevention Coordinators from eight of the 16 CAs; Michigan State Police Office of Highway Safety Planning; Michigan Department of Education; Prevention Network; MDCH epidemiology units representing public health initiatives; local and community-based substance abuse prevention providers; epidemiologists from two local public health departments; Pacific Institute for Research and Evaluation (PIRE); Little Traverse Band of Chippewa Indians; and representation from colleges and universities. A BSAAS Prevention Section staff person is the staff liaison for the SEOW. Please reference the chart below for additional detail on SEOW composition.

The primary activities of the SEOW for FY 2012-2013 will be to: (1) Expand the scope of the SEOW to include treatment and recovery (not just prevention) and to include mental health disorder prevention and treatment; 2) Continue to gather new data as it becomes available, particularly around prescription and over-the-counter drug abuse; (3) Analyze data being gathered, and serve as a resource for both the state and local Community Epidemiology Workgroups (CEWs); (4) Continue work on establishing a web-based central data repository for Michigan that can be easily accessed and updated; and (5) Evaluate and prioritize continued data gaps, and develop plans for filling these gaps.

STATE EPIDEMIOLOGICAL OUTCOMES WORKGROUP MEMBERS As of January 10, 2011		
Member Name	***Organization***	***Workgroup Affiliation***
Elizabeth Agius	*Wayne State University*	*Member / SEOW Project Evaluator*
Minou Carey	*Michigan Department of Community Health (MDCH), Bureau of Substance Abuse and Addiction Services (BSAAS), Center for Substance Abuse Prevention (CSAP) Prevention Fellow*	*Staff Support*
Lisa Coleman	*Genesee County Community Mental Health*	*Member*
Denise Herbert	*Network 180*	*Member*
Joel Hoepfner	*Mid-South Substance Abuse Commission / Michigan Association of Substance Abuse Coordinating Agencies (MASACA) Representative*	*Member*
Charlotte Kilvington	*Michigan State Police*	*Member*
Kim Kovalchick	*Michigan Department of Education*	*Member*
Mary Ludtke	*MDCH Mental Health*	*Member*

Dr. Corinne Miller	*MDCH Bureau of Epidemiology*	*Member / Chairperson*
Dr. Su Min Oh	*MDCH BSAAS (Prevention)*	*Member / SEOW Epidemiologist*
Larry Scott	*MDCH BSAAS (Prevention)*	*Member / SEOW Project Director*
Felix Sharpe	*MDCH BSAAS*	*Member*
Brenda Stoneburner	*MDCH BSAAS (Prevention)*	*SEOW Staff Liaison*
Jeff Wieferich	*MDCH BSAAS (Treatment)*	*Member*
Jill Worden	*Bay Area Behavioral Health/Riverhaven Coordinating Agency*	*Member*

In Michigan 78.9% of residents identify as white; 14.2% as African American; 2.4% as Asian; 0.6% as American Indian/Alaskan Native; .03% as Native Hawaiian/Pacific Islander; 1.5% as "Other" and 2.3% as two or more categories. Overall, 4.4% of the population identifies as Hispanic. Michigan includes major urban areas, like the cities of Detroit, Flint and Saginaw along with some very rural areas such as parts of northern Michigan and the Upper Peninsula.

CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (SED)

According to the 2010 US Census, Michigan is the 8th most populous state in the United States with an estimated population of 9,883,640, with 2,344,068 of those residents being children, ages 0-18. Prevalence data supplied by the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2009 National Outcome Measures Prevalence Report suggests 7-13% of the 1,225,162 children from ages 9 to 17 in Michigan could be identified as having SED. That means anywhere from 85,761 to 159,271 children ages 9 to17 might have been eligible for services in the public mental health system in 2009 alone. However, data reported in the fiscal year 2009 Finger Tip Report compiled by MDCH indicates 40,183 children (ages 0 through 17) with SED were served in the public mental health system. Improvement in identifying and engaging children who may be in need of mental health services in Michigan is needed. According to MDHS FY10 data, 13,098 children were residing in out-of-home foster care and juvenile justice placements which cost $164,123,227.31 that year. According to the MDE, the statewide high school drop out rate in fiscal year 2010 was 11.7% despite a concerted effort by education to reduce youth leaving school before graduation. According to Human Rights Watch, as of 2009, Michigan is second in the nation for the number of juveniles (346) serving a life sentence without parole. Also, according to the 2009 Youth Risk Behavior Survey as noted in the 2011 Michigan Epidemiological Profile, 16% of Michigan public high school students reported having seriously considered suicide in the past 12 months, compared to 13.8% of youth nationally. About one in every 11 Michigan public high school students (9.3%) reported having attempted suicide one or more times in the past year with three percent of respondents requiring medical attention after an attempted suicide. Data reported on the National Center for Children in

Poverty website (http://nccp.org/publications/pub_687.html#26) indicates nationally that up to 44% of youth with mental health problems drop-out of school; up to 50% of children in the child welfare system have mental health problems; and 67 to 70% of youth in the juvenile justice system have a diagnosable mental health disorder. Finally, 75 to 80% of children and youth with mental health problems do not receive needed services nationwide. When considering this national data, it is clear that a significant percentage of the children and youth represented in the Michigan education, child welfare and juvenile justice statistics have SED and are not receiving needed services. A collaborative approach to addressing the needs of these children/youth and families is needed to achieve better outcomes for the children/families involved.

Furthermore, Michigan is experiencing a fiscal crisis which is the result of the worst economic conditions since the 1930s. The combination of the crisis in the domestic auto industry and the most severe national recession in decades contributed to the reduction of state general fund revenues to levels not experienced in the last 50 years. This has continued to put stress on an already taxed network of human services and has resulted in cuts to major state funded programs across all child and family serving departments, including education, child welfare and mental health/substance abuse. As of March 2011, the unemployment rate in Michigan was 10.3%, which was 1.5% above the national average for that same time according to the Michigan Department of Technology, Management and Budget. Also, according to information provided by SAMHSA in the 2009 National Outcome Measures Prevalence Report, Michigan went from a poverty ranking of 20th nationwide in 2007, putting it the mid tier, to a ranking of 35th in 2008, which put it in the high poverty tier. Data reported in the MDHS' Green Book Report of Key Statistics, March 2011 edition, indicates that 1,944,848 Michigan residents were eligible for Medicaid in that month and of those eligible residents, 977,130 were children. Also, according to the Annie E. Casey Foundation Kids Count Data Center, in 2009, 23% of the children (ages 0-18) in Michigan were living below the federal poverty level, which is above the national average of 20% for that same time period. In addition, Medicaid births in Michigan are now approximately 50% of all births. Additional data from the National Center for Children in Poverty website indicates that 21% of low-income children and youth, ages 6 through 17, have mental health problems. It is prime time in Michigan for partnerships to be forged to attempt to meet the needs of Michigan's children and families collaboratively on a larger scale and a statewide SOC is an effective way to achieve this.

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

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

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

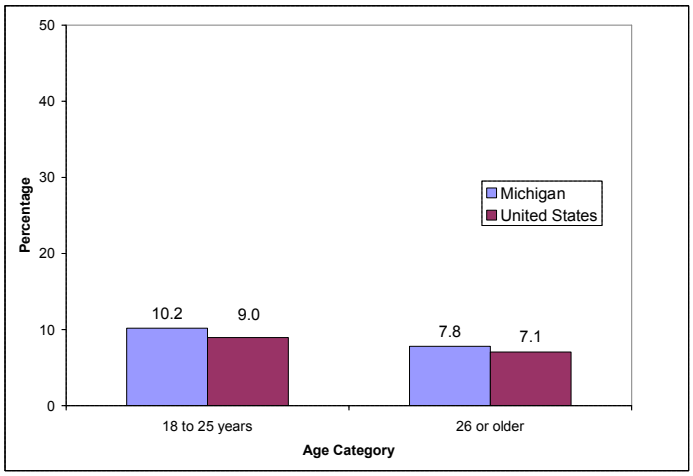
These issues are themes that have repeatedly arisen in discussions with system partners, family and youth. MDCH believes that there are many reasons that these needs have not been fully addressed at this point after so many years of SOC work in the State, but two main reasons appear to be that the SOC has historically been viewed as a mental health initiative that can either be imposed upon or opted out of by other systems instead of a statewide initiative to better serve the children with SED in every system. There is a need to unify the approach and encourage all partners to recognize their vital role in the statewide SOC and understand the benefits to them for their involvement because the mental health system cannot do this alone. Secondly, Michigan has never developed an infrastructure for governance and oversight of the expansion of the pockets of excellence that exist across the state into a statewide SOC. There have been great collaborations in certain areas that have demonstrated incredible outcomes and benefits for the communities involved, but that has never been translated into a formal statewide initiative. Michigan plans to continue to use children's mental health block grant funds, in addition to other resources, to provide the means to build upon strengths in Michigan and to address need areas with the outcome being a viable and sustainable statewide SOC for children/youth with SED and their families.

ADULTS WITH SERIOUS MENTAL ILLNESS (SMI)

Of Michigan's estimated population of 9,883,640 reported in the 2010 US Census, 76.4% are over the age of 18, an adult population estimate of 7,551,101. Per the 2009 data set provided by the National Survey on Drug Use and Health (NSDUH), 4.8% of American adults (approximately 11 million) were found to have SMI. Michigan's total number of civilian adults with SMI as calculated in 2009 by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute's State Data Infrastructure Coordinating Center (NRI/SDICC) was estimated at 411,191 for a prevalence rate of 5.4%. Applying the NRI/SDICC low/high prevalence rate range of 3.7-7.1% to the 2010 state adult population total

would predict Michigan's adult SMI population to be between 279,391 and 536,128. Per FY10 data reported by Michigan's public mental health care system, only 130,904 adults were provided with Community Mental Health services, suggesting a significant gap between the prevalence of serious mental illness in Michigan's adult population and the penetration of public sector mental health services, as it is unlikely that the differential can be fully accounted for by the cohort of SMI adults served in the private-sector, or via other systems. Clearly, improvement in identifying and engaging adults who may be in need of public sector mental health services in Michigan is needed. This gap between prevalence and service penetration continues to support the global need for greater availability and access to care for Michigan's adult SMI population, a need that block grant resources can assist in meeting.

Additional indicators of the need for mental health services include Michigan's data on the incidence rates of suicide and major depressive episodes. According to data provided by the SEOW, Michigan's 2009 age-adjusted suicide rate was 11.3 per 100,000 individuals, slightly lower than the national rate of 11.6 suicides per 100,000. However, when compared to NSDUH findings of the prevalence of a Major Depressive Episode within the prior year, Michigan's young adults in the 18-25 age range showed higher rates (10.2%) than the national average (9%) in 2006-07. Michigan adults 26 or older also were found to have higher incidence rates of a Major Depressive Episode within the prior year (7.8%) when compared to the national average (7.1%) for the same time period, as indicated in the figure below.



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

Data supplied by SAMHSA's 2009 Mental Health National Outcome Measures report appears to indicate that Michigan lags behind the reported national average in each of the following areas of evidence-based practice (EBP) delivery:

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

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

Michigan's Mental Health Code requires that an annual needs assessment be conducted with every CMH service provider across the State. This input is solicited through various means, including local Town Hall meetings, surveys of service recipients, board members, staff, and community members. Primary themes of the most recent findings of this process (FY10) are represented below, organized by Block Grant Application Table 5 categories, as another indicator of reported service need for adult service recipients.

<u>HEALTHCARE HOME/PHYSICAL HEALTH</u>

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

<u>OUTPATIENT SERVICES</u>

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

<u>RECOVERY SUPPORTS</u>

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

SYSTEMS IMPROVEMENT

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

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

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

These and other inputs are what have informed Michigan's strategic planning process for how to best advance the optimally effective use of limited resources to best serve the needs of our State's adult SMI population, reflected below and subsequently in the Table 2 / Step 3 section that follows. The role of block grant funding to assist in advancing many of the involved initiatives will be critical to Michigan's efforts to continue to move in the direction of more effective, recovery-supporting service development and delivery.

BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES ADMINISTRATION STRATEGIC PLAN GOALS

(Note: Each Objective will have Tasks, Lead Staff, Completion Date, and Measure (Metrics) added as part of the Work Plan)

1. **Individuals served by the Behavioral Health and Developmental Disability (BH&DD) Service System receive appropriate general health care services that effectively identify, treat and reduce co-morbidities (1 and 2; 1a and 2d)**
    a. Integrate Behavioral Health and General Health services to assure easy, effective and timely access.
    Objectives:
        1. Develop plan for integration of health care services
        2. Include primary prevention of health problems; such as obesity, diabetes, cardiovascular disease, chronic obstructive pulmonary disease (COPD), hypertension, substance use disorders, and promotion of health as explicit activities

3. Develop plan for viable Health Home models for persons with chronic and co-morbid conditions (or tendencies toward same)
4. Promote evidence-based protocols for assessment of adverse health effects of psychotropic medications as routine part of psychiatric visits.

b. Integrate services for persons with substance use disorders (SUD) with services for persons with serious mental illness (SMI) in order to improve efficiency, care and access

Objectives:

1. Develop plan for the administrative integration of SUD and CMH service systems in order to reduce the number of distinct administrations in a cost-effective manner
2. Improve co-occurring treatment capacities across the system

2. Stakeholders (individuals who receive services, their families, other allies, and persons with a significant interest in the BH & DD Service System) are involved in policy development and decision-making at the local, regional (i.e., affiliation) and state levels (2 and 4)

Objectives:

a. Increase/improve stakeholder involvement at all levels in order to more appropriately address their concerns, with special consideration given to the concerns expressed by persons served and their families
b. Promote Peer Support Specialists, Peer Mentors, Parent Support Partners, and Peer Recovery Coaches as active participants in planning, implementation and monitoring/evaluation of services and supports at the state and local levels

3. There is improvement in performance of the local BH&DD Service Systems (CMHSPs & CAs) in helping persons served achieve positive outcomes (2)

a. Treatment outcomes for each population improve

Objectives:

1. Establish measures for key outcomes
2. Promote and support the expansion and continuation of evidence-based and promising practices

b. Quality of Life for each population is improved

Objectives:

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

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

Objectives:

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

d. BHDDA helps ensure system accountability regarding performance improvement

Objectives:

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

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

Objectives:

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

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

Objectives:

a. PIHPs consolidate administrative functions within affiliations to reduce costs and/or improve the consistency of policies and services
b. PIHPs and CMHSPs reduce redundancies in reporting, training and oversight requirements in their contracting with providers
c. Disparities in access, type and intensity of services across the system are minimized
d. BHDDA reduces redundancies in reporting and oversight requirements of CMHSPs, PIHPs, and CAs
e. BHDDA provides the leadership to local BH&DD Service Systems, as well as BHDDA Central Office, in achieving positive results regarding administrative efficiency and effectiveness

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

Objectives:

a. Services and supports for individuals with mental illness are based on a foundation of recovery
b. SUD services and supports are offered within a recovery-oriented system of care

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

II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

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Start Year:

End Year:

Number	State Priority Title	State Priority Detailed Description
1	System of Care for Children/Youth with Serious Emotional Disturbance and Their Families	An expanded statewide structure for an accessible and comprehensive system of care for children/youth with serious emotional disturbance and their families supported by block grant funding, in addition to other resources.
2	Enhanced Partnerships	Enhanced partnerships with other state departments, service providers, parents, and youth to develop collaborative projects, using block grant funds and other resources, that maximize funding opportunities, reduce duplication of efforts and target traditionally underserved populations of children with SED in areas such as child welfare, juvenile justice, and minority groups.
3	Health Reform / Integrated Health	Expanded integration of mental health and substance abuse services with physical health care services. Improved coordination with primary care service providers, including an emphasis on more effective care to prevent and/or treat communicable diseases within populations with mental health recovery needs.
4	Outpatient Services / Data, Outcomes, and Quality	Improve the quality and effectiveness of outpatient clinical services (Co-occurring Disorders: Integrated Dual Disorder Treatment, Dialectical Behavior Therapy, and Motivational Interviewing) and community supports (Supported Employment and Supported Housing) provided through Michigan's public sector mental health system.
5	Recovery Support Services	Greater development of Peer Support Service availability within provider systems and more comprehensive training and supervision for staff providing peer-delivered services, including knowledge/competencies pertinent to both mental health and substance abuse recovery.

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6	Trauma-Informed / Trauma -Specific Services	Promote trauma-informed and trauma-specific service development and implementation across the State of Michigan.

Footnotes:

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

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Start Year:

End Year:

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
		1. Develop a structure to expand the availability and access to a statewide comprehensive SOC for children/youth and their families that includes improved treatemnt outcomes, using block grant funding in addition to oterh resources.		

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System of Care for Children/Youth with Serious Emotional Disturbance and Their Families	Treatment outcomes for children/youth with SED and their families improve statewide.	2. Obtain a SAMHSA SOC Expansion Planning Grant. 3. Engage system partners and stakeholders in the process of developing as statewide SOC. 4. Utilize block grant funding to support system improvement activities such as statewide PMTO and Trauma Informed Initiative for children with SED, state supported training and technical assistance in targeted areas such as co-occurring treatment, wraparound, home -based services, early childhood screening and assessment, family-driven and youth-guided service provision and peer-to peer parent and youth support activities. 5. Utilize block grant funding to support projects identified by CMHSPS to fill gaps in their local systems of care for services that improve outcomes for children/youth with SED and their	Outcomes are improved for children/youth with SED and their families through participation in a statewide SOC.	1. Statewide total CAFAS scores from intake to discharge for children/youth with SED served in the public mental health system will go down in FY12 and again in FY13 from a baseline average obtained from FY10 data. Source: Statewide aggregate CAFAS data – Kay Hodges, PhD and the Michigan Level of Functioning Project. 2. The number of children/youth with SED served in the public mental health system that receive wraparound services will increase in FY12 and again in FY13 from a baseline of number served in FY10. Source: Numbers served in wraparound - MDCH Division of Quality Management and Planning state encounter data. 3. The number of children/youth with SED served in the public mental health system that receive PMTO will increase in FY12 and again in FY13 from a baseline of number served in FY10. Source: Numbers served in PMTO – MDCH Division of Quality Management and Planning state encounter data. 4. The number of children/youth with SED served in the public mental health system that receive TFCBT will increase in FY12 and again in FY13 from a baseline of number served in FY10. Source: Number served in TFCBT- MDCH Division of Quality Management and Planning state encounter data. 5. The number of certified Parent Support Partners trained to work in the public mental health will increase in FY12 and again in FY13 from a baseline of number trained in FY10. Source: Number of Parent Support Partners trained – Michigan Parent Support Partner Training Project, statewide Parent Support Partner evaluation through Georgetown University.

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		families. 6. Utilize data to inform policy and program decision making and improvements.		
Enhanced Partnerships	Enhanced partnerships exist to serve children/youth with SED and their families, including traditionally underserved populations, using block grant funds and other resources, that reduce duplication of efforts.	1. Expand the SEDW 2. Continue to support DHS access positions in SEDW sites. 3. Continue to support juvenile justice projects and foster the relationship between MDCH and MDHS and the State Court Administrative Office to encourage more collaborative work. 4. Continue to pursue and support integrated physical health and behavioral health initiatives for children and youth with SED and their families. 5. Identify effective treatment models for youth with SED and co-occurring substance use disorders (SUD) and begin training and support initiative. 6. Research cultural adaptations for treatment models to ensure culturally relevant treatment is being provided.	The number of children/youth with SED and their families effectively served by collaborative projects will increase in FY12 and again in FY13 from baseline.	1. The number of children enrolled in the SEDW will increase. Source: # of children enrolled in SEDW – SEDW Pilot Specialist 2. A baseline of youth served by the public mental health system who are also involved in the juvenile justice system at any level will be obtained. Source: # of children served by mental health and juvenile justice system – MDCH Division of Quality Management and Planning state encounter data, statewide Wraparound Evaluation data, SEDW data. 3. A baseline of children served in integrated physical and mental health projects wil be obtained. Source: Project LAUNCH and SKIPP Project data. 4. Co-occurring treatment model identified and training for providers of mental health service to children and youth with SED and their families is initiated. Source: MDCH and BSAAS adult treatment programs, SAMHSA 5. Possible treatment adaptations for culturally diverse populations are identified. Source: SAMHSA

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Health Reform / Integrated Health	Advance the progress of improved care coordination and effective behavioral and primary physical health care service integration across the State of Michigan.	1. Emphasize the importance of care coordination between behavioral health care providers and primary care providers as part of regular site reviews. 2. Provide funding to support various models of integrated primary care and behavioral health care, requiring model programs to share lessons learned and program design details across the statewide CMHSP/PIHP system to inform and support statewide progress.	Number of unduplicated new instances of integrating physical healthcare and public sector behavioral healthcare services.	1. An emphasis on targeting this indicator as a part of already existing MDCH site reviews will provide the data needed to ascertain improvement in the documentation of appropriate care coordination with primary care service providers by mental health service providers. 2. MDCH is already supporting and monitoring various integrated health care pilot projects, and would continue to do so with ongoing and new projects supported by block grant funding, also serving as the recipient and statewide disseminator of information on viable program design options and useful lessons learned.
		1. Provide redesigned staff training, consultation, and client outcome tracking to support improved delivery of treatment services to		

Outpatient Services / Data, Outcomes, and Quality	Improve the quality and effectiveness of outpatient clinical services (COD/IDDT, DBT, Motivational Interviewing) and community supports (Supported Employment, Supported Housing) provided through Michigan's public sector mental health system.	individuals with all levels of co-occurring mental health and substance use disorder dual recovery needs. 2. Provide redesigned staff training, consultation, and competency/skill improvement tracking in the area of Motivational Interviewing / Motivational Enhancement. 3. Provide redesigned staff training, consultation, and client outcome tracking to support improved delivery of Dialectical Behavior Therapy to service recipients with Borderline Personality Disorders recovery needs. Identify and utilize a service billing code modifier to distinctly identify DBT service delivery. 4. Provide statewide training in the SAMHSA-endorsed Supported Employment model, and encourage the development of a continuum of employment support services.	Improvement in NOMs outcomes for adult service recipients.	1. CMHSP providers already provide service penetration data via billing submissions that are coded with HH and TG modifiers indicating COD/IDDT service delivery. The existing Michigan Fidelity Assessment and Support Team (MIFAST) members and other experts would continue to provide site reviews, along with indicated consultation and training. The additional use of the DDCMHT review instrument by the MIFAST reviewers would allow for improved support for the development and delivery of COD services at less than IDDT levels of intensity. 2. A more robust, differently designed model of providing Motivational Interviewing / Motivational Enhancement training, coaching and review utilizing the VASE-R instrument will allow for greater longitudinal support for MI implementation, and more objective reckoning of practice skill movement tied to training/coaching. 3. A more effective, differently designed model of providing DBT training, coaching and review is proposed, along with the identification of a DBT service code modifier that will allow for distinct identification of DBT services, differentiating them from other individual therapy or group treatment sessions. Additionally, the use of the Borderline Symptom Checklist (BSL-23) to measure service recipient outcomes will be strongly recommended. 4. Recently enhanced Supported Employment (SE) training is expected to lead to improvements in number of staff trained, as well as an increase in the number of service recipients receiving SE services as measured via billing code submissions.

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Recovery Support Services	Increase the number of employed individuals with lived experience trained and capable of delivering value-added Recovery Support Services, and increase the number of Peer Support Services delivered across Michigan's public sector mental health system.	1. Strongly encourage additional hiring of Peer Support Specialists/Recovery Coaches as part of proposed Block Grant project resources offered to regional PIHPs, track/validate the reported numbers, and require post-grant-funding sustainability of these positions. 2. Eliminate obstacles to more regular delivery and reporting of Medicaid-billable Peer Support Services, accomplishing any indicated billing systems changes, and providing clarification / technical assistance to providers as needed. 3. Upgrade the existing Peer Support training curriculum and certification process to include knowledge and skills that would equip trainees with basic competencies applicable to both mental health and substance abuse recovery.	Number of unduplicated new Peer Support Services provider hirings/position expansions.	1. PIHP/CMHSP providers will be required to report the number of individuals with lived experience employed to provide Peer Support Services both at the beginning of the Block Grant cycle and subsequently. 2. Tracking of the billing codes that are submitted for Peer Support Services will provide the core data for assessing whether there is an increase in this service delivery area. 3. MDCH would track the number of individuals trained/certified through an upgraded and integrated curriculum/process resulting in a knowledge base and skill set more consistent with SAMHSA's Peer Support Services definitions.

Trauma-Informed / Trauma-Specific Services	Promote trauma-informed and trauma-specific service development and implementation across the State of Michigan.	Provide training to PIHP/CMHSP providers on various models for trauma-informed and trauma specific services, including Seeking Safety, Trauma Recovery and Empowerment Model (TREM), Trauma-focused CBT, and Prolonged Exposure (for DBT service recipients).	Number of staff receiving trauma-informed or trauma-specific training	MDCH would track the number of PIHP/CMHSP provider staff who participated in trauma-informed and/or trauma-specific training and consultation in support of greater service development and implementation, as a foundational element toward moving forward with this initiative.

Footnotes:

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III: Use of Block Grant Dollars for Block Grant Activities

Table 4 Services Purchased Using Reimbursement Strategy

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Start Year:

End Year:

Reimbursement Strategy	Services Purchased Using the Strategy
Grant/contract reimbursement	MDCH uses the grant/contract reimbursement approach for services or system improvements purchased with Mental Health Block Grant funds. The contracts require the submission of various reports and data to MDCH, including the filing of Financial Status Reports (FSRs), which are typically submitted quarterly. These reports are monitored and compared to the contractual budget plan input into the MDCH accounting system. The draft Fiscal Year 2012 Mental Health Block Grant spending plan for adults and children is added as an attachment to this application.

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 Projected Expenditures for Treatment and Recovery Supports

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Start Year:

End Year:

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	• General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services	<10% 6
Engagement Services	• Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach	<10% 6
Outpatient Services	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers	10-25% 6
Medication Services	• Medication management • Pharmacotherapy (including MAT) • Laboratory services	<10% 6
Community Support (Rehabilitative)	• Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services	<10% 6
Recovery Supports	• Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care	10-25% 6
Other Supports (Habilitative)	• Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services	<10% 6

	• Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters	
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	<10% 6
Out-of-Home Residential Services	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Adult Substance Abuse Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	<10% 6
Acute Intensive Services	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services	<10% 6
Prevention (Including Promotion)	• Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention /Wellness Recovery Support • Warm line	<10% 6
System improvement activities		51-75% 6
Other		<10% 6

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 Primary Prevention Planned Expenditures Checklist

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Start Year:

End Year:

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	$	$	$	$	$
Information Dissemination	Selective	$	$	$	$	$
Information Dissemination	Indicated	$	$	$	$	$
Information Dissemination	Unspecified	$	$	$	$	$
Information Dissemination	Total	$	$	$	$	$
Education	Universal	$	$	$	$	$
Education	Selective	$	$	$	$	$
Education	Indicated	$	$	$	$	$
Education	Unspecified	$	$	$	$	$
Education	Total	$	$	$	$	$
Alternatives	Universal	$	$	$	$	$
Alternatives	Selective	$	$	$	$	$
Alternatives	Indicated	$	$	$	$	$
Alternatives	Unspecified	$	$	$	$	$
Alternatives	Total	$	$	$	$	$
Problem Identification and Referral	Universal	$	$	$	$	$
Problem Identification and Referral	Selective	$	$	$	$	$
Problem Identification and Referral	Indicated	$	$	$	$	$
Problem Identification and Referral	Unspecified	$	$	$	$	$
Problem Identification and Referral	Total	$	$	$	$	$

Community-Based Process	Universal	$	$	$	$	$
Community-Based Process	Selective	$	$	$	$	$
Community-Based Process	Indicated	$	$	$	$	$
Community-Based Process	Unspecified	$	$	$	$	$
Community-Based Process	Total	$	$	$	$	$
Environmental	Universal	$	$	$	$	$
Environmental	Selective	$	$	$	$	$
Environmental	Indicated	$	$	$	$	$
Environmental	Unspecified	$	$	$	$	$
Environmental	Total	$	$	$	$	$
Section 1926 Tobacco	Universal	$	$	$	$	$
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Total	$	$	$	$	$
Other	Universal	$	$	$	$	$
Other	Selective	$	$	$	$	$
Other	Indicated	$	$	$	$	$
Other	Unspecified	$	$	$	$	$
Other	Total	$	$	$	$	$

Footnotes:

Michigan does not currently use mental health block grant dollars for prevention activities as defined in Table 6.

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 Projected State Agency Expenditure Report

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Start Year:

End Year:

Date of State Expenditure Period From: 10/01/2011 Date of State Expenditure Period To: 09/30/2013

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	$	$	$	$	$	$
2. Primary Prevention	$	$	$	$	$	$
3. Tuberculosis Services	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$
5. State Hospital		$	$	$	$	$
6. Other 24 Hour Care	$	$	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care	$	$	$	$	$	$
8. Administration (Excluding Program and Provider Level)	$	$	$	$	$	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$	$	$	$	$	$
10. Subtotal (Rows 5, 6, 7, and 8)	$	$	$	$	$	$
11. Total	$	$	$	$	$	$

Footnotes:

Michigan does not currently use mental health block grant dollars for prevention activities as defined in Table 7.

III: Use of Block Grant Dollars for Block Grant Activities

Table 8 Resource Development Planned Expenditures Checklist

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Start Year:

End Year:

Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment	$		$			$
2. Quality Assurance	$		$			$
3. Training (Post-Employment)	$		$			$
4. Education (Pre-Employment)	$		$			$
5. Program Development	$		$			$
6. Research and Evaluation	$		$			$
7. Information Systems	$		$			$
8. Total	$	$	$	$	$	$

Footnotes:

Michigan does not currently use mental health block grant dollars for prevention activities as defined in Table 8.

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

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Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

IV: Narrative Plan

E. Data and Information Technology

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Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
  - Provider characteristics
  - Client enrollment, demographics, and characteristics
  - Admission, assessment, and discharge
  - Services provided, including type, amount, and individual service provider
  - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
  - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
  - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
  - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
  - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
  - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
  - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
  - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
  - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
  - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
  - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

IV: Narrative Plan

F. Quality Improvement Reporting

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Narrative Question:

SAMHSA expects 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 that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their 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 critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

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

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 recommendations for improvement from the Centers for Medicare and Medicaid Services (CMS).

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 on Accreditation of Health Care Organizations (JCAHO), 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: JCAHO, CARF, COA, National Council on Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAAHC) and the American Osteopathic Association (AOA). Licensing actions are the responsibility of the MDCH, 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. 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. Formal monthly meetings occur between MDHS and MDCH to share information regarding the findings from the respective settings. 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.

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.

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 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 has reviewed and approved each of the PIHP's customer services handbooks and requires the PIHPs to resubmit the handbooks for review and approval each time 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. 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.

IV. EXTERNAL QUALITY REVIEW

For FY12 MDCH will continue to contract with Health Services Assessment Group (HSAG) to conduct the EQR State contracting requirements will necessitate re-bidding the EQR contract for FY'13 and 14. 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'12-14 are:

a. Validation of Performance improvement projects:
    i. For FY'12-14, 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 12-14 EQR will look 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
    ii. In FY'13-14, the EQR will focus on following up on any problems identified in the FY 12-13 review cycle.

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. This site visit strategy incorporates for <u>all</u> beneficiaries served by the specialty waiver the more rigorous standards for assuring the health and welfare of the 1915(c) waiver beneficiaries,

including visits to beneficiaries' homes. 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 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 by the EQR 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:

- Compliance with the Medicaid Provider Manual
- Written agreements with providers, community agencies
- The results of the PIHPs' annual monitoring of its provider network
- Adherence to contractual practice guidelines
- 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 conducts 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, analysts. 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 by MDCH and 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.

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 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 persons in licensed residential settings, 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.

F. 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 A-87 requirements and the annual audit compliance review tests for compliance. Reports are due annually to MDCH and reviewed for: compliance audit 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) 28-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.

IX. 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.

Trend patterns have been used to develop strategies for improvement. Data from site reviews, individual remediation and other sources have been used for systems improvement (SI) activities. In 2009, MDCH issued the Application for Renewal and Recommitment which lays out the Department's direction and vision for supports and services provided for all people served by the public mental health system (details can be found on the MDCH website). Creating a Culture of Gentleness (COG) is an SI activity aimed at helping providers understand that there are preferred alternative ways to work with individuals who have reputations for challenging behaviors, primarily by developing true relationships with them and helping them to feel safe, loved, be loving and be engaged. Regional intensive trainings are being provided for direct care workers, supervisors, and professional support staff who serve people with reputed challenging behaviors. MDCH also established a "safety net plan" to respond to PIHPs/CMHSPs that have exhausted their capacity to respond appropriately to people who exhibit behaviors that threaten their welfare or that of others. The plan builds on the intensive trainings by adding a mobile crisis response, and a temporary crisis placement. Information from the QMP site reviews, individual remediation, the COG initiative and safety net plan are used to inform the process for implementing further systems improvements toward reducing and/or eliminating restrictive interventions. Another statewide initiative focuses on prevention by developing parameters to help the PIHPs/CMHSPs identify people who may be vulnerable or at risk. By identifying people earlier, the PIHP/CMHSP can monitor closely and implement strategies to try to prevent critical incidents before they occur.

Another strategy MDCH may use to address immediate issues for a participant who has either experienced a critical incident or is a high risk of experiencing a critical incident is through its contract with the Center for Positive Living Supports. During the first year of operation in FY10, the services of the Center have primarily focused on the individuals who transitioned from the last ICF/MR in Michigan. The Center offers several services that can address immediate crisis situations in an effort to prevent a critical incident from

occurring or re-occurring. Services include 1) a 24-hour crisis line that is available for any authorized CMHSP representative, The Center clinician manning the Crisis Line will assist the CMHSP representative in identifying the environmental and relationship variables that may be influencing the crisis situation, and will attempt to provide clinical impressions and recommendations. If additional advice or consultations need to occur, the Center clinician will seek that assistance and call the CMHSP back within two hours. Should this consultation not resolve the crisis, the Center will request permission from MDCH for further support from the Center; 2) a Mobile Training/Crisis Team may be dispatched upon approval by MDCH and after all prerequisites have been met by the CMHSP, including training for its staff in culture of gentleness approaches. Within the first eight hours of service, the individual's care-givers will be asked to participate in the structure and interaction patterns established by the team. The team members will coach and mentor the individual's care-givers in this process. The manager and shift leader need to be the first staff working directly with the Mobile Team and the individual. The team may remain on-site for up to two weeks, unless extended by authorization from MDCH; and 3) a Training and Crisis Transition Home - A CMHSP may request MDCH approval for the use of the Training and Crisis Transition Home once they have exhausted all local options of support and training and have utilized the services of the Center's Mobile Training/Crisis Team. Utilization of the Training and Crisis Transition Home will occur only after approval by MDCH and the Center.

The QIS is reviewed on an on-going basis by MDCH-BHDDA staff and the QIC. The QIC also has a formal opportunity to identify issues at a meeting in anticipation of the annual contract renewal. To the extent that the MDCH- BHDDA/PIHP contract must be modified to achieve changes in QI strategy, those revisions would be included in the next fiscal year's contract. If the QIC were to identify an issue that would require changes to the contract prior to the expiration of the current contract, the BHDDA could amend the contract. Procedural changes that do not require contract changes can be implemented immediately. Additionally, if issues are identified through trending and analysis, the QIC may make recommendations to BHDDA upper management team to revise the QIS. The final decision on changes to the QIS is made by the BHDDA upper management team.

IV: Narrative Plan

G. Consultation With Tribes

Page 43 of the Application Guidance

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to 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 opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, 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 include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description 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.

Footnotes:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTHCARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

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
Live 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:

FORM HCFA-179(07-92)

Instructions on Back

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)(i) 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.

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, t 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.

IV: Narrative Plan

H. Service Management Strategies

Page 44 of the Application Guidance

Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

IV: Narrative Plan

I. State Dashboards (Table 10)

Page 45 of the Application Guidance

Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year:

Priority	Performance Indicator	Selected
System of Care for Children/Youth with Serious Emotional Disturbance and Their Families	Outcomes are improved for children/youth with SED and their families through participation in a statewide SOC.	é
Enhanced Partnerships	The number of children/youth with SED and their families effectively served by collaborative projects will increase in FY12 and again in FY13 from baseline.	é
Health Reform / Integrated Health	Number of unduplicated new instances of integrating physical healthcare and public sector behavioral healthcare services.	é
Outpatient Services / Data, Outcomes, and Quality	Improvement in NOMs outcomes for adult service recipients.	é
Recovery Support Services	Number of unduplicated new Peer Support Services provider hirings/position expansions.	é
Trauma-Informed / Trauma-Specific Services	Number of staff receiving trauma-informed or trauma-specific training	é

Footnotes:

IV: Narrative Plan

J. Suicide Prevention

Page 46 of the Application Guidance

Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America?s service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:

A statewide evaluation is being conducted by the Michigan Association for Suicide Prevention which will inform the update of the Suicide Prevention Plan for Michigan. This evaluation is in process and the intent is to have the plan updated in the next two years. The most recent version of the plan is from 2005.

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 Prevention[1] 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 Facts[2]

M*ost suicides are preventable with appropriate education, awareness and intervention methods.*

F*or every suicide death, there are an estimated 25 attempts.*

E*lderly are the highest risk group per capita.*

F*or youth, suicide is the 3rd leading cause of death.*

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

F*irearms are the most frequent method used.*

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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:

Did You Know

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
- built on data, research, and best practices
- public health focused
- 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 attempts[7]. 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

	Number	Avg./day	Rate	% of all deaths
Nation	31,655	86.7	11.0	1.3
Males	25,409	69.6	17.9	2.1
Females	6,246	17.1	4.3	0.5
Whites	28,731	78.7	12.2	1.4
Non-whites	2,924	8.0	5.5	0.9
Blacks	1,939	5.3	5.1	0.7
Native Americans	324	0.8	10.5	---
Asians/Pacific Islanders	661	1.8	5.2	---
Elderly (65+ years)	5,548	15.2	15.6	0.3
Young (15-24 years)	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 study[12] 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

Suicide Method	***No.***	***Rate***	***% of total***
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

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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 2003[13]

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 annually[15].

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 survey[16]. 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.

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Table 4. Average Annual Number of Suicides By Age, Race, and Sex, Michigan Residents, 1999-2002[5]

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.

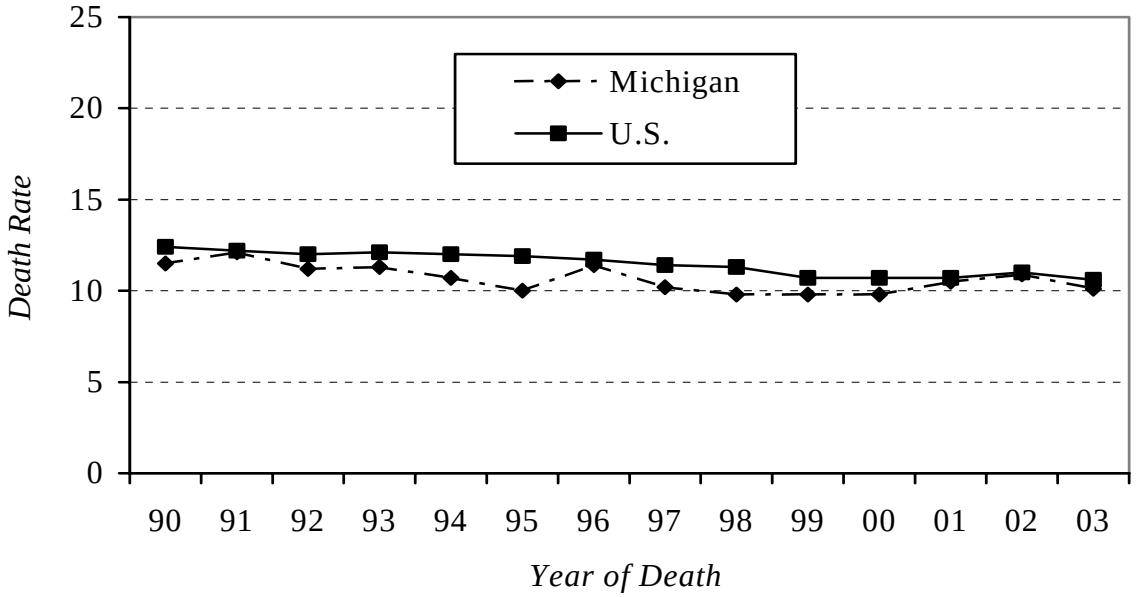

FIGURE 1. Suicide rates, Michigan and U.S. Residents, 1990-2003[17]

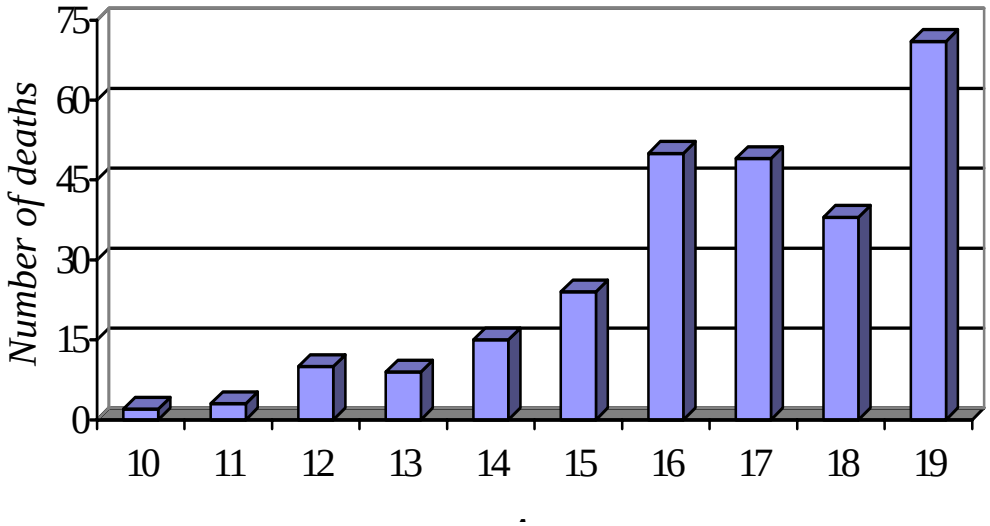

Figure 2. Adolescent suicide deaths, Michigan, 1999-2002[18]

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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

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

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

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	Pat Smith
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Newsletter:	*Michael Swank*
	Karen Amon
Research:	*Robin Bell*

IV: Narrative Plan

K. Technical Assistance Needs

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Narrative Question:

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. 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.

Footnotes:

IV: Narrative Plan

L. Involvement of Individuals and Families

Page 46 of the Application Guidance

Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State 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:

- •How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coachers and or peer specialists)?
- •Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- •Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- •How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- • How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

Michigan has developed and implemented a statewide Parent Support Partner training curriculum and a statewide family-driven and youth-guided policy. Please see the attached documents for further information.

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

December 15, 2010

TO: Executive Directors of Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs)

FROM: Michael J. Head, Director
Mental Health and Substance Abuse Administration

SUBJECT: Family-Driven and Youth-Guided Policy and Practice Guideline

Attached is the final version of the Family-Driven and Youth-Guided Policy and Practice Guideline that was forwarded for your review and comment in June 2010. We received comments from staff of seven CMHSPs, two advocacy organizations and one court staff person. We have reviewed all of the public comments and incorporated feedback and suggestions into this final version of the policy.

The purpose of this policy guideline is to provide guidance and support to PIHPs, CMHSPs and their contract agencies regarding the delivery of family-driven and youth-guided services and supports for children and their families. This guideline outlines essential elements of family-driven and youth-guided policy and practice at the child and family level, system level and peer-delivered level.

Family-driven means that families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community. Youth-guided means that young people have the right to be empowered, educated, and given a decision-making role in their own care as well as the policies and procedures governing the care of all youth in the community, state, and nation. A youth-guided approach views youth as experts and considers them equal partners in creating system change at the individual, state, and national level (SAMHSA).

It is the intent of the Michigan Department of Community Health (MDCH) to adopt a policy that promotes all publicly supported mental health agencies to engage in family-driven and youth-guided approaches to services with children and families. The attached policy is being issued as a technical advisory initially which MDCH encourages be used over the next year. MDCH does intend to incorporate this policy guideline/technical advisory into the Medicaid Provider Manual and into the contract negotiating process in the future. A technical companion guide will also be developed to assist in meeting the policy requirements.

If you have questions, please contact Connie Conklin at 517-241-5765 or at conklinc@michigan.gov, or Sheri Falvay at 517-241-5762 or at falvay@michigan.gov.

Attachment

c: Irene Kazieczko
Sheri Falvay
Connie Conklin
Mental Health and Substance Abuse Management Team

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH (MDCH)
MENTAL HEALTH & SUBSTANCE ABUSE ADMINISTRATION
FAMILY-DRIVEN AND YOUTH-GUIDED POLICY AND PRACTICE GUIDELINE

A. Summary/Background

The purpose of this policy guideline is to establish standards for the Prepaid Inpatient Health Plans (PIHPs), Community Mental Health Services Programs (CMHSPs) and their contract agencies regarding the delivery of family-driven and youth-guided services and supports for children and their families. This policy guideline will outline essential elements of family-driven and youth-guided policy and practice at the child and family level, system level and peer-delivered level.

Person-centered planning is the method for individuals served by the community mental health system to plan how they will work toward and achieve personally defined outcomes in their own lives. The Michigan Mental Health Code establishes the right for all individuals to develop individual plans of services through a person-centered planning process regardless of disability or residential setting.

For children and families, the Person-Centered Planning Policy Practice Guideline states: "The Michigan Department of Community Health (MDCH) has advocated and supported a family-driven and youth-guided approach to service delivery for children and their families. A family-driven and youth-guided approach recognizes that services and supports impact the entire family; not just the identified youth receiving mental health services. In the case of minors, the child and family is the focus of service planning, and family members are integral to a successful planning process. The wants and needs of the child and his/her family are considered in the development of the Individual Plan of Service." As the child matures toward transition age, services and supports should become more youth-guided.

As a result of the effort to develop family-driven and youth-guided services, the Substance Abuse and Mental Health Services Administration (SAMSHA) in partnership with the Federation of Families for Children's Mental Health, has developed a set of principles (described in section C of this policy) which serve as the basis for the delivery of family- driven and youth-guided services. These principles comprise the standards which should guide the delivery of services to children and their families and are essential to development of an effective system of care.

This policy is consistent with the "Application for Renewal and Recommitment (ARR) to Quality and Community in the Michigan Public Mental Health System," as issued by MDCH on February 1, 2009. The ARR formally introduced new and enhanced expectations of performance and revitalized MDCH's commitment to excellence in partnership with PIHPs and CMHSPs.

While agencies are expected to collaborate, they are not intended to be the primary decision-makers on behalf of a child or family. It is important for systems to actively engage families in leading all decisions about the care of their child. Similarly, as appropriate, based on their age and functioning, youth should have opportunities to make decisions about their own care. Family and youth involvement is also important on a broader level, with an expectation that they are active participants in system-level governance and planning (Wilder Foundation, Snapshot: Mental Health Systems of Care for Children, August 2009).

B. Policy

It is the policy of MDCH that all publicly-supported mental health agencies and their contract agencies shall engage in family-driven and youth-guided approaches to services with children and families and will engage family members and youth at the governance, evaluation, and service delivery levels as key stakeholders.

How this Policy will be supported:

- MDCH staff in partnership with the family organizations will work with PIHPs, CMHSPs, and contract agencies to support successful implementation of the family-driven and youth-guided policy guideline.
- MDCH will work with other system partners at the state level to ensure PIHPs, CMHSPs and contract agencies can build an effective system of care.
- Through ARR progress reviews, updates and technical assistance. The different sections of the ARR have applicability to family-driven and youth-guided care, e.g., stakeholder involvement, developing an effective system of care, improving the quality of services and supports, assuring active engagement, etc.

C. Family-Driven and Youth-Guided Principles

Family-driven and youth-guided principles should be measured at several different levels: the child and family level, the system level and the peer-to-peer level. These principles incorporate all levels, and will be detailed under section D: Essential Elements.

- Families and youth, providers and administrators share decision-making and responsibility for outcomes.

- Parents, caregivers and youth are given accurate, understandable, and complete information necessary to set goals and to make informed decisions and choices about the right services and supports for individual children and their family as a whole.

- All children, youth and families (parents) have a biological, adoptive, foster, or surrogate family voice advocating on their behalf.

- Families and family-run organizations engage in peer support activities to reduce isolation, gather and disseminate accurate information, and strengthen the family voice.

- Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports and advocate for families and youth to have choices.

- Providers take the initiative to change policy and practice from provider-driven to family-driven and youth-guided.

- Administrators allocate staff, training, support and resources to make family-driven and youth-guided practice work at the point where services and supports are delivered to children, youth, and families.

- Community attitude change efforts focus on removing barriers and discrimination created by stigma.

- Communities and public and private agencies embrace, value, and celebrate the diverse cultures of their children, youth, and families and work to eliminate mental health disparities.

- Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes so that the needs of diverse populations are appropriately addressed.

D. Essential Elements for Family-Driven and Youth-Guided Care

1. "Family-driven" means that families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community. This includes:

   - Being given the necessary information to make informed decisions regarding the care of their children
   - Choosing culturally and linguistically competent supports, services, and providers
   - Setting goals
   - Designing, implementing and evaluating programs
   - Monitoring outcomes
   - Partnering in funding decisions

2. "Youth-guided" means that young people have the right to be empowered, educated, and given a decision-making role in their own care as well as the policies and procedures governing the care of all youth in the community, state, and nation. A youth-guided approach views youth as experts and considers them equal partners in creating system change at the individual, state, and national level (SAMHSA).

3. "Family-run organization" means advocacy and support organizations that are led by family members with lived experience raising children with SED and/or DD thus creating a level of expertise. These organizations provide peer-to-peer support, education, advocacy, and information/referral services to reduce isolation for family members, gather and disseminate accurate information so families can partner with providers and make informed decisions, and strengthen the family voice at the child and family level, service delivery level, and systems level.

4. Child and Family-Level Action Strategies:

   - Strength and Culture Discovery - Children, youth and family strengths will be identified and linked to treatment strategies within the plan of service.
   - Cultural Preferences - The plan of service will incorporate the cultural preferences unique to each youth and family.
   - Access - Children, youth and families are provided usable information to make informed choices regarding services and supports and have a voice in determining the services they receive. Services and supports are delivered in the home and community whenever possible.

- Voice - Children, youth and families are active participants in the treatment process, their voice is solicited and respected, and their needs/wants are written into the plan in language that indicates their ownership.
- Ownership - The plan compliments the strengths, culture and prioritized needs of the child, youth and family.
- Outcome-based - Plans are developed to produce results that the youth and family identify. All services, supports and interventions support outcome achievement.
- Parent/Youth/Professional Partnerships - Parents and youth are recognized for having expertise, are engaged as partners in the treatment process, and share accountability for outcomes.
- Increase Confidence and Resiliency - The plan will identify specific interventions that maximize the strengths of the child, youth, and family, increase the skills of the youth to live independently and advocate for self, and equip the family with skills to successfully navigate systems and manage the needs of their child and family.
- Participation in Planning Meetings - Youth and families determine who participates in the planning meetings.
- Crisis and Safety Planning - Crisis and safety plans should be developed to decrease safety risks, increase confidence of the youth and family, and respect the needs/wants of the youth and family.

5. System-level Action Strategies:

- Agencies have policies that ensure that all providers of services to children, youth and families incorporate parent/caregivers and youth on decision-making groups, boards and committees that support family-driven and youth-guided practice.
- Agencies have policies that ensure training, support, and compensation for parents and youth who participate on decision-making groups, boards and committees and serve as co-facilitators/trainers.
- Policies are in place within the agency to support employment of youth and parents.
- Youth and parents are part of the program and service design, evaluation, and implementation of services and supports.
- Children, youth and families are provided opportunities to participate in and co-facilitate training and education opportunities.
- Services are delivered where the children, youth and family feel most comfortable and in a way that is relevant to the family culture.
- All stakeholder groups include diverse membership including youth and family members who represent the population the agency/community serves.

6. Peer-delivered Action Strategies:

- Parents/caregivers, youth who have first-hand experience with the public mental health system are recruited, trained and supported in their role as parent/peer support partners.
- Family Organizations are involved in the recruiting, supporting, and training of family members and youth peer-to-peer support partners. They may also serve as the contract employers of the parent support partners.
- Peer-to-peer support models approved by MDCH for parents and youth are available.

E. Biography

National Technical Assistance and Evaluation Center. A Closer Look: Family Involvement in Public Child Welfare Driven Systems of Care. February 2008

http://www.childwelfare.gov/pubs/acloserlook/familyinvolvement/familyinvolvement.pdf
http://www.samsha.gov

ACMH Youth Advisory Council Focus group (January 16, 2010)

ACMH Staff Retreat (December 14, 2009)

Michigan has implemented a statewide parent-to-parent support training curriculum in partnership with the Association for Children's Mental Health (ACMH), the state chapter of the National Federation of Families for Children's Mental Health. This partnership ensures the implementation and maintenance of a training, certification and technical assistance program for Parent Support Partners (PSP) in Michigan. PSPs will provide Medicaid reimbursable peer-to-peer support and training to parents and caregivers who have a child currently served through the public mental health system. The goal is to have authentic peer-to-peer support and training as a viable option for all eligible families in Michigan. Below, please see what is included the Medicaid covered PSP service:

Excerpt from the Michigan Medicaid Provider Manual
Mental Health/Substance Abuse Date: July 1, 2011 Page 111

17.3.F. FAMILY SUPPORT AND TRAINING
Family-focused services provided to family (natural or adoptive parents, spouse, children, siblings, relatives, foster family, in-laws, and other unpaid caregivers) of persons with serious mental illness, serious emotional disturbance or developmental disability for the purpose of assisting the family in relating to and caring for a relative with one of these disabilities. The services target the family members who are caring for and/or living with an individual receiving mental health services. The service is to be used in cases where the beneficiary is hindered or at risk of being hindered in his ability to achieve goals of:

 performing activities of daily living;
 perceiving, controlling, or communicating with the environment in which he lives; or
 improving his inclusion and participation in the community or productive activity, or opportunities for independent living.

The training and counseling goals, content, frequency and duration of the training must be identified in the beneficiary's individual plan of service, along with the beneficiary's goal(s) that are being facilitated by this service.

Coverage includes:
 Education and training, including instructions about treatment regimens, and use of assistive technology and/or medical equipment needed to safely maintain the person at home as specified in the individual plan of service.
 Counseling and peer support provided by a trained counselor or peer one-on-one or in group for assistance with identifying coping strategies for successfully caring for or living with a person with disabilities.
 Family Psycho-Education (SAMHSA model) for individuals with serious mental illness and their families. This evidence-based practice includes family educational groups, skills workshops, and joining.
 Parent-to-Parent Support is designed to support parents/family of children with serious emotional disturbance or developmental disabilities as part of the treatment process to be empowered, confident and have skills that will enable them to assist their child to improve in functioning. The trained parent support partner, who has or had a child with special mental health needs, provides education, training, and support and augments the assessment and mental health treatment process. The parent support partner provides these services to the parents and their family. These activities are provided in the home and in the community. The parent support partner is to be provided regular supervision and team consultation by the treating professionals.

IV: Narrative Plan

M. Use of Technology

Page 47 of the Application Guidance

Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
b. What specific applications of ICTs does the State plan to promote over the next two years?
c. What incentives is the State planning to put in place to encourage their use?
d. What support systems does the State plan to provide to encourage their use?
e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

IV: Narrative Plan

N. Support of State Partners

Page 48 of the Application Guidance

Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

IV: Narrative Plan

O. State Behavioral Health Advisory Council

Page 49 of the Application Guidance

Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

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Table 11 List of Advisory Council Members

Pages 51 and 52 of the Application Guidance

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Regina Allen	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	State Advisory Council on Aging	2309 Belaire Drive Lansing, MI 48911 PH: 517-708-7972	signothetimes@comcast.net
Stephen Batson	Individuals in Recovery (from Mental Illness and Addictions)	Turning Point Clubhouse	1809 Bacon Avenue Berkley, MI 48072 PH: 248-224-8838	stevebatson@wowway.com
Joel Berman	Individuals in Recovery (from Mental Illness and Addictions)	Detroit Central City	1101 W. Warren #413 Detroit, MI 48201 PH: 313-831-1128	berman_joeli@yahoo.com
Jasmine Boatwright	Individuals in Recovery (from Mental Illness and Addictions)	Detroit-Wayne County CMH Agency	6900 McGraw Detroit, MI 48210 PH: 313-895-2860	jboatwri@co.wayne.mi.us
Linda Burghardt	Others (Not State employees or providers)	NAMI - Michigan	921 N. Washington Avenue Lansing, MI 48906 PH: 517-853-0950	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
Dennis Hart	State Employees	Vocational Rehabilitation	11611 W. Pine Lake Road Plainwell, MI 49080 PH: 269-664-9212	hartd1@michigan.gov

Dwane Hight	Individuals in Recovery (from Mental Illness and Addictions)	Self	1370 Lakeview Drive Gladwin, MI 48624 PH: 989-426-9295	dhight@cmhcm.org
Janet Irrer	State Employees	Housing	735 E. Michigan Avenue, P.O. Box 30044 Lansing, MI 48912 PH: 517-335-3038	irrerj@michigan.gov
Colleen Jasper	Individuals in Recovery (from Mental Illness and Addictions)	Office of Consumer Relations Department of Community Health	2529 Limerick Holt, MI 48842 PH: 517-373-1255	jasper@michigan.gov
Shareen McBride-Wicklund	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Association for Children's Mental Health	5938 W. Fourth Street Ludington, MI 49431 PH: 231-499-3333	shareenmm@yahoo.com
Adrienne McCain	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Association for Children's Mental Health	6900 McGraw Street Detroit, MI 48210 PH: 313-895-2860	acmh-adrienne@att.net
LaTrice McCants	Individuals in Recovery (from Mental Illness and Addictions)	Southwest Counseling Solutions	14820 Turner Detroit, MI 48238 PH: 313-963-2266	lmccants@swsol.org
Arlene Naganashe	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Self	34 Bridge Street Petoskey, MI 49770 PH: 231-347-9093	arlenenaganashe@gmail.com
Jeff Patton	Providers	Kalamazoo CMH & Substance Abuse Services	3299 Gull Road, P.O. Box 63 Nazareth, MI 49074 PH: 269-553-8000	jpatton@kazoocmh.org
Malisa Pearson	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Association for Children's Mental Health	6017 W. St. Joseph Highway, Suite 200 Lansing, MI 48917 PH: 517-372-4016	acmhmalisa@aol.com
Jamie Pennell	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Self	211 Butler Leslie, MI 49251 PH: 517-589-9074	bnj00@cablespeed.com
Jane Reagan	State Employees	Education	608 W. Allegan Street, Hannah Building, 2nd Floor Lansing, MI 48933	reaganj@michigan.gov

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			PH: 517-335-2250	
Mark Reinstein	Others (Not State employees or providers)	Mental Health Association in Michigan	30233 Southfield Road, Suite 220 Southfield, MI 48076 PH: 248-647-1711	msrmha@aol.com
Ben Robinson	Others (Not State employees or providers)	Rose Hill Center	5130 Rose Hill Boulevard Holly, MI 48442 PH: 248-634-5530	brobinson@rosehillcenter.org
Kerin Scanlon	Individuals in Recovery (from Mental Illness and Addictions)	Self	3877 S. Shepherd Road Mt. Pleasant, MI 48858 PH: 989-594-2325	kscanlon@tm.net
Sally Steiner	State Employees	Office of Services to the Aging	300 E. Michigan Avenue Lansing, MI 48909 PH: 517-373-8810	steiners@michigan.gov
Clayton Straseske	State Employees	Criminal Justice	P.O. Box 30003 Lansing, MI 48909 PH: 517-373-3318	straseca@michigan.gov
Jocelyn Vanda	State Employees	Social Services	Grand Tower, Suite 1514 Lansing, MI 48909 PH: 517-373-7985	vandaj@michigan.gov
Brian Wellwood	Individuals in Recovery (from Mental Illness and Addictions)	Justice in Mental Health Organization	520 Cherry Street Lansing, MI 48933 PH: 517-371-2221	brwellwood@yahoo.com
Stephen Wiland	State Employees	Mental Health	320 S. Walnut, 5th Floor Lansing, MI 48913 PH: 517-241-2616	wilands@michigan.gov

Footnotes:

Stephen Wiland represents Medicaid as well as Mental Health. In Michigan, the Department of Community Health includes both Mental Health and Medicaid. Mental Health staff are responsible for the Medicaid policy and contract mechanisms for Medicaid funding for mental health services.

IV: Narrative Plan

Table 12 Behavioral Health Advisory Council Composition by Type of Member

Pages 52 and 52 of the Application Guidance

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	26	
Individuals in Recovery (from Mental Illness and Addictions)	8	
Family Members of Individuals in Recovery (from Mental Illness and Addictions)	6	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	4	
Total Individuals in Recovery, Family Members & Others	18	69.23%
State Employees	7	
Providers	1	
Leading State Experts	0	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	8	30.77%

Footnotes:

IV: Narrative Plan

P. Comment On The State Plan

Page 50 of the Application Guidance

Narrative Question:

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

Michigan's Community Mental Health Services Block Grant Application is posted on the Department of Community Health's website with information on how to provide comments on the plan.

All Prepaid Inpatient Health Plans and Community Mental Health Services Programs in the state are given information on the availability of the plan and contact information for comments. A notice soliciting comments is provided for them with the request that they post it in their lobbies. They are also asked to provide the information to all of their subcontract agencies.

A press release will also be issued by the department's Communications Office for publication in newspapers. As a result of efforts in past years, numerous comments were received from the public on the block grant program and on mental health services in general.

In addition, all meetings of the Advisory Council on Mental Illness (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.

*** ATTACHMENT TO SECTION III, TABLE 4 ***

Draft Spending Plan for FY12 Adult Mental Health Block Grant	
Contract Title	**Amount**
Ongoing Projects:	
Admin Costs (Estimated)*	$374,600
Assertive Community Treatment Association	$119,121
Detroit-Wayne - Comprehensive	$4,500,000
Detroit-Wayne - Recovery Center of Excellence	$200,000
Eastern Michigan University - Older Adult	$63,103
Inter-Tribal Council of MI	$14,056
JIMHO - Director's Meetings / Self-Help Groups	$245,484
Lansing Community College - Older Adult	$99,040
MDRC - Peer Staffing	$75,000
MSU - Creating a Quality Improvement Tool for Clubhouses	$37,820
NAMI - Executive Director	$125,000
NorthCare - UP Consumer Conference	$19,990
SEMHA Older Adult MH and Dementia Program Consultant	$64,140
Multi-Year Projects:	
Barry - Recovery and Relapse Prevention	$13,693
Bay-Arenac - Supporting Recovery Through Collaboration	$62,000
Central MI - Consumer Run Drop-in Center (CRDIC)	$54,100
CEI - Crisis Response Initiative Incorporating PSS Services	$52,254
CEI dba CMH Affiliation of Mid-Michigan - Supported Employment	$70,000
Detroit - Systems Trans. to Empower Peer Support Practices	$70,000
Genesee - Development of a Recovery Oriented System of Care	$70,000
Gogebic - Encouraging Recovery	$70,000
Gratiot - Mental Health Services for Uninsured Adults	$62,173
Hiawatha - Peer Support Expansion	$59,500
Huron - Community Recovery Services & Supports Grant	$70,000
Ionia - Wellness First	$70,000
Lapeer - Expansion of CPSS's to Enhance Recovery	$70,000
Lenawee - Promoting Recovery	$70,000
LifeWays - Recovery Environment Enhancement Through CPSS	$70,000
LifeWays PIHP - Supported Employment	$36,695
Macomb - PSS Activities in Early Engagement & Health Promotion	$70,000
Macomb PIHP - Supported Employment	$70,000
Manistee-Benzie - Implementation of the LOCUS	$70,000
Monroe - Community Outreach Initiative	$57,400
Montcalm - Promoting Recovery	$11,660
Muskegon - Change Agent Team for Recovery	$70,000
network180 - Community Recovery Services & Supports	$70,000
network180 PIHP - Supported Employment	$58,799
Newaygo - Community Recovery Services and Supports	$70,000
North Country - Community Based Services Program	$48,206
North Country dba Northern Affiliation - Supported Employment	$100,300
Northeast MI - Bay View Center	$60,816
Northern Lakes - Culture Change to Embrace Recovery	$65,500
Northpointe - Supporting the Community	$68,857
Oakland - Integrated Healthcare	$70,000
Ottawa - Group Counseling/WRAP Expansion Project	$50,000
Pathways - Pathways Peer Supported Recovery Initiative	$60,496
Pines - Recovery Support Services Project	$70,000
Saginaw - Primary Health Care Co-Location	$70,000

Contract Title	Amount
Sanilac - Enhancement of EBP's and Peer Support Services	$40,000
Shiawassee - Certified Peer Support Partnership Project	$12,658
St. Clair - Community Recovery Services and Supports	$70,000
St. Clair dba Thumb Alliance - Integrated Supported Employment	$35,000
St. Joseph - Bienvenido Implementation Project	$2,049
Summit Pointe - Peer Support Health Services	$68,000
Summit Pointe dba Venture - Supported Employment	$31,100
Tuscola - Community Integration and Recovery Initiative	$70,000
Van Buren - Community Recovery Group Services and Supports	$70,000
Washtenaw - Recovery Training and Resource Academy	$45,282
West MI - PILLARS Vocational Program	$70,000
New Projects:	
Bay-Arenac dva Access Alliance - Promoting Recovery and Wellness	$80,810
Central MI - Walk-in Clinic Expansion	$130,000
CEI dba CMH Affiliation of Mid-Michigan - Integrated Health Care for Uninsured Adults &	$130,000
Detroit-Wayne - New Center Integrating MH/SA & PH Program Expansion	$130,000
Genesee - Health Home Navigation in Recovery-Oriented System of Care	$130,000
Kalamzoo dba Southwest MI Affiliation - Recovery Enhancement Project	$130,000
LifeWays - Integrated Health and Recovery Expansion	$129,575
Macomb - Implementation of Supported Employment EBP	$130,000
Muskegon dba Lakeshore - CMH Primary Care Integration Project	$123,985
network180 - Support Service for Housing Assistance & for Consumers Receiving Outpat	$129,967
North Country dba Northern Affiliation - Healthy Living	$130,000
Northern Lakes dba Northwest Affiliation - Adult Mental Health Block Grant	$130,000
Oakland - Volunteer Driver Program	$130,000
Pathways dba NorthCare - Outreach Project by CMHSP Recovery Coordinators	$130,000
St. Clair dba Thumb Alliance - In Shape Health Mentors	$130,000
Saginaw - Co-Location & Non-Medicad Fudned Services Expansion	$130,000
Summit Pointe dba Venture - Expanding Opportunities for the Uninsured	$130,000
Washtenaw dba Southeast MI - CPSS Expansion & Integrated Health	$130,000
Training Projects:	
Recovery Projects	$160,000
Improving Practices Initiative	$50,000
Consumer Participation in Systems Transformation	$20,000
Co-occurring Disorders Systems Change	$115,000
COD:IDDT:MiFAST & Supported Employment Fidelity Reviews	$130,000
Motivational Interviewing	$15,000
Cultural Competency	$40,000
Dialectical Behavioral Therapy Training	$265,000
Peer Support Specialist Training Program	$450,000
ACT Training	$17,000
FPE Transition to Sustainability	$65,300
Clubhouse Training	$50,000
Anti-Stigma	$15,000
Systems Transformation Project Coordination	$120,615
* Admin Costs include: staff salaries, random moments, DIT,	
indirect, CSS&M, staff travel, and ACMI.	
Subtotal	$12,431,144
FY12 Award	$8,354,921
FY11 Carryforward (Est.)	$4,676,332
Total Remaining	$600,109

Draft Spending Plan for FY12 Children's Mental Health Block Grant	
Contract Title	**Amount**
ACMH Family Advocacy Project	$ 136,600.00
ACMH Parent Support Partners	$ 150,951.00
Youth Peer to Peer	$ 30,000.00
CEI TFCBT Coordination and Training	$ 310,105.00
CEI SEDW DHS Access Position	$ 46,336.00
EMU LOF Project	$ 103,329.00
MACMHB Training ISII (PMTO & PTC)	$ 104,165.00
MACMHB FAS CAFAS/PECFAS Software	$ 180,131.00
MACMHB 5% Extra	$ 14,215.00
MPHI Wraparound Training	$ 179,512.00
SEMHA Community Collaborative Planning/Early Intervention	$ 169,553.00
Wraparound National Consultants	$ 60,000.00
Parent Leadership Training	$ 20,000.00
Random Moment Sampling	$ 68,498.00
ACMI Parent Support	$ 3,000.00
CSSM	$ 4,000.00
MHSCF Travel	$ 9,136.00
MHSCF Staff	$ 142,526.00
MHSCF Staff Indirect	$ 10,333.00
MSU Wraparound Evaluation	$ 129,017.00
PMTO Training & TA (Kalamazoo)	$ 200,415.00
PMTO Trg Support Access Alliance PIHP (Bay Arenac)	$ 50,000.00
PMTO Trg Support North Care PIHP (Pathways)	$ 50,000.00
PMTO Trg Support CMH for Central MI PIHP (Central)	$ 105,000.00
PMTO Trg Support Lakeshore PIHP (Muskegon)	$ 50,000.00
PMTO Trg Support CMH Partnership of SE MI (Washtenaw)	$ 50,000.00
PMTO Trg Support Macomb/Oakland	$ 50,000.00
PMTO Trg Support CMH Affiliation of Mid MI PIHP (CEI)	$ 50,525.00
DECA-I/T Pilot Coordinator	$ 33,659.00
DECA Evaluation	$ 5,000.00
Mary Mackrain - Early Childhood	$ 82,151.00
Inter-Tribal Council (GrandTraverse Ottawa/Chippewa Indians)	$ 7,800.00
Co-occuring Training	$ 25,000.00
Home-Based Training	$ 25,000.00
Subtotal	$ 2,655,957.00
Multi-Year Projects:	
Bay-Arenac Brief Strategic Family Therapy (yr 1 of 3)	$ 75,000.00
Berrien Juvenile Justice & Mental Health Intensive Home-Based (yr 1 of 3)	$ 75,000.00
Central Michigan Parent Child Interaction Therapy (yr 4 of 5)	$ 18,438.00
Central Michigan Brief Strategic Family Therapy (yr 3 of 5)	$ 28,378.00
Copper Country School Social Work Program (yr 2 of 5)	$ 75,000.00
Detroit-Wayne Parent Partners (yr 4 of 5)	$ 50,000.00
Detroit-Wayne Support Our Young Moms (yr 4 of 5)	$ 50,000.00
Detoit-Wayne Adolescent Family Psychoeducation (yr 3 of 5)	$ 37,500.00
Detroit-Wayne Child	$ 1,043,582.00
Genesee Juvenile Justice Wraparound (yr 1 of 3)	$ 75,000.00
Genesee Maltreated Infant/Toddler Treatment Court (MITC) (yr 4 of 5)	$ 50,000.00
Genesee SEDW DHS Access Position	$ 50,000.00
Gratiot Home-Based Juvenile Justice Co-Occuring (yr 3 of 5)	$ 35,393.00
Ionia Treatment Foster Care for Youth in the JJ System (yr 1 of 3)	$ 75,000.00
Kalamazoo Northside Community Outreach (yr 3 of 5)	$ 37,320.00

Contract Title	Amount
Lifeways Multisystemic Therapy (yr 3 of 3)	$ 37,500.00
Muskegon SEDW DHS Access Position	$ 50,000.00
Network 180 Juvenile Detention Wraparound (yr 1 of 3)	$ 75,000.00
Network 180 Prevention Groups (yr 4 of 5)	$ 50,000.00
Network 180 Access Clinician at DHS (yr 4 of 5)	$ 39,394.00
Northeast Michigan Implementing the System of Care (yr 3 of 5)	$ 46,853.00
Northern Lakes Triple-P Parenting Program (yr 2 of 2)	$ 55,165.00
Oakland Child Care Expulsion Prevention Services Project (yr 4 of 5)	$ 50,000.00
Oakland SEDW DHS Access Positon	$ 32,433.00
Ottawa Parent Peer (yr 2 of 5)	$ 55,604.00
Saginaw Mobile Crisis Team (yr 3 of 4)	$ 50,000.00
Saginaw SEDW DHS Access Position	$ 41,500.00
St. Joseph Treatment Foster Care (yr 2 of 2)	$ 75,000.00
VanBuren Brief Strategic Family Therapy (yr 1of 3)	$ 75,000.00
Washtenaw SEDW DHS Access Position	$ 50,000.00
West Michigan Youth Advisory Council (yr 3 of 5)	$ 50,000.00
Subtotal	$ 2,609,060.00
Total (FY12 draft allocations)	$ 5,265,017.00
FY12 Award (same as FY11)	$ 4,177,460.00
FY11 Carry-forward (Est.)	$ 1,908,236.00
Total Available to Spend in FY12 (Est.)	$ 6,085,696.00
Total FY12 Funds Obligated (Est.)	$ 5,265,017.00
FY12 Remaining Amount to Spend (Est.)	$ 820,679.00

August 19, 2011

Olga Dazzo, Director
Michigan Department of Community Health
201 Townsend Street
Lansing, MI 48913

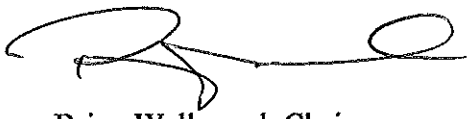
Dear Ms. Dazzo:

The state's Advisory Council on Mental Illness (ACMI) met on August 12, 2011, to review and discuss Michigan's fiscal year 2012-2013 Community Mental Health Services Block Grant Application.

The ACMI, which is comprised of consumers, family members, advocates, service providers, and representatives of state departments, appreciates the opportunity to offer input on the Block Grant Application. We hope that the submission of this report is met with favorably by the federal government.

We look forward to continuing our advisory role related to the state's mental health activities, and we appreciate the support the department has continually given to the work of the ACMI.

Sincerely,



Brian Wellwood, Chair
Advisory Council on Mental Illness

Contact information:
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E-mail: brwellwood@yahoo.com