Improving Practices in Michigan's Public Mental Health System

Michigan Department of Community Health

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
IMPROVING PRACTICES LEADERSHIP TEAM MEETING

MONDAY, NOVEMBER 5, 2007
LANSING COMMUNITY COLLEGE WEST CAMPUS

IMPROVING PRACTICES LEADERSHIP TEAMS IN MICHIGAN'S PUBLIC MENTAL HEALTH SYSTEM

It is the vision of the Michigan Department of Community Health (MDCH) that: "Michigan's children, families and adults will have access to a public mental health and substance abuse service system that supports individuals with mental illness, emotional disturbance, developmental disabilities and substance use disorders by promoting good mental health, resiliency, recovery, and the right to control one's life within the context of the benefits and responsibilities of community."

Together with consumers, providers, families, advocates, community stakeholders, and policy makers, the MDCH is engaged in a system transformation process aimed at achieving the vision. In May 2005, the MDCH used federal Community Mental Health Block Grant funds to issue a request for proposals (RFP) to the state's 18 Prepaid Inpatient Health Plans (PIHPs) for Medicaid Specialty Mental Health and Substance Abuse Services and Supports. The RFP invited PIHPs to partner with MDCH and affiliate community mental health services programs to improve practices in the public mental health system. All 18 PIHPs responded to this invitation and agreed to use funding to convene Improving Practices Leadership Teams (IPLTs) and join in statewide practice improvement. The formation of the IPLTs is aimed at fostering a learning organization within the public mental health system so that emerging, promising and evidence-based practices can quickly become part of the choices available to consumers during the person-centered planning process.

The MDCH charged IPLTs to:

- Adopt a vision for a transformed system of care for adults and children;
- Establish leadership capabilities and organizational capacity to communicate the vision and lead the transformation;
- Create an environment or climate of working that is receptive and amenable to the transformation;
- Develop and communicate a strategy that is tailored to the context and the roles, capabilities, and interests of the stakeholder groups involved in the public mental health system;
- Identify and mobilize program leaders or change agents within the organization to implement the activities required to achieve the desired outcomes;
- Develop an ongoing process to maximize opportunities and overcome obstacles; and
- Monitor outcomes and adjust processes based on learning from experience.

IPLTs are expected to:

- Align relevant persons, organizations, and systems to participate in transformation process;
- Assess parties' experience with change;
- Establish effective communication systems;
- Ensure effective leadership capabilities;
- Enable structures and process capabilities;
- Improve cultural capacity; and
- Demonstrate their progress in system transformation by implementing evidence-based, promising and new and emerging practices.

IPLT membership includes:

- An Improving Practice Leader
- Specialists in each of these areas: services for individuals with serious mental illness; services for children with serious emotional disturbance; and services for people with a developmental disability

- Finance
- Data
- Evaluation
- Consumer employed by the PIHP or subcontract agency
- Family member of a child receiving PIHP services
- An identified program leader for each practice being implemented by the PIHP
- An identified program leader for peer-directed or peer-operated services
- A peer support specialist

This document highlights some of the statewide accomplishments in fostering:

- A system of care based in recovery for adults with mental illness;
- A system of care for children; and
- Improved practices for delivering services and supports for people with developmental disabilities.

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MDCH PRACTICES IMPROVEMENT STEERING COMMITTEE

The Evidence-Based Practice Steering Committee was established by the Michigan Department of Community Health (MDCH) in 2004 to address how to implement evidence-based practices (EBPs) in Michigan's public mental health system. This initiative grew out of national mandates (e.g., President's New Freedom Commission and the resulting Federal Action Agenda, Institute of Medicine's Improving Quality of Health Care for Mental and Substance Use Conditions), federal Mental Health Block Grant (MHBG) funding requirements, and Michigan's Governor's Mental Health Commission that all called for using EBPs where they exist, and improving other practices that are currently being used by the public mental health system.

The Committee, later renamed Practice Improvement Steering Committee, is made up of representatives from universities, Prepaid Inpatient Health Plans (PIHPs), advocacy organizations, consumers and MDCH. It initially focused on identifying a small number of EBPs that would be implemented by PIHPs and supported by the MHBG dollars, and then become contractually required to be available at each PIHP beginning FY 08. The Committee selected two adult practices that already had free "toolkits" developed for the federal Substance Abuse and Mental Health Administration (SAMHSA): family psycho-education and integrated treatment for persons with co-occurring mental health and substance use disorders. One children's practice, Parent Management Training/Oregon model, was chosen for competitive opportunity to receive block grant funds to support its implementation. Subcommittees of the Steering Committee were established to oversee the implementation process, and an additional subcommittee was charged with identifying common measurements of success across the practices. Each EBP has an evaluation component that involves a university.

The Steering Committee also serves as a clearinghouse of information about, or provides advice on, efforts to adopt and train on other evidence-based, best, or promising practices, and on improving existing or usual practices. Examples of these are: Assertive Community Treatment, Developmental Disabilities services, Peer Specialists, Cognitive Behavioral Therapy, Multi-systemic Therapy, and Medication Algorithms. The Steering Committee has been supported in its efforts to implement EBPs, best practices and promising practices by the Michigan Association of Community Mental Health Boards (MACMHB) which has served as fiduciary and facilitator for the individual practice trainings, and has dedicated its last three spring conferences to providing training and information on improving practices.

For FY08, the Steering Committee advised MDCH to make MHBG funds available to two additional EBPs: supported housing and supported employment.

In the coming year, the Steering Committee is addressing how the improving practices initiative can be sustained at the state level and at the local level, once MHBG funds are not available for day-to-day implementation. In addition, the Committee is concerned about the practices maintaining fidelity to their evidence-based models and what measures can be taken to assure that.

Steering Committee Co-chairs are:
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RECOVERY

It is the policy of the Michigan Department of Community Health (MDCH) to support systems transformation efforts to one based on the fundamental principle of recovery for persons with mental illness. The U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), published a National Consensus Statement on Mental Health Recovery. The Consensus Statement defined recovery as "a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential." Michigan has supported a variety of initiatives that coincide with the release of the National Consensus Statement. Some of the major building blocks of recovery have been the creation of the Michigan Recovery Council and the availability of Certified Peer Support Specialists.

MDCH appointed the Recovery Council in December of 2005, with funding from a Center for Medicare and Medicaid Services (CMS) Mental Health Systems Transformation Grant. The Council meets every other month to assure rapid movement towards a public system of care based in recovery. To demonstrate the MDCH strong commitment for consumer participation in systems transformation efforts and policy development, the Recovery Council is comprised of over 75% primary consumer representation. Included in this large percentage are 18 individuals from each Prepaid Inpatient Health Plan (PIHP) who also serve on the Improving Practices Leadership Team (IPLT) for the region.

Recently the Recovery Council issued a Request for Proposals (RFP) to establish a statewide Recovery Center of Excellence (RCE). The RCE will serve as the platform for linking and supporting a virtual community of statewide change agents that will foster and support recovery initiatives. The RCE will utilize Certified Peer Support Specialists and consumers across the state to accomplish the goals. The RCE will also assist with MDCH efforts to measure recovery environments and individual recovery.

With consultation and partnership with the Human Services Research Institute (HSRI), the Recovery Council has selected the Recovery Enhancing Environment (REE) Measurement as the system-wide tool to evaluate individual and organizational performance indicators of recovery. Yale University Program for Recovery and Community Health, HSRI and the Recovery Council are working closely over the next two months to finalize implementation efforts of the REE.

Each of the state-level initiatives for practice improvement for adults with mental illness is being implemented in partnership with consumers and is aimed at supporting recovery. Information about each initiative is presented as a choice and option during the development and enhancement of the Individual Plan of Service completed through a person-centered planning process. Recovery Council members that serve on the Improving Practices Leadership Team provide the necessary link to ensure the MDCH vision for a system based in recovery.

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CERTIFIED PEER SUPPORT SPECIALISTS

Overview: Beginning in the late 1990s, the Michigan Department of Community Health (MDCH) began systems transformation efforts in promoting adults with mental illness to serve peers by working in local mental health agencies across the state. Positions as Peer Advocates and Case Management Assistants were areas applied for in the Substance Abuse and Mental Health Services Administration (SAMHSA) block grant Request for Proposals.

These early initiatives led the way in developing and supporting a peer-trained workforce. One of the early barriers in maintaining peer positions centered on funding and reimbursement. This barrier was addressed on March 15, 2006 when Peer Support Specialists were added as a covered service in the 1915 b(3) waiver. Michigan was one of the first states to use Medicaid funding for Peer Support Specialists. Medical necessity criteria of community inclusion, participation, and/or independence are addressed by Peer Support Specialists in partnership with peers they serve when developing the Individual Plan of Service (IPOS) using a person-centered planning process. Some of the implementation areas include: plan facilitation, employment, housing, accessing entitlements, assisting with arrangements to support self-determination, Advance Directives, and crisis plans.

Education and Training: At the present time, Michigan is nationally known for educating and supporting a Certified Peer Support Specialist workforce. As of November 2007, 242 individuals have been trained and certified as Peer Support Specialists. To complete certification, peers apply for a week-long training program of 35 hours with over 26 modules developed from a foundation of recovery. Some of the modules include: five stages of recovery, effective listening, facilitating recovery dialogues, accomplishing recovery goals, facings one's fears, creating environments that promote recovery, problem solving, combating negative self-talk and power, conflict and integrity in the workplace.

After the week-long training, peers attend an 8-hour day follow-up training with additional modules that are specific to Michigan including: ethics, Advance Directives, person-centered planning and self determination, medical necessity criteria, documentation, encounter coding, housing and employment. Several weeks after, training peers are given a 4-hour examination. All of the follow-up training and testing is completed at Lansing Community College (LCC).

The training team consists of a partnership between the Appalachian Group of Georgia and Michigan trainers who are Certified Peer Support Specialists and are supported by their local agencies to assist as trainers. Information regarding Michigan module training is presented by MDCH staff in partnership with peers who have expertise in the subject areas.

A variety of topics are currently being offered for continuing education opportunities. MDCH has developed a partnership with the Copeland Center who offers certification for facilitation of Wellness Recovery Action Planning (WRAP). A Certified Peer Support Specialist in Oakland County with Master-level training status has been instrumental in providing 3-day introductory trainings to WRAP while co-facilitating the full-week training with the Executive Director of the Copeland Center. In partnership with Yale Program for Recovery and Community Health and Focus on Recovery United, a full-week facilitation training is offered for Peer Support Specialists in implementing the book "Pathways to Recovery." MDCH is committed to maintaining a quality trained peer workforce and will continue to work with others across the country to provide state of the art training. In July of 2007, a continuing education conference was held with over 150 peers participating. This conference will be offered annually and developed by Certified Peer Support Specialists.

Collaboration with Higher Education: MDCH has developed a collaborative relationship with LCC with activities moving towards a future agreement and a formal contract for training, testing, and certifying Peer Support Specialists. LCC is examining the full curriculum to move

toward awarding 3 elective credits for completion of training and certification. In 2008, the collaborative vision is that Michigan peers will receive certification from LCC, with follow-up continuing education trainings completed in partnership with LCC towards the goal of offering continuing education credits. When this process in completed, Peer Support Specialists who choose to further their education will be provided with career counseling and educational support to continue career paths of their choice.

Utilization and Effectiveness: According to the statewide encounter data of October 1, 2007, Michigan serves over 132,303 with a serious mental illness. Peer Support Specialists served 4,469 individuals totaling 3.38% of the total statewide population. This data points to the need for training and certifying more peers statewide to ensure that all individuals who have an Individual Plan of Service developed through a person-centered planning process are provided with the choices and options of Peer Support Specialists to implement goals and objectives.

To assist in promoting effectiveness and utilization, MDCH has scheduled meetings with liaisons from all CMHSPs for Certified Peer Support Specialists. Six meetings are scheduled throughout the year to focus on best practices, technical assistance, sharing agency forms, hiring practices and support models.

Peer Support Specialists have moved from Practice-Based Evidence, to a Promising Practice. National research is underway to evaluate this initiative as an Evidenced-Based Practice. Certified Peer Support Specialists are the keystone for Michigan's systems transformation efforts for adults with mental illness.

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ADVANCE DIRECTIVE FOR MENTAL HEALTH CARE

On January 3, 2005, Advance Directives for Mental Health Care became law in Michigan. The legal reference is contained in the Estates and Protected Individuals Code, PA 1998 No. 386, as amended by PA 2004 No. 532. The statutory citation is MCL 700.5506 et seq.

The Michigan Department of Community Health (MDCH) published a pamphlet that was written by Bradley Geller, Esq., in partnership with the Michigan Recovery Council. The document is based on providing information and forms to assist adults with mental illness in developing an advance directive that documents their wishes and choices about care provided. In Michigan, an advance directive for mental health care, also referred to as a durable power of attorney for mental health care, is a document in which you appoint another individual to make mental health decisions for you in the future. Individuals can choose to have a durable power of attorney for health care, an advance directive for mental health care or no durable power at all.

To provide additional technical assistance in conjunction with the pamphlets and brochures, MDCH, in partnership with Michigan Protection and Advocacy Services, completed a variety of trainings around the state for consumers, families, providers and other stakeholders. This includes six regional trainings for consumers, administrators, and staff this year; a workshop at the annual Consumer Conference which over 500 consumers attended; and the Upper Peninsula consumer conference also held a session on Advance Directives for consumers, families, and staff.

Michigan is one of several states nationally that has supported recovery by providing the right to have an advance directive. Specific information on each state is available at the website hosted by the National Resource Center for Psychiatric Advance Directives (PAD). This website provides an important voice with quotes from adults with mental illness who have chosen to develop an advance directive. Some of the listed quotes include:

- "it was really crowded in the ER so I showed intake my psychiatric advance directive and told them that I needed to go somewhere quiet….so that I could calm down….The intake nurse sat with me in a quiet room until I calmed down."
- "I would recommend PADs because people can have you committed and you don't have a say about anything, and at least this way you do have some say in your treatment, if it's read and people see it and it's legal."
- "My therapist suggested I make copies of my PAD, so I did that, and gave a copy to everyone I wanted to. There is a copy of file at the hospital, just in case, along with my general healthcare directive. I don't want any mistakes made…Those are my wishes and that's a legal document, and it must be followed.
- This time, with a PAD, I did not receive any treatments that I did not want. They were respectful. I really felt like the hospital took better care of me because I had my PAD in fact, I think it's the best care that I've ever received.

The quotes above are proof that developing an advance directive is beneficial and addresses freedom, liberty or independence that is central to dignity. For further information on advance directives in Michigan, visit the MDCH website at: http://www.michigan.gov/mdch/0,1607,7-132-2941_4868_41752---,00.html

Assisting individuals in determining choices and options of developing an advance directive during the person-centered planning process is a fundamental need for strengthening initiatives for practice improvement.

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INTEGRATED TREATMENT FOR INDIVIDUALS WITH MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Overview: To implement the Co-occurring Disorders: Integrated Dual Disorder Treatment (COD:IDDT) model evidence-based practice (EBP), Prepaid Inpatient Health Plans (PIHPs) need to look at the system as a whole. This means that the system must address the issues and barriers that consumers with complex needs face every day. In Michigan, the Michigan Department of Community Health (MDCH) uses the principles of the Continuous, Comprehensive Integrated System of Care (CCISC) model developed by Dr. Ken Minkoff and Dr. Chris Cline to effectively change the system. To develop a successful and sustainable change, the public mental health system must look at the entire system of care and develop a comprehensive plan that addresses co-occurring disorders and integrated treatment.

The COD:IDDT model is for people who have serious mental illness and have a co-occurring substance use disorder. This treatment approach helps people recover by offering treatments that combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. This means the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in an integrated fashion. The goal of COD:IDDT intervention is recovery from two serious illnesses. A wide variety of services are offered in a stage-wise fashion because some services are important early in treatment, while others are important later on. Individualized treatment is offered depending on what stage of recovery a person is in. Ultimately, the goal of integrated treatment is to help people manage both their mental illness and substance disorders so that they can pursue their own meaningful life goals.

FY 07 Accomplishments: All of Michigan's 18 PIHPs are involved in IDDT. At the program level, 17 PIHPs are currently in the process of developing or implementing the federal Substance Abuse Mental Health Administration (SAMHSA) EBP model. Twelve PIHPs currently have a charter/consensus agreement and/or a working document. Seventeen PIHPs did Co-FIT or COMPASS and developed action plans based on these assessments. Through FY 07, MDCH funded 11 PIHPs through block grants to develop integrated treatment capacity. During FY 08, 4 more PIHPs were awarded block grant funding. Michigan has more than 60 IDDT teams in different developing stages. MDCH, through block grant funding, is supporting a peer review process for fidelity monitoring and technical assistance for these 60 plus IDDT teams. This peer review process, called Michigan Fidelity Assessment Support Team (MiFAST), is coordinated by Wayne State University staff and is staffed by 15 trained clinicians from different Community Mental Health Services Programs (CMHSPs). At the clinical level, several trainings were provided through the Michigan Association of Community Mental Health Boards that focused on staff competency. Through the Subcommittee for Co-occurring Disorders, a regularly scheduled "Learn and Share" meets quarterly to share and learn information among all the PIHPs/CMHSPs and Coordinating Agencies (CAs) regarding resources, and learning from each one's experiences. Consumer involvement in integrated treatment is steadily improving. There are seven Dual Recovery Anonymous (DRA) groups that currently meet in different parts of the state.

Training Plans for FY 08:

A. Ken Minkoff/Chris Cline

1. Change Agent Trainings: Train a group of change agents from each PIHP/CA region that would become an enduring statewide team of clinical and administrative change agents to translate the implementation of co-occurring capability, integrated services, and co-occurring clinical competency into every layer of the public mental health system.

2. PIHP System Change Consultation: In addition, Drs. Minkoff and Cline will continue to provide a combination of on- and off-site training and technical assistance activities with PIHPs and CAs.

B. Ohio Coordinating Center of Excellence/Case Western University
Programmatic Consultation: Administrative consultation as required for PIHPs to develop and sustain services.

1. Training on certain fidelity items:
   - **A. Learn and Share:** Quarterly
   - **B. Wayne State University:** Will provide trainings on several IDDT fidelity items
   - **C. Fidelity Reviews:** Fidelity reviews and Readiness Assessments for the IDDT teams at no cost

Expected Outcome: Due to all these efforts, there is an increase in screening, assessment and treatment for individuals with substance use disorder in the public mental health system. There is also much more cooperation and coordination between the public mental health system and the substance abuse CAs. MDCH identified two modifier codes and issued instructions to both mental health and substance abuse system on how to report COD:IDDT and other integrated services. The co-occurring disorder measurement workgroup is discussing ways to collect accurate data of the number of individuals with substance use disorder in the public mental health system through the Quality Improvement data files.

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FAMILY PSYCHOEDUCATION

Family Psychoeducation (FPE) is a specific method of working in partnership with consumers and families in a long-term treatment model to help them develop increasingly sophisticated coping skills for handling problems posed by mental illness. The goal is that practitioner, consumer, and family work together to support recovery. Common issues addressed through FPE include participation in outpatient programs, understanding prescribed medication, dealing with alcohol or other drug abuse, and managing symptoms of mental illness that affect the consumer. FPE respects and incorporates individual, family, and cultural perspectives. It engenders hope in place of desperation and demoralization and can significantly help people with a mental illness in their recovery process.

FPE services in Michigan have been implemented as an evidence-based practice (EBP) under our federal Block Grant consistent with the federal Substance Abuse Mental Health Administration (SAMHSA) FPE toolkit. Local Community Mental Health (CMH) agencies throughout the state have been funded to offer FPE consistent with the model developed by Dr. William McFarlane. This includes staff training, coaching and supervision through Dr. McFarlane or his associates to maintain model fidelity. FPE programs follow the McFarlane model with regard to consumer recruitment and joining activities, FPE facilitator's role, content of FPE sessions and other aspects of this proven method of intervention.

During FY 07, MDCH funded thirteen CMH agencies to provide FPE through the Block Grant. Ten CMH agencies (Central Michigan, Detroit-Wayne County, Genesee County, Lakeshore Alliance, LifeWays, Northern Affiliation, Oakland County, Pathways, Southeast Michigan and Venture) completed their second and final year of FPE Block Grant operation while three CMH agencies (Northwest Affiliation, Saginaw County and Southwest Affiliation) completed their first year of FPE Block Grant operation. Based upon quarterly progress reports submitted by the CMH agencies, a total of 61 FPE groups were in operation throughout the state serving a combined total of approximately 593 consumers and family members.

For FY 08, funding has been approved for three CMH agencies (Northwest Affiliation, Saginaw County and Southwest Affiliation) to complete a second year of FPE Block Grant operation. Four CMH agencies (Bay-Arenac/ Access Alliance, Clinton-Eaton-Ingham/Mid-Michigan Affiliation, Macomb County and network180) were also approved for year-one FPE funding, while Muskegon/Lakeshore Alliance was approved to provide an FPE enhancement project to complement their two-year FPE project.

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ASSERTIVE COMMUNITY TREATMENT

The challenge to the evidence-based practice (EBP) of Assertive Community Treatment (ACT) is not implementing ACT, but creating and sustaining an environment which looks at the practice, identifies needed improvements to attain the essential elements of ACT, implements and maintains them. Implemented in Michigan approximately 20 years ago, attention to adhering closely to the model has increased as the Improving Practices Initiative continues.

Originated in the 1970's in Wisconsin as a 'hospital without walls,' the Programs of Assertive Community Treatment (PACT) model, advocated by the federal Substance Abuse Mental Health Administration (SAMHSA), is difficult to fund and sustain. Few programs follow the model. An early adopter, Michigan made adaptations to address the treatment needs of consumers in our state. The primary differences between ACT and PACT are team size, team shifts, team qualifications and credentials and non-brokering of services.

To assist teams to self-assess and improve, the Flinn Family Foundation provided funding, and teams were evaluated. From the Flinn study, a tool, the draft Field Guide to ACT, was created. The Field Guide takes into account fidelity, Medicaid, best practice and feedback from the field visits. The Field Guide is not intended to be a fidelity check done by each team and reported as a fidelity measurement. Fidelity of each ACT team will be addressed in a different manner.

The Field Guide draft went out for public comments; feedback has been examined and some has been incorporated into the product.

The evaluation group will sample some state teams this year. Field visits will teach teams how to use the Field Guide and how to use the results of the findings to improve practice. Other training on the Field Guide will occur later in this fiscal year and will be provided by the Assertive Community Treatment Association (ACTA).

A crosswalk was developed to compare the Field Guide to Medicaid, Dartmouth Assertive Community Treatment Scale-draft and SAMHSA Minimum ACT standards. Since then, the crosswalk has been expanded to compare ACT, Integrated Dual Disorder Treatment (IDDT), and Supported Employment (SE) with Family Psychoeducation (FPE) to come. SAMHSA toolkits conflict between one another with some confusion within individual toolkits. The comparison will result in recommendation for Michigan practice and Medicaid revisions.

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MOTIVATIONAL INTERVIEWING TRAIN THE TRAINER MODEL

Overview: In a joint initiative, the Mental Health and Substance Abuse Administration and ODCP training projects are supporting six phases of Motivational Interviewing (MI) training that will be delivered regionally. The purpose of this initiative is to develop regional clinical staff/supervisor expertise in Motivational Interviewing.

Summary of Accomplishments: Phases 1 and 2 were completed in FY 07, and phases 3 to 5 are scheduled for FY 08. Phase 1 was targeted for Supervisors and Administrators to learn about MI and how to select participants for the following phases. Four Phase 1 trainings were provided. The trainings were open to staff from both the mental health and substance abuse provider networks. 128 staff from both mental health and substance abuse provider networks participated in the Phase 2 trainings. There are differences in participation, cost and resulting expectations depending on the provider network.

FY 08 Plans: It is expected that Phases 3 through 5 will be completed during this fiscal year. Phase 3 advanced training will start in November 2007. It is expected that once the individuals are trained in advanced MI techniques, they will submit individual tapes for coding.

Expected Outcome: Individuals successfully completing Phases 2 through 5 will gain a regionally limited, Michigan-specific Motivational Interviewing training credential. There is space for 128 individuals in the training, and it is expected that approximately 32 individuals will get the Michigan-specific training credential through Mr. Michael Clark.

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EVIDENCE-BASED SUPPORTED EMPLOYMENT

Evidence-based Supported Employment (EBSE) is an approach to vocational rehabilitation that emphasizes helping people obtain competitive work in the community, and providing the supports necessary to ensure success at the work place. The principles and critical elements of supported employment and practices involve rapid job search, jobs tailored to individuals, time-unlimited following supports, integration of supported employment and mental health services, and zero exclusion policy.

FY 05/06:

- EBSE was included in block grant RFP
- 2-day training with David Lynde from Dartmouth Evidence-Based Practices Center
- Three CMHSPs received block grant funds to implement EBSE

FY 06/07:

- Two 2-day trainings with David Lynde and Amy Miller
- EBSE was incorporated in Detroit-Wayne Comprehensive Project

FY 07/08:

- Block grant was allowed on a non-competitive basis for PIHPs who have already implemented both Family Psychoeducation and Co-Occurring Disorders: Integrated Dual Disorder Treatment
- 2 PIHPs received block grant funds
- Regional and statewide training will be provided
- Statewide workgroup will be developed
- Recommendations for Medicaid Provider Manual being discussed along with COD:IDDT and Assertive Community Treatment

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JAIL DIVERSION

Overview: The Michigan Department of Community Health (MDCH) has made a commitment to the principal of addressing the needs of the community and society to better serve persons with serious mental illness, serious emotional disturbance or developmental disability who come in contact with the criminal justice system but would be better served by the mental health system rather than incarceration. It is recognized that many of these individuals with serious mental illness have a co-occurring substance disorder. The MDCH Jail Diversion service programs are designed to serve those individuals who commit crimes of a misdemeanor or non-violent nature and voluntarily agree to participate in the diversion program.

Consistent with Section 207 of the mental health code, each Community Mental Health Services Program (CMHSP) shall provide services to divert persons with serious mental illness, serious emotional disturbance, or developmental disability from possible jail incarceration when appropriate. The adult Jail Diversion Policy Practice Guidelines of February 25, 2005 reflects the commitment to the principles and conveys MDCH Jail Diversion policy and resources for CMHSPs.

FY 07 Activities: Three new Jail Diversion service programs were developed and funded through the federal block grant process. The focus for these programs was multi-faceted around staff hiring to coordinate Jail Diversion service delivery, cross- training of law enforcement, court, substance abuse and mental health professionals on how to recognize, access and screen individuals on the diversion system and how to recognize and treat individuals exhibiting behavior warranting Jail Diversion intervention. Education and outreach, along with the development of a broad array of community-based resources that address the fragmentation of services, are also made available through these CMHSP Jail Diversion programs.

MDCH sponsored a Jail Diversion mini-conference to convene mental health Jail Diversion program staff, law enforcement staff, and court personnel to provide a forum for information sharing and a review of successful Jail Diversion programs from around the state. This mini-conference was designed for CMHSP program staff and their partners who are involved at any level with Jail Diversion activities or are experiencing significant barriers to Jail Diversion programming. A statistical analysis of Jail Diversion data reports was given to address the need for accurate Jail Diversion numbers for evaluation and programming purposes its implication for practice.

FY 08 Plans: MDCH will fund three new Jail Diversion programs which focus on strengthening Jail Diversion services and coordinating participating partners who are needed to address the many areas of need for the at-risk population. MDCH will also monitor the development and implementation of two mental health courts operating within our state. In addition, MDCH will sponsor and participate in a train-the-trainer workshop developed through our federal block grant training contract with the Michigan Association of Community Mental Health Boards, in partnership with the Oakland County Community Mental Health Authority.

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DIALECTICAL BEHAVIOR THERAPY

Overview: Through this initiative, the Michigan Department of Community Health (MDCH) is supporting 16 Dialectical Behavior Therapy (DBT) teams who have no previous training or who have some training in DBT to develop increased clinical skills. The goal of the training and consultation is to systematically implement DBT and increase the availability of this treatment modality as a choice in the person-centered planning process. Sixteen DBT teams were selected for this three-year initiative. Each team consists of a maximum of 8 members, including peer support specialist(s)/consumer(s). The orientation training was held in Lansing in September 2007. Teams also received materials including DBT text book and skill manual.

FY 07 Accomplishments and Plans for FY 08:

Phase/Time Line	Description	Status
Phase I	Orientation training – Two day workshop followed by a day of consultation	Completed – September 2007
(2-3 months following orientation training)	Onsite Intensive Training Part I: 5 days	December 10-14, 2007
6 months between Intensive training and Advanced training	Consultation Services: 1 hour per team per month (x 6 months)	Phone consultation. start in January 2008
Online learning for Intensive Team Participants	20 hours of online learning focused on the skills component of the treatment (Intensive Training participants)	Started and ongoing September 2007
6 months post part II of Advanced training	Consultation Services: 1 hour per team per month (x 6 months)	Phone Consultation
6 months following Part II of Advanced Training	Advanced training for staff that completed Intensive Training– Review of team progress and program development. Review/refine content/delivery of treatment	TBD
Phase II – FY 08	Clinical Case Consultation 4 hours per team per month	Phone consultation
Advanced Training	Advanced training for staff that completed Intensive Training– Review of team progress and program development. Review/refine content/delivery of treatment	Part 1 May 5- 9, 2007 Part II June 9-13, 2007

Expected Outcome: Through this initiative, it is expected there will be a consistent statewide approach for implementation and support of DBT. It is expected that all 16 teams will complete this three-year initiative, and consumers will be able to receive DBT as a choice during person-centered planning throughout the public mental health system.

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INITIATIVES FOR INDIVIDUALS WITH DEMENTIA AND THEIR CAREGIVERS

The Michigan Department of Community Health (MDCH) is enhancing efforts to improve identification of older adults in all settings who exhibit significant changes and disturbances in mood, cognition, or behavior and to improve integration of services to persons with dementia and serious mental illness among primary, long-term, and mental health care. Family caregivers of isolated older adults with mental illness or progressive disabling medical conditions are also the focus of interventions designed to improve coping skills, mental health needs, reduction of stress, burden, depression, and family conflicts. Wraparound pilot projects have developed family teams that focus on strengths of natural supports and goals of the person with dementia and their family caregivers. Networks of support are developed for the families and with a Community Team, which is a collaborative group of community-based resources. These Community Teams have been tremendously successful at building relationships and sharing information and resources. Education on dementia care has been identified as a need for family members and respite care workers, and all pilot organizations have added this training to their regular programming. Two pilot sites are funded through federal mental health older adult block grants and two are funded by the Administration on Aging's Alzheimer's Disease Demonstration Grants to States; all four include rural communities. A model for a new target of adults with dementia who exhibit acute behavioral symptoms of distress and their family caregivers will be finalized in 2008.

Outreach strategies include traditional and innovative techniques to establish trust, rapport, acceptance, and increased use of mental health services by older adults at-risk. Case managers involved in Senior Neighbor programs and HUD public housing programs are receiving mental health training and consultation to increase linkages with CMHSP network of care and assist them in identifying the mental health needs of adults living in low-income housing sites. Staff of community and housing services assists their consumers, many of whom are reluctant to seek treatment. Another block grant program provides in-home assessment and treatment of elderly persons with severe mental illness who have not been able to meet their mental health needs due to living in a rural area. Local service providers, physicians, senior citizen programs, churches and nursing homes are educated to detect and refer elderly persons for mental health services. In addition, community education has focused on de-stigmatizing mental illness, developing support groups for elderly, and providing services in places that seniors frequent and trust.

Expertise is being developed to provide customized information, education, and case consultation to staff that work in health care and community services organizations, as well as increasing community mental health clinicians' knowledge and use of assessment tools and protocols. Two community mental health organizations (one rural, one urban) have designed seminar series on the use of cognitive impairment intervention protocols that help the professional assess a person's ability to process information, to express desires and needs verbally and nonverbally, and to perform tasks in the context of the environment and interactions with other people. A Train-the Trainer manual on dementia care for direct care workers has been updated and modified to include the newly released Dementia Core Competencies. Dementia care training for Home Help workers has been extended, particularly focusing on Detroit and Flint areas that have exhibited large needs. Printing of the manual, "Understanding Difficult Behaviors," is provided to family caregiver education programs throughout the state.

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COGNITIVE BEHAVIORAL THERAPY FOR OLDER ADULTS

Recognized as an underserved population in the public mental health system, older adults, aged 65 or older, with serious mental illness may be at risk of suicide, experience dementia with depressed mood, behavioral disturbances or delusions, or have co-occurring problems with substance use or dependency, and often there are other complicating factors that can include multiple medical conditions that may mask psychiatric conditions, multiple medication interactions, age-related changes to physical and mental functioning, and increasing isolation.

Older adults have greater mental health needs than are currently being served. The Michigan Mental Health Commission Report of 2004 stated that, "Special outreach efforts need to be targeted to older adults, persons with dementia, and their caregivers." The President's New Freedom Commission recognized the need for increased workforce development. This initiative addresses workforce development but not penetration rates or outreach or service efforts.

Cognitive Behavioral Therapy (CBT), modified for older adults, is an evidence-based practice (EBP) and a new initiative for older adult service providers. This is a block grant funded-FY 08 initiative, and it is in the final stages of planning.

Community Mental Health Services Program (CMHSP) older adult treatment staff will be identified; about one-half of the CMHSPs (about 20) will be able to have one treatment staff trained in CBT. Once identified, they will be invited by letter to participate. Training will be offered either in southeast Michigan or in Gaylord or Marquette, depending upon where the majority of recruits come from. Training includes an initial two-day session, monthly individual viewing of submitted tapes for supervision and feedback, with additional technical assistance available as needed, and one additional training day at the end of the year. The model has been adapted to older adults, and fidelity assessments occur within the supervision activities. Certification from the Beck Institute is also included and required.

Future potential: Using block grant money in one-year additional increments:

1. Group 1 training and supervision of Older Adult Mental Health (OAMH) therapists in EBP-CBT, as modified for older adults.
2. Group 2 training for additional CMHSP OAMH therapists (approximately 20).
3. Select OAMH therapists trained in CBT for older adults to participate in additional training in training others in CBT for older adults. Individuals selected for this additional training will need to agree to train another generation of staff to help expand this EBP statewide.

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SYSTEM OF CARE FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES AND THEIR FAMILIES

Overview: To improve outcomes for children with serious emotional disturbance (SED) and their families, the development of a community system of care is encouraged. *The system of care is to be comprehensive, family-centered, community-based, culturally and linguistically competent. It is a* system that is developed for children/youth and their families that represents the organization of public and private services within the community into a comprehensive and interconnected network in order to accomplish better outcomes for all children. An integral part of the system of care development is the involvement of parents and youth. The process is to be family-centered where the family members (parents and youth) guide the development of the system of care**.**

Communities were requested to utilize a system of care planning process in preparation for application for funding from the Children's Mental Health Block Grant (FY 07 and FY 08) and in implementing the 1915(C) SED Waiver. The Michigan Department of Community Health (MDCH) is particularly interested in increasing access to specialty mental health services and supports for Medicaid eligible children/youth in Child Welfare (i.e., abuse/neglect and/or adopted children/youth) and Juvenile Justice who have SED.

Community Mental Health Services Programs (CMHSPs) were asked to take leadership and join with local stakeholders to identify all of the mental health services for children/youth and their families available in the community, the number of children/youth served in FY06, the capacity of the program/agency, total cost and funding source(s) as part of the environmental scan. Stakeholders were asked to determine if the services identified are an evidence-based or promising practice. Parents and youth were required members of the stakeholders group.

Accomplishments:

- CMHSPs utilized the system of care planning process as they developed their applications for Children's Mental Health Block Grant funding for FY07 and FY08.
- Children's mental health services planned for through the system of care process and submitted for Children's Block Grant funding were an evidence-based or a promising practice (Wraparound, Multi-Systemic Therapy, Therapeutic Foster Care, Infant Mental Health, etc.) and/or supported a systemic approach to screening/assessment or service provision.
- CMHSPs attended training in development of a system of care for children with serious emotional disturbance, and four CMHSPs have been funded to continue working with their partners to develop a comprehensive system of care through the implementation of evidence-based programs, a cross system screening process or the SED Waiver.
- Several of the CMHSPs applying for Children's Block Grant identified another agency/organization as providing a portion of the match funds for the block grant-funded service.

Plans for FY08:

Continue to utilize the system of care planning process as a precursor for the Children's Block Grant application.

- FY 08 mental health capitation for children has been increased and performance measures have been established for the Prepaid Inpatient Health Plans (PIHPs) to increase the number of children served and the expenditures for both children with SED and developmental disabilities with a special focus on children in the Department of Human Services (i.e., abuse/neglect, foster care).

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PARENT MANAGEMENT TRAINING-OREGON MODEL

Overview: The Parent Management Training-Oregon (PMTO) is a family-based intervention designed to empower parents by teaching them effective parenting practices. Research has demonstrated that when parents improve these skills, their children show commensurate increases in pro-social behavior and decreases in problem behavior. The PMTO method emphasizes identifying and building upon strengths already present in parents, children, and their environment. Professionals teach parents to shape their children's behavior with the use of positive and negative contingencies. Thus, professionals coach parents as they socialize their children. The key parenting practices taught are skill encouragement, limit setting, monitoring, problem solving, and positive involvement.

Parents are engaged in a collaborative process to strengthen their child rearing strategies. Common teaching approaches include the following: problem solving, eliciting goal behavior, assessing skills and filling in gaps, breaking content into teachable units, identifying obstacles and brainstorming ways to overcome them, role play, and exercises to assess and practice effective parenting practices. Professionals avoid didactic teaching and instead engage the parents in an active learning process.

Professionals follow an agenda with goals and objectives relevant to parenting skill development, use appropriate and sensitive pacing and timing, maintain leadership of sessions without dominating, are responsive to the needs of parents, and intervene in crises as needed. Sometimes the PMTO skills are applied to crisis situations, for example, use of strategizing through group problem solving. Sophisticated process or clinical skills are employed to help parents feel joined, understood, and supported during the change process. Common approaches include normalizing, reflection, use of humor, punctuating, mirroring, use of metaphors, use of movement, and use of drama.

Plans for FY 08: *Trainees from 2006 are finishing up, and Michigan will have 18 new specialists trained throughout the state. Another statewide training using some of these 18 individuals as trainers has also started, and 16 new therapists will be trained FY 07-08. In addition to the statewide training, the state has been divided into six regions for local training. Region 1 - North Care; Region 2 - CMH Affiliation of Mid Michigan and surrounding counties; Region 3 - network180, Lakeshore Behavioral Health Alliance, Southwest Affiliation; Region 4 - CMH for Central Michigan, Northwest Affiliation, and Northern Affiliation, Region 5 - CMH Partnership of Southeast Michigan and Region 6 - Wayne County.*

The regions are planning training as well. Region 2 and Region 5 have started their training that consists of 22 new therapists between the two regions. Region 1, 3 and 4 will begin training 28 new therapists in January 2008. Region 6 will be working with ISII and training 28 new therapists. All regions have been given block grant money to help set up their infrastructure to support additional training in PMTO. Kalamazoo CMH is also developing a database and video streaming to help with training, coaching, and fidelity monitoring.

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MULTISYSTEMIC THERAPY (MST)

MST is a pragmatic and goal-oriented treatment that specifically targets those factors in each youth's social network that are contributing to his or her antisocial behavior. Thus, MST interventions typically aim to improve caregiver discipline practices, enhance family affective relations, decrease youth association with deviant peers, increase youth association with prosocial peers, improve youth school or vocational performance, engage youth in prosocial recreational outlets, and develop an indigenous support network of extended family, neighbors, and friends to help caregivers achieve and maintain such changes. Specific treatment techniques used to facilitate these gains are integrated from those therapies that have the most empirical support, including cognitive behavioral, behavioral, and the pragmatic family therapies.

MST services are delivered in the natural environment (e.g., home, school, community). The treatment plan is designed in collaboration with family members and is, therefore, family-driven rather than therapist-driven. The ultimate goal of MST is to empower families to build an environment, through the mobilization of indigenous child, family, and community resources, that promotes health. The typical duration of home-based MST services is approximately 4 months, with multiple therapist-family contacts occurring each week.

Although MST is a family-based treatment model that has similarities with other family therapy approaches, several substantive differences are evident. First, MST places considerable attention on factors in the adolescent and family's social networks that are linked with antisocial behavior. Hence, for example, MST priorities include removing offenders from deviant peer groups, enhancing school or vocational performance, and developing an indigenous support network for the family to maintain therapeutic gains. Second, MST programs have an extremely strong commitment to removing barriers to service access (see e.g., the home-based model of service delivery). Third, MST services are more intensive than traditional family therapies (e.g., several hours of treatment per week vs. 50 minutes). Fourth, and most important, MST has well-documented long-term outcomes with adolescents presenting serious antisocial behavior and their families. The strongest and most consistent support for the effectiveness of MST comes from controlled studies that focused on violent and chronic juvenile offenders.

Providers of Multisystemic Therapy: MST is available through the following Community Mental Health Service Programs (CMHSP's): Berrien Mental Health Authority, Summit Point, network180, Genesee County CMH Services, and Lifeways. In many of these CMHSP's, MST is jointly funded between the local court and the CMHSP.

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MULTIDIMENSIONAL TREATMENT FOSTER CARE (MTFC)

The goal of the MTFC program is to decrease problem behavior and to increase developmentally appropriate normative and prosocial behavior in children and adolescents who are in need of out-of-home placement. Youth come to MTFC via referrals from the juvenile justice, foster care, and mental health systems.

MTFC treatment goals are accomplished by providing:

- close supervision
- fair and consistent limits
- predictable consequences for rule breaking
- a supportive relationship with at least one mentoring adult
- reduced exposure to peers with similar problems

The intervention is multifaceted and occurs in multiple settings. The intervention components include:

- behavioral parent training and support for MTFC foster parents
- family therapy for biological parents (or other aftercare resources)
- skills training for youth
- supportive therapy for youth
- school-based behavioral interventions and academic support
- psychiatric consultation and medication management, when needed

MTFC is currently available through AuSable Valley CMH Services. Macomb County CMH Services and CMH Authority of Clinton-Eaton-Ingham Counties are planning to develop MTFC.

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DEVELOPMENTAL DISABILITIES (DD) PRACTICE IMPROVEMENT TEAM

The Michigan Department of Community Health (MDCH) established the DD Practice Improvement Team (PIT) in the spring of 2005 for the purpose of identifying best practices and otherwise improving supports and services for people with developmental disabilities who are served by the public mental health system. The 50-member team meets monthly and is made up of advocates, family members, and staff from provider organizations, Community Mental Health Services Programs (CMHSPs) and the MDCH. The team crafted for itself a mission statement: "*to promote, articulate, encourage, provide leadership, and make recommendations to the Michigan Department of Community Health for improvements to supports and services that enable people with developmental disabilities to achieve the lives they envision wherever they reside in Michigan.*"

To that end, the team has focused primarily on educating the public mental health system about how to help people with developmental disabilities "get a life" in the community. It was successful in advocating for a Developmental Disabilities track of workshop sessions at each of the three annual Michigan Association of Community Mental Health Board (MACMHB) conferences; and for a community-based track at the annual Developmental Disabilities Conference sponsored by MDCH and Michigan State University; and has identified the content and presenters for all of these sessions. The team also assisted in the development of a series of day-long training sessions for mental health staff to be sponsored by the MACMHB on improving the lives of people with developmental disabilities. The topics include: addressing problem behaviors, interventions for co-occurring physical disabilities, planning for children and families, and measuring success. The sessions commence in November 2007 and continue through May 2008.

The team also developed a vision that "*adults with developmental disabilities have the supports and services necessary to be healthy and safe and successfully:*

- *contribute to their communities,*
- *earn an income in a non-segregated, community setting,*
- *live in their own homes,*
- *have full community inclusion, meaningful participation and membership,*
- *have friendships and relationships, and*
- *have a fulfilling life."*

And, that "*children and their families successfully:*

- *live with a supportive birth or adoptive family,*
- *participate in their neighborhood community school,*
- *play an active role in the neighborhood and community activities,*
- *enjoy childhood and have friendships and relationships, and*
- *prepare for adult life."*

In the coming year, the team will identify ways to measure the accomplishment of the vision through performance indicators, and possibly, standard measures of individuals' success.

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VIRTUAL TEAM

Purpose of Virtual Team:

MDCH has assembled a virtual consultation team composed of MDCH staff and external participants with recognized expertise in this area to assist CMHSPs and PIHPs in identifying support and service options to stabilize individuals with developmental disabilities during crisis situations. The team is aimed at developing the capacity in communities statewide for resolving challenging situations for persons with developmental disabilities with minimal disruption to the individual's life.

Examples of Challenging Situations for Virtual Team:

- Living situation jeopardized by:
  physical aggression
  property destruction
  frequent elopement
  self-injurious behavior
  sexual offender issues
  exacerbation of co-occurring DD/MI

- Overwhelmed/aging families

- Avoiding Mt. Pleasant admissions/assisting with discharges

- Identifying clinical expertise at local level, and targeting areas where expertise needs to be developed

Virtual Team Network:

- Central Office group - 17 individuals with varied experience and backgrounds

- Non-State of MI - experts from CMHSPs/PIHPs:
  private providers - psychologists, therapists, etc.
  DDI
  consumers/families
  advocacy groups - those with hands-on experience/expertise

Virtual Team Communication:

- Face-to-face meetings - decisions made for set-up, hypothetical situations, and protocol
- E-mail account - out of office correspondence to MDCH-Virtual Team
- Team Room – in-house discussion to formulate situational response

Plans for FY 08:

- Launch Virtual Team with memo to CMHSPs/PIHPs in mid-November
- Maintain database of types of requests
- Assess changes needed based on feedback from Satisfaction Surveys

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CULTURAL COMPETENCY

Culture is critical in determining what people bring to settings and services, the language they use, how they express and report their concerns, how they seek help, the development of coping styles and social supports, and the degree to which they attach stigma to mental health and substance abuse disorders. Culturally competent services are defined as "the delivery of services that are responsive to the cultural concerns of racial and ethnic minority groups, including their language, histories, traditions, beliefs, and values."

The Michigan Department of Community Health (MDCH) is working with the Michigan Association of Community Mental Health Boards (MACMHB) in developing a cultural competency plan to address cultural competency and diversity in the public mental health system.

Accomplishments during FY 07: MDCH and MACMHB are working with a group of stakeholders to address cultural competency and diversity in the public mental health system. The MACMHB issued a Request for Proposals (RFP) during FY 07 to address cultural competency and diversity. Four organizations submitted proposals; Wayne State University's (WSU) Project Care was selected.

Plans for FY 08: As stated in the RFP, WSU will work with the workgroup to develop the following:

- Develop a statewide action plan for cultural competency in the public mental health system.
- Identify and evaluate models and instruments for organizational assessment.
- Research and present model cultural competency/diversity plans for use at the local level.
- Identify evidence-based assessments and training instruments.
- Produce an inventory of clinical best and promising practices.
- Survey the Community Mental Health Services Programs (CMHSPs) to identify best and promising practices currently used.
- Summarize policies of the federal Substance Abuse Mental Health Administration, National Association of State Mental Health Program Directors, MDCH and other sources that are current and relevant.
- Identify ways to improve knowledge and resources on a statewide basis.
- Develop a draft plan for statewide training and technical assistance including web-based training.
- Coordinate with MDCH and the Improving Practices Steering Committee.

Expected Outcome: Lead the system toward improved awareness, competency and proficiency around ethnic and cultural issues and assure that all consumers receive services and supports that promote community inclusion and participation, independence, productivity and recovery.

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HOUSING AND HOMELESSNESS PROGRAMS/PARTNERSHIPS

Supportive Housing Program and Ending Homelessness Partnership: This program is in its 9th year of existence and continues to produce more than 100 units per year in 9 counties through the use of low income housing tax credits used in tandem with other federal, state and local resources.

10 Year Plan to End Homelessness: This year's innovations include the Michigan State Housing Development Authority (MSHDA) focus of $28,600,000 on creating community collaboratives, with housing resources targeted to end homelessness. Each area of the state now has a plan in place, and MSHDA resources will be targeted to help realize that goal. A project to provide 100 units of housing for veterans in Detroit has been effective in bringing new private partners to the table.

Michigan Department of Community Health (MDCH) Homeless Programs: These programs consist of Housing Opportunities for People Living with AIDS, PATH, Shelter Plus Care, and Supportive Housing Program grant programs in addition to a program of training and technical assistance made available to sub-grantees. This year's innovations include using PATH dollars to create a Housing Resource Center in Detroit.

Home Ownership: MDCH participates in a homeownership coalition for people with disabilities. Recent innovations have included making MSDHA down payment assistance available to people who are getting a USDA Rural Development loan to purchase a home.

2006 and 2007 Mental Health Block Grant-Supported Housing & Homeless Programs:

1. Macomb County CMH funded to provide recruitment, training, and implementation of a mental health outreach team for adults with SMI in Macomb County who are chronically homeless.
2. Macomb County CMH developed, piloted & evaluated a training program for peers, family members and agency staff so they could act with consumers to obtain & sustain independent living arrangements in the community. Peer graduates are able to serve as peer housing specialists.
3. Oakland County CMH funded to create a pre-transitional house targeted for the young adult population that provides support and guidance to learn the skills to live independently while working closely with core provider agencies and supportive services to access community resources.
4. Ionia County CMH funded to create a supported housing position to identify available housing opportunities in Ionia County, teach landlords and consumers how to work with each other, have landlords call CMH to intervene before evictions process begins.
5. St. Clair SMH funded to develop a local website that organizes and provides access to local, state, and national resources to obtain and maintain stable housing.
6. Detroit Wayne CMH funded to develop a training program that employs consumers to develop an apartment maintenance service to assist consumer tenants to successfully remain in independent living and avoid evictions.
7. Detroit Wayne CMH funded to include housing as part of a comprehensive systems change proposal.
8. Macomb CMH funded for a Housing Resource Center that will provide professional and peer support services for those seeking or working to maintain independent housing.
9. Northern Lakes CMH funded to provide Supported Housing services with peer support specialists and case management services for coordination and increasing focus on obtaining affordable and safe housing for adult consumers with severe mental illness.
10. Oakland County CMH funded to develop a comprehensive guide for adults with SMI and their families about transitioning from congregate living settings to independent supported housing.

11. Saginaw County CMH funded to provide supports to adults with SMI to facilitate their access and initial success with independent community housing.
12. Summit Pointe funded to collaborate with the SHARE Center, and the Greater Battle Creek Homeless Coalition to add Peer Support Specialists to its recovery initiative to increase the opportunity for persons with MI to remain in permanent supported housing.

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EVIDENCE-BASED PRACTICES MEASUREMENT WORKGROUP

Overview: This workgroup was convened in order to create a forum to discuss issues specific to the measurement of evidence-based practices (EBPs). The work of the Measurement Workgroup includes the development of performance indicators specific to EBPs, developing approaches for improved data collection of consumer characteristics and reporting of EPBs, and the discussion of the training and consulting needs specific to measurement. The work of the group has been based on the following set of guiding principles:

Guiding Principles:

- Measurement is an essential strategy for promoting systems change, informing learning organizations, and supporting implementation of EBPs.
- Measurement adds value to practice and management when it generates information that is useful for informing decisions.
- Measurement must be based on data that is explicitly defined, readily accessible, and on measurement instruments that are valid and reliable.
- Measurement methods must be standardized and implemented with consistency across systems.
- Measurement requirements must be designed to be efficient, minimizing imposition on the time and resources of consumers, providers, and managers while maximizing the utility of the information generated.

Tasks and Accomplishments of Workgroup:

- A review of data elements currently collected by the Michigan Department of Community Health (MDCH) for mental health and coordinating agencies.
    - The group routinely reviews the reporting of selected EBPs to the state's encounter data file including family psychoeducation, parent management training, and integrated dual diagnosis treatment.
    - The group has reviewed the completeness of reporting in numerous key demographic items including employment, residential living situation, and involvement with the criminal justice system. One demographic item that the group has focused on is the reporting of substance use disorder, which was shown to be substantially underreported. MDCH staff has worked with the Prepaid Inpatient Health Plan Information Technology staff to improve reporting of this item. Also, the workgroup has redesigned the approach for measuring substance abuse disorders as collected in the Quality Improvement data file reported to the state.
- Prioritized and selected 'key' measurements for implementation.
    - The workgroup compiled an extensive list of performance indicators for EBP that were taken from various sources including the state's performance measurement system, SAMHSA's National Outcomes Measures, and Substance Abuse Prevention and Treatment (SAPT).
    - Based on these indicators, MDCH has reviewed the relationship between the presence of co-occurring disorder and various demographic factors such as residential living situation, employment, and involvement with the criminal justice system.
- MDCH and Wayne State University have received a grant from SAMHSA for FY08-10 to develop training programs that provide education on how to use measurement in clinical decision-making, and provide instructions on how to implement measurement. This project will include a plan to obtain feedback regarding the utility and effectiveness of measurement.

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