

II: Planning Steps

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

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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:

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

The Michigan Department of Community Health (MDCH) is one of 18 departments of state government, responsible for health policy and management of the states publicly funded health service systems. The Michigan Public Health Code, Public Act 368 of 1978 (as amended) Sections 6201 and 6203, establishes the state substance abuse authority (SSA) and its duties. The Bureau of Substance Abuse and Addiction Services (BSAAS), within the MDCH Behavioral Health and Developmental Disabilities Administration (BHDDA), functions as the Michigan SSA. BSAAS' duties include the administration and coordination of public funds such as Substance Abuse Block Grant for the prevention and treatment of substance use disorders (SUD).

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

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

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

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

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

CAs are expected to employ the six SAMHSA Center for Substance Abuse Prevention (CSAP) strategies to universal, selective and indicated populations in efforts to engage individuals and the community to effect population-based change. This

multi-component and strategic approach should cover all age groups including support for children, senior citizens, all socio-economic classes, diverse cultures, minority and under-served populations, service men and women, gender-specific and targeted high-risk groups.

Consistent with the SAMHSA Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness, MDCH Strategic Initiatives, and the BSAAS Strategic Plan, the following has been identified as prevention priorities through 2013.

1. Reduce childhood and underage drinking.
2. Reduce prescription and over-the-counter drug abuse/misuse.
3. Reduce youth access to tobacco (Synar and Synar-related activity).

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

Treatment is intended to assist those individuals identified as having a substance abuse or dependence diagnosis. Each regional CA utilizes an Access Management System (AMS) that acts as a gatekeeper to the publicly funded services in their region. Through the AMS, individuals and their families are screened and referred to services at the appropriate level of care, and the provider of their choice. The AMS is responsible for monitoring service capacity of network providers to ensure that individual seeking treatment will be able access it. In situations where services are not immediately available, the AMS maintains and monitors a waiting list to ensure appropriate access when services become available.

The SUD treatment system in MI provides outpatient, residential, sub-acute detoxification and medication assisted treatment to those seeking services within the publicly funded system. All CAS are required to make these services available within their respective regions. These services are available to adults and adolescents. In addition to these primary treatment services, CAS are also required to make available specialized services in the areas of peer recovery and recovery support, early intervention, case management and integrated treatment for those with a co-occurring mental health and SUD.

As Michigan moves forward on the transformation of our system to a ROSC, regions are in the beginning stages of establishing formalized networks of support to assist an individual in maintaining their recovery or sobriety. These supports can be in the form of, but not limited to, peer mentors, recovery coaches, aftercare programming, employment assistance, housing assistance, educational counseling and a commitment to supporting an individual throughout their recovery journey. Recovery supports are organized at the regional level, and vary by CA. Michigan is in the process of identifying a curriculum and training program for recovery coaches, with the assistance of regional CA representatives and representatives from the recovery community, to be instituted statewide.

CAS maintain contracts, based on state guidelines and requirements, with a provider network that offers all of the services above. These contracts ensure that state policies and procedures are followed and a baseline for services is maintained statewide. CAS may provide services above this baseline and these services are generally based on the identified needs of the region's population. Each region is required to maintain and adhere to a cultural competency plan that addresses the needs of the population in their region. This plan also addresses the hiring expectations and practices at the CA and provider level based on the demographics of the regional population, practices that are in place to ensure appropriate cultural training for staff and culturally appropriate resources for the individuals accessing services.

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

Persons who are intravenous drug users (IDUs):

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

Adolescents with substance abuse and/or mental health problems:

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

Women who are pregnant and have a substance use and/or mental disorder:

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

Parents with substance use and/or mental disorders who have dependent children:

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

American Indians/Alaska Natives:

There are 12 federally recognized tribes in the state of Michigan. The Inter-Tribal Council of Michigan manages all Native American specific SUD programming in Michigan, although tribal members can access services through the publicly funded system also. The Inter-Tribal Council of Michigan was successful in obtaining an Access to Recovery grant and a continuation grant through SAMHSA, and their voucher program is called Anishnaabek Healing Circle. Tribal members are able to access SUD services through identified access points and referred to participating SUD treatment programs.

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

Individuals with tuberculosis (TB):

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

Persons with or at risk for HIV/AIDS and who are in treatment for substance abuse: Each CA must assure staff knowledge and skills in the provider network are adequate and appropriate for addressing communicable disease related issues in the client

population. To assist in meeting this requirement, BSAAS, in conjunction with other partners in MDCH, has developed a web-based Level I training curriculum. In addition, CAS are required to assure that all SUD clients entering treatment have been appropriately screened for risk of HIV/AIDS, STD/Is, TB and hepatitis, and that they are provided basic information about risk. For those clients with high risk behaviors, additional information about the resources available and referral to testing and treatment must be made available.

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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:

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

Implemented as part of the SPF/SIG grant, Michigan has maintained a functioning epidemiological workgroup. The State Epidemiology Outcomes Workgroup (SEOW) is a standing workgroup under the auspices of the ROSC Transformation Steering Committee (TSC.) The chairperson of the SEOW (or his/her designee) attends TSC meetings to not only provide input into the overall ROSC efforts from a SEOW perspective, but also to be available as a resource to the TSC if data needs are identified. Recommendations from the SEOW will be made to the TSC, which in turn will make recommendations to BSAAS for ultimate decisions.

The project director for the SEOW is a BSAAS staff member, as are the SEOW epidemiologist and the SEOW liaison. The chairperson of the SEOW is the director of the MDCH Bureau of Epidemiology, and the evaluator is contracted through BSAAS with Wayne State University. Membership on the SEOW includes representatives of various state-level departments including Michigan Department of Education, Michigan State Police, and various divisions and administrations within MDCH including epidemiology, mental health, and SUD treatment. In addition, CAs, community coalitions, and the Michigan Primary Care Association are represented on the SEOW.

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

The following represent data sources used by the SEOW:

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

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

The findings for Michigan youth include:

- Between 2004 and 2009, alcohol-related traffic crashes involved at least one driver, aged 16-20, who had been drinking, caused an annual average of 183 deaths and serious injuries.

- In 2010, 4,389 youth, 12-20 years-of-age, were admitted for alcohol involved treatment in Michigan, accounting for 11.6% of all alcohol involved treatment admissions in the state.
- In 2009, both male and female youth in public schools that consumed alcohol, were more likely to display feelings of mental distress.
- Between 2007 and 2009, the prevalence of reported depressive feelings and lifetime illicit drug use co-occurrence slightly increased, while depressive feelings and current illicit drug use co-occurrence declined.
- In 2009, 46 percent of Michigan 9 through 12th grade students had tried smoking, including 52% of 11th and 12th graders.
- In 2009, 16% of Michigan youth reported having seriously considered suicide and one in every 11 (9.3%) students reported having attempted suicide one or more times.

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

- Of all 2009 traffic crash fatalities, 28.8% involved at least one alcohol-impaired operator, bicyclist, or pedestrian.
- Between 2004 and 2009, alcohol-related traffic crashes involving at least one driver, 16-25 years-of-age, who had been drinking, caused an average of 474 deaths and incapacitating injuries.
- During 2007-2009, an estimated 5.6% of individuals over the age of 18 years old were heavy drinkers and 17.6% of them were binge drinkers.
- The prescription drug overdose death rate was the highest in males 40-49 years-of-age.
- In 2010, prescription drugs totaled 5,126 treatment episodes with the highest rates in adults 21-54 years-of-age.
- Between 2006 and 2009, the largest increase in the number of legitimate prescriptions was noted as Opioid antagonists (Suboxone).
- In 2009, Michigan's age-adjusted suicide rate was 11.3 per 100,000 population, with the rate of death for males, four times higher than for females.
- Between 2006-2007, young adults 18-25 years-of-age in Michigan, had higher rates of a major depressive episode and psychological distress, compared to adults 26 years-of-age.

Primary indicators used in assessing community needs include: nonmedical use of pain relievers, level of past 30 day use of alcohol and binge drinking among youth aged 12 to 20, alcohol involved death and serious injuries, past year psychological distress, past year major depressive episode, and age adjusted suicide rates. As a result of this work, unmet service needs and critical gaps have been identified as follows:

- Availability of medication-assisted treatment for addiction treatment - Impacted by the geographic location of the treatment programs and access to medications other than methadone.
- Psychiatric and prescription services for the mild to moderate level co-occurring client - Impacted by the availability of appropriate psychiatric services within various regions of the state.
- Prescriber training regarding addictive medications and the "drug-seeking" patient.
- Greater collaboration between primary care physicians and treatment programs, especially medication-assisted treatment programs.

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Table 2 Step 3: Prioritize State Planning Activities

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Start Year:

2012

End Year:

2012

Number	State Priority Title	State Priority Detailed Description
1	Establish a Recovery Oriented System of Care for behavioral health in MI	Continue to transform the current system of substance use disorder services into a Recovery Oriented System of Care. This will include the integration of behavioral health and physical health care; community health promotion; peer based recovery support services; prevention services that are environmental and population based.
2	Reduce childhood and underage drinking	Develop and implement strategies that reduce youth access and delay the onset of initiation.
3	Reduce prescription and over-the-counter drug abuse	Develop and implement strategies that reduce youth access and increases public knowledge of proper disposal.
4	Reduce youth tobacco access	Develop and implement strategies that reduce youth access to tobacco.
5	Expand integrated treatment for persons with mental health and substance use disorders	Establish a system of care for individuals with a co-occurring mental health and substance use disorder to receive needed services from one provider.
6	Prevent or reduce adult problem drinking	Develop and implement strategies that impact the consequences of adult problem drinking
7	Integrate the behavioral health and physical health care service systems	As part of health care reform efforts the behavioral health and physical health service systems will be combined into one entity.

8	Align elements in the substance use disorder system with other overall MDCH priorities	As possible, align elements in the substance use disorder system with other overall MDCH priorities including reducing obesity; reducing infant mortality; reducing tobacco use; reducing the percent of high school students who smoke cigarettes; increasing percentage of children age 19-35 months of age who receive all recommended vaccines; and promoting patient-centered medical home concepts.
9	Prevent suicides and attempted suicides among populations at high risk	Develop and implement strategies that promote mental health among high risk populations
10	Reduce alcohol related traffic crash deaths involving drivers under 21	Develop and implement strategies that impact the consequences of alcohol related traffic crash deaths involving drivers under 21

Footnotes:

II: Planning Steps

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

2012

End Year:

2012

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
Establish a Recovery Oriented System of Care for behavioral health in MI	Transform the current SUD service system from an acute care model to one that supports recovery and is based on national ROSC standards of care	Develop guiding principles for the creation and establishment of recovery coach services within the SUD service system Establish a peer recovery advisory council to assist with ROSC efforts statewide Provide regional training sessions to behavioral health agencies and coalitions on evidence-based and promising prevention practices for the purpose of implementing prevention prepared communities Focus on sustainability	Percentage of CAs reporting ROSC services	Review of Early Intervention and Recovery Support line-items (including costs, unduplicated persons, and units of service) annual Legislative Reports on the services provided within each region. Review of submitted encounters with approved Early Intervention and Recovery Support CPT and HCPCS codes. Will be measured by a completed document with justification for services being submitted to the department.

and fidelity

<p>Reduce childhood and underage drinking</p>	<p>Provide targeted support to communities with high incidences and emerging trends of underage drinking</p>	<p>Update profile of alcohol related health consequences including an illustration of the magnitude, severity, incidence, and prevalence of underage drinking Update logic model including a profile of intervening variables and causal factors promoting and discouraging underage drinking Issue Action Plan Guidelines for developing and implementing multi-year prevention plans for the prevention of underage drinking to CAs Assess and provide training and technical assistance needed to implement local plans Develop, produce and distribute an underage drinking video targeting adults with a responsibility for supervising youth. Develop and implement an evaluation construct, including site visits,</p>	<p>Percentage of high school students who drink</p>	<p>Approved deliverable via CSAP SEOW grant and via NSDUH reports, and YRBS.</p>
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to assess local implementation of underage drinking prevention plans

<p>Reduce prescription and over-the-counter drug abuse</p>	<p>Provide targeted support to communities with high incidences and emerging trends of prescription drug abuse.</p>	<p>Establish and convene a statewide Workgroup Update profile of Prescription Drug related health consequences including an illustration of the magnitude, severity, incidence, and prevalence of prescription drug abuse Develop a logic model with priority goals and objectives Develop a strategic plan for State and community-level implementation Assess and provide statewide training and technical assistance to CAs, providers, primary health care professionals, pharmacists, law enforcement and other stakeholders on evidence-based practices designed to reduce prescription drug and over-the-counter drug abuse Develop and implement an evaluation</p>	<p>Percentage of high school students taking prescription drugs not prescribed for them one or more times in their lifetime</p>	<p>via NSDUH and YRBS reports a. Decrease in the percentage of high school students taking prescription drugs not prescribed for them one or more times in their lifetime from 10 percent in 2009 to 7 percent by 2013. b. Decrease in the percentage of high school students taking prescription drugs not prescribed for them during the past 30 days from 6 percent in 2009 to 3 percent by 2013. c. Reduce the number of accidental deaths attributable to prescription drug abuse from 186 in 2009 to 176 by 2013. (via NSDUH and YRBS reports)</p>
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		construct, including site visits, to assess local implementation of prevention plans. Disseminate best-practice and evidence-based models implemented at the community-level via training and technical assistance		
Reduce youth tobacco access	Provide targeted support to communities with high incidences and emerging trends of youth tobacco access	Disseminate best-practice and evidence-based models implemented at the community-level via training and technical assistance	Synar Retail Violation Rate	Decrease youth access to tobacco by reducing the Retailer Violation Rate from 18.8 percent in 2010 to 14 percent in 2013. Annual Synar Survey – Annual Synar Report to CSAP
Expand integrated treatment for persons with mental health and substance use disorders	Integrate services for persons with mental health and SUD in order to improve efficiency, care and access.	Establish policies and technical advisories. Promote and support Evidence Based Practices and COD Training at statewide and local levels. Work with mental health system to plan the annual COD conference. Continue oversight of the local change agent teams that are charged with implementing integrated treatment practices.	Percentage of CAs providing integrated treatment services	Review of line items for spending, unduplicated persons, and units delivered under Integrated Treatment in annual legislative reports on the services provided by each region. Review of submitted encounters with Integrated Treatment HH HCPCS modifier a. Expand the number of CAs providing and funding integrated treatment services from 11 in 2009 to 16 by 2013 b. Develop a plan for the administrative integration of SUD and CMH service systems in order to reduce the distinct administrations in a cost-effective manner

Issue Action Plan
Guidelines for

Prevent or reduce adult problem drinking	Reduce Provide targeted support to communities with high incidences and emerging trends of adult problem drinking.	developing and implementing multi-year prevention plans for the prevention of adult problem drinking to CAs Assess and provide training and technical assistance needed to implement local plans	Percentage of adults who binge drink on one or more of the past 30 days	Decrease in the percentage of high school students who binge drink on one or more of the past 30 days (Via NSDUH reports)
Prevent suicides and attempted suicides among populations at high risk	Provide targeted support to communities with high prevalence and emerging trends of suicides	Develop and implement strategies that promote mental health among high risk populations	Percentage of youth considering, planning, or attempting suicide	Collected via YRBS and NSDUH.
Reduce alcohol related traffic crash deaths involving drivers under 21	Provide targeted support to communities with high incidences and emerging trends of alcohol related traffic crash deaths involving youth	Disseminate best-practice and evidence-based models implemented at the community-level via SPF/SIG grant projects, and via training and technical assistance	Alcohol Related Traffic Crash Deaths	Decrease the number of alcohol related traffic crash deaths involving drivers under 21 from 120 in 2010 to 115 in 2013. Annual Michigan State Police Traffic Crash Facts

Footnotes: