

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

Michigan has achieved some success in creating the foundation for a statewide system of care (SOC) for children with serious emotional disturbance (SED) and co-occurring disorders (COD). All public mental health providers in Michigan utilize a standard definition of SED and uniform access standards, as outlined in an attachment to the Michigan Department of Health and Human Services (MDHHS – former MDCH) contract with the Prepaid Inpatient Health Plans (PIHPs) and with the Community Mental Health Services Providers (CMHSPs). In fiscal year 2009, the SOC planning process was formally incorporated into the public mental health system through the Program Policy Guidelines (PPGs) through which the former MDCH (now MDHHS) requires CMHSPs to provide an assessment of their local SOC and how they plan to move forward to improve outcomes for children with SED and their families and children with developmental disabilities and their families. MDHHS continues to work individually with PIHPs to provide technical assistance regarding progressing to more comprehensive SOCs. CMHSPs were also required to utilize a SOC planning process to prepare their applications for funding through the children's portion of the mental health block grant and/or in implementing the 1915(c) Waiver for children with SED (SEDW).

As indicated earlier in this document, recent legislation passed in Michigan required that each Coordinating Agency (CA) be incorporated into an existing PIHP to formally integrate mental health and substance use disorder services statewide by January 1, 2013. We are still determining the impact of this consolidation on the way service providers have formally integrated behavioral health services into a network statewide. Some PIHPs had already placed a specific focus on training on co-occurring disorders (COD) for youth and these include Oakland and Central Michigan. Oakland County CMH Authority has held training in Motivational Interviewing in order to increase engagement of families in treatment, as well as addressing the mental health and substance use issues of adolescents and family members. CMH for Central Michigan also includes a specific COD focus on children/adolescents to assist with meeting goals around their substance use. Several other PIHPs use Multi-Systemic Therapy (MST) as a strategy for addressing CODs. At least one mid-Michigan region submitted a multi-year block grant proposal for a regional MST training initiative which was funded beginning in FY15. There continues to be a need for additional cross-agency cooperation between mental health and substance abuse services with regard to serving youth with CODs.

There has been increased interagency collaboration in the state which has contributed to a more comprehensive SOC for children with SED that will continue into FY16-17. In responding to Request for Proposals (RFP) for the children's portion of the federal mental health block grant for the past five years, CMHSPs were asked to take the lead with their community stakeholders including the other agencies (child welfare, juvenile justice, education, etc.) and family members to plan the SOC for children with SED and propose projects in their RFP submissions that would fill identified gaps in the local SOC. Many of these projects will continue into FY16-17. Michigan also continues to apply for and receive local SOC grants from SAMHSA and most recently two SOC expansion grants were awarded to Kalamazoo and Kent counties. However, many barriers remain in the development of a statewide comprehensive SOC and access to mental health services for children who need them. Human service agencies recognize that they need to continue to explore ways to reduce the duplication of services, especially case management and the provision of services through the use of the wraparound process and family-driven and youth-guided practice, to maximize the use of funds.

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

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

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

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

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

MDHHS has been a leader in increasing collaboration with other state agencies, local communities, and families. MDHHS – Division of Mental Health Services to Children and Families (MHSCF) participates in many interagency groups and emphasizes collaboration for children's services. Through these groups, the SOC has improved through the elimination of duplicative efforts and new projects being planned with joint efforts in development, implementation, and evaluation of services. More work is being planned to further improve the SOC, increase parent leadership development, and increase and maintain youth involvement on interagency committees. FY16-17 appears to bring additional opportunities for collaborative efforts in the areas of juvenile justice, screening, identification and treatment of social/emotional/mental health issues in home and community-based environments, Mental Health First Aid training for schools, law enforcement and other child serving entities, services to transition-aged youth and public/private collaboration to address the needs of children with SED (and often times SED along with a developmental disability and/or cognitive impairment) who repeatedly cycle through residential and psychiatric placements. Now that MDHHS encompasses physical health, behavioral health, child welfare and juvenile justice in one department, new opportunities for collaboration at the state level should be available.

MDHHS- MHSCF has been particularly interested in increasing access to specialty mental health services and supports for Medicaid eligible children/youth with SED in child welfare (i.e., abuse/neglect, foster care and/or adopted children/youth) and juvenile justice. Also at the

community level, interagency administrative groups serve to assure interagency planning and coordination. Of these various local committees, the most pivotal group is the Community Collaborative. All of Michigan's 83 counties are served by a single county or multi-county Community Collaborative which functions to oversee the planning and development of children's services. The local collaborative bodies are comprised of local public agency directors (public health, community mental health, child welfare, juvenile justice, and substance abuse agencies), family court judges, prosecutors, families and sometimes a youth, private agencies and community representatives.

Key components of SOC (family-driven and youth-guided, cross system funding for services for child welfare foster care children with SED, etc.) have been the focus of interagency planning at the state level for many years, and great strides have been made in the past two years. As a result of participation in the February 2009 National Federation of Families for Children's Mental Health's Policy Academy on Transforming Children's Mental Health through Family-Driven Strategies and continuing work by that team, a statewide policy on Family-Driven and Youth-Guided Practice is utilized by PIHP/ CMHSP providers to operationalize the concepts of family-driven and youth-guided service provision. A statewide Parent Support Partner training curriculum was developed in a partnership between the family organization and MDHHS-MHSCF, and training began in 2010 and will continue in FY16-17. Also, a new youth peer curriculum has just been developed and trainings will begin in this curriculum in FY16. The mental health block grant supports both these statewide training initiatives.

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

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

MDHHS-MHSCF is supporting with block grant funds the statewide implementation of two evidence-based practices Parent Management Training-Oregon Model (PMTO) (Bank, Rains, & Forgatch, 2004; Forgatch, 1994)¹ and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (Cohen, Mannarino, Deblinger, 2006)². Local communities have also identified evidence-based practices that they would like to implement and have applied for and been awarded block grant contracts to train CMHSP staff in evidence-based practices that will meet the needs of their local communities. These have included joint projects with CMHSPS and local courts to serve youth involved with the juvenile justice system with relevant evidence-based practices.

The Michigan Association of Community Mental Health Boards, Michigan's SUD Training Project, provides support in this area as well. Each year, the SUD field is given the opportunity to request training on specific topics in addition to the topics identified as a need at the state level.

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

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

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

Standardized, validated and reliable outcome measures, the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 1989)³ for youth ages 7-17 and its counterpart for children ages 3-7 the Preschool Early Childhood Functional Assessment (PECFAS) (Hodges, 1994a)⁴ are used to assess treatment effectiveness for all children served in the public mental health system. Beginning in FY16, MDHHS will require the use of the Devereux Early Childhood Assessment (DECA) for Infants (1 to 18 months), Toddlers (18-36 months) or Clinical (24-47 months) (Powell, Mackrain, LeBuffe, 2007)⁵. MDHHS has a contract with Dr. John Carlson at Michigan State University who analyzes statewide CAFAS, PECFAS and DECA data and provides reports to the state and CMHSPs regarding outcomes of children/youth receiving treatment in the public mental health system.

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

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

6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?

The Michigan Department of Education (MDE) and MDHHS continue to demonstrate their ongoing partnership through a shared position of a mental health consultant, Lauren Kazeel kazeel@michigan.gov. This consultant serves at MDE to provide schools, state-wide, with any training, technical assistance and support around school mental health initiatives. She also serves as the MDE representative on the statewide Behavioral Health Advisory Council. In her work for MDHHS, Lauren also oversees all the mental health services provided in the 100 state-funded school based health centers, along with other projects related to mental health from that office.

Additionally, Michigan was one of 19 states awarded the 2014 - 2019 NITT-Project AWARE-SEA grant by SAMHSA. The purpose of this grant is to build and expand MDE's capacity to increase awareness of mental health issues among school-aged youth, provide training for school personnel and other adults who interact with school-aged youth to detect and respond to mental health issues in children and young adults, and connect children, youth, and families who may have behavioral health issues with appropriate services. One part of the grant is to fund Youth Mental Health First

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

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

⁵ G. Powell, M. Mackrain, P. LeBuffe (2007). Devereux Early Childhood Assessment for Infants and Toddlers Technical Manual, Lewisville, NC: Kaplan Early Learning Corporation.

Aid in three primary Intermediate School Districts (Jackson, Kent, and Oakland) and other locations. There are two half-time project coordinators for this grant, Sarah Williams from MDE (williamss8@michigan.gov) and Elizabeth Newell from MDHHS-MHSCF (newelle@michigan.gov). Elizabeth Newell is also the MDHHS staff assigned to the Safe Schools/Healthy Students State Program grant that MDHHS collaboratively applied for with MDE, who was awarded the grant. With this grant, MDHHS-MHSCF and MDE will work with SAMHSA, three local school districts and their communities (including CMHSPs), to fund projects focused on decreasing barriers to learning, building a safe and supportive school environment, supporting student health and academic achievement and identifying students with mental health and/or substance use disorders and referring them for services. These projects require a coordinated approach, driven by state-level leadership and facilitated through community partnerships. The MDE staff assigned to this grant is Shawn Cannarile (CannarileS@michigan.gov).

7. What age is considered the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

The cut-off for most children's services through the public mental health system is typically age 18, except for SED Waiver services and EPSDT state plan services which can continue until age 21. Transitioning in the public mental health system from children's behavioral health services to adult behavioral health services, or elsewhere, begins with a transition plan. Plans address the youths' needs holistically.

Attention is given to all aspects of the youth's life like living situation, self-sufficiency, needed medical and behavioral health supports and services, education/employment, etc. A need for any ongoing mental health treatment should be made with referrals in place before the transition occurs. Youth in care need to understand their rights as children who were in the foster care system; including the right to voluntarily continue their foster care status while living in the community and their Medicaid status until age 21. Education plans, including educational rights related to college tuition that result from being in care, are made as needed along with employment support. Youth can continue to be supported in many public mental health systems in programs that will assist them in transitioning. Please see the attached transition planning booklet for additional information.

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant ([Title XIX, Part B, Subpart II, Sec.1922 \(c\)](#)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at <http://www.samhsa.gov/women-children-families>: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges*.

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

All regional entities and programs providing services for pregnant and parenting women are required to develop brochures for outreach to advertise the availability of specialty services in the region. In addition, some regions and programs have developed public service announcements, social media ads, or participate in outreach activities. All outreach materials are required to indicate that “pregnant and parenting women are a priority for treatment,” whether they are printed materials or media advertisements. This information is also requested to be provided at any outreach events. The Office of Recovery Oriented Services periodically requests and reviews all brochures from pregnant and parenting women’s programs to ensure that this requirement is being followed and implemented appropriately.

Contractual requirements with the ten regional entities in Michigan include priority population screening and admission requirements. The Access Center for each region is responsible for the screening process and works with each pregnant and parenting woman to identify appropriate programming, and a provider that has the capacity for their admission within 48 hours. If there is no capacity in region, Access Center staff contact other regions for access to their pregnant and parenting programs. In addition, there are 4 statewide pregnant and parenting programs that accept admission from all regions in the state. If an eligible woman presents at a provider agency for treatment admission, the provider contacts the Access Center for assistance with screening and placement as necessary to ensure admission within 48 hours.

The state collects Priority Population Wait List Deficiency reports monthly. It is extremely rare that a pregnant woman is on the wait list for any region in Michigan. On these occasions, the reasoning is that a woman prefers to wait for a specific program to have availability. However, interim services are offered, and the program makes every effort to admit the pregnant woman at the earliest opportunity. The provision of interim services is part of the required monthly report, and the definition of interim services is provided in contract language. These contractual requirements are passed along to providers, per contract with each regional entity. Michigan’s Women’s Treatment Specialist monitors the above referenced requirements and provides technical assistance to regional entities and programs as needed.

The following table lists the programs that serve Pregnant and Parenting women and their infants and dependent children. The majority of our residential programs will accept children up to age 12, and there is one residential program that will allow children through age 17. Any program that will accept a child will also accept an infant, therefore the table below represents both reporting requests.

Level of Care	Number of Pregnant and Parenting Women Programs
Residential	12
Detoxification	2
Intensive Outpatient	23

Outpatient	47
Case Management	5

There are two programs that offer medication assisted treatment and are identified as pregnant and parenting programs. However, there are an additional two residential programs that will transport pregnant and parenting women to a medication assisted treatment clinic for medication services, and numerous other medication assisted treatment programs that offer services to pregnant and parenting women, but are not considered to be a pregnant and parenting program.

The northern portion of the Lower Peninsula and the entire Upper Peninsula has a scarcity of programs available to meet the needs of pregnant and parenting women. Programming tends to be available where populations are most dense in those regions, leaving those in rural areas with long commutes to receive treatment services. For pregnant and parenting women seeking residential services in rural northern areas, there are limited options with one facility in the northern Lower Peninsula and two in the Upper Peninsula. In addition, there are only four medication assisted treatment programs in the northern regions, and no programs offering methadone in the Upper Peninsula.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).⁹⁶

Please indicate areas of technical assistance needed related to this section.

⁹⁶ http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

- 1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).**

The most recent copy of Michigan's suicide prevention plan has been uploaded. The MDHHS Behavioral Health and Developmental Disabilities Administration is currently working closely with the Michigan Association for Suicide Prevention and the MDHHS Injury and Violence Prevention Section to finalize and implement the state plan.

- 2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.**

The state plan addresses broader systems change as well as some specific populations, including:

Children who have experienced trauma

Objective 4.3 - Through collaboration and partnerships, MDCH will increase the number of and provide support to existing communities or counties that are implementing an evidence-based early intervention strategy for children who have experienced significant childhood traumas.

Survivors

Objective 4.4 - MASP will encourage and assist communities to develop guidelines for effective comprehensive support programs for survivors of suicide. These support services provide early intervention to reduce suicidality in this population, which is at an increased risk for suicide themselves.

Incarcerated individuals

Objective 6.3 - Within three years, the Michigan Department of Corrections will adopt and disseminate system wide policies and practices for suicide prevention in accordance with the American Correctional Association Standards for Emergency Care and Training, or the National Commission on Correctional Health Care.

Persons with co-occurring disorders

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

- 3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.**

The *Suicide Prevention Plan for Michigan* was developed by the Michigan Suicide Prevention Coalition and adopted by the former Michigan Department of Community Health (now the Michigan Department of Health and Human Services) as the official state plan in 2005. The Michigan Association for Suicide Prevention is currently heading up the revision of the 2005 plan, based on the results of a recent evaluation of the progress toward the goals in the initial plan, as well as on the *2012 National Strategy for Suicide Prevention (NSSP)*. While some objectives in the state plan are state specific and may not link directly to the National Strategy, and vice versa, the *NSSP* has contributed a great deal to the work being done to update the state plan so that it reflects how the world of suicide prevention has changed in the last eight years. Within all but one goal in the state plan and one goal in the national plan there is at least one objective that relates to an objective in the other plan.

Michigan Suicide Prevention Plan 2014 Goals	2012 National Strategy for Suicide Prevention: Goals and Objectives for Action												
	Strategic Direction 1				Strategic Direction 2			Strategic Direction 3			Strategic Direction 4		
	Goal 1	Goal 2	Goal 3	Goal 4	Goal 5	Goal 6	Goal 7	Goal 8	Goal 9	Goal 10	Goal 11	Goal 12	Goal 13
Goal 1													
Goal 2	X												
Goal 3		X	X	X									
Goal 4					X	X	X			X			
Goal 5					X	X							
Goal 6				X	X				X				
Goal 7					X	X	X					X	
Goal 8		X	X					X	X				
Goal 9											X		
Goal 10											X	X	

Updated
**SUICIDE
PREVENTION
PLAN
for
MICHIGAN**
2014

*Originally developed in 2005
Michigan Suicide Prevention Coalition
and updated by the Michigan Association for Suicide
Prevention*



Logo Design: L. Franklin

One Year Later

I've Learned

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

That life can be tough even when you are faithful

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

Hell can exist on earth

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

Grief can overtake you ... but only temporarily

That everyone grieves differently

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

That silence is the most wicked sound I have ever heard

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

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

and everything

Elly, 2004

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

Michigan Association for Suicide Prevention

INTRODUCTION

Suicide is preventable, yet suicide trends in Michigan are headed in the wrong direction. In 2002, the state was ranked 32nd in the rate of suicides in the population when compared to the other states. By 2010 we had moved up one more spot to having the 31st worst rate in the country. As we learn more about what communities can do to prevent suicides, we must continue to promote a comprehensive suicide prevention strategy that offers the hope of reducing the number of suicides in Michigan by at least 20% by 2020.

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

The Michigan Department of Community Health (MDCH) responded to the state resolutions by forming a work group to begin drafting a state suicide prevention plan. Work continued until the end of 2000, but the group was unable to complete a plan before it became inactive. It was past time for Michigan to construct, approve, and begin implementation of a coordinated, effective, and proven approach to reducing suicide deaths and attempts. In 2003, after the publication of the initial *National Strategy for Suicide Prevention*, the Michigan Association for Suicidology created the Michigan Suicide Prevention Coalition (MiSPC) to take on the task of creating the *Suicide Prevention Plan for Michigan*. This plan was accepted by MDCH as the official state plan in 2005. Michigan communities also responded. Small, community-based groups have addressed suicide in a number of ways over the past decade, but the work is often fragmented and has had little impact on overall state suicide rates, which have increased for most groups.

The MiSPC had a broad-based membership that included public and private organizations and agencies, foundations, individuals involved in suicide prevention, survivors (those who have lost a loved one to suicide), and professionals from around the state (see Appendix B). They used their combined experience with survivorship, advocacy, and service to present an honest and critical assessment of what prevention efforts in Michigan require.

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

In every year since the Michigan legislature approved the suicide prevention resolutions, more than 1,000 Michigan

Suicide Facts¹

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

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

Adults ages 45–59 have the highest suicide rates.

For young people ages 10–24, suicide is the 3rd leading cause of death.

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

Firearms are the most frequent method used.

residents have died by suicide. And, each year, an estimated 25,000 more make attempts that often require medical intervention and which can result in short and long-term disability.

There are more deaths by suicide in this state each year than deaths resulting from either car crashes or homicides. In those startling statistics, Michigan is not alone—our experience mirrors the nation’s.

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

<i>Did You Know</i>	
U.S. Deaths in 2010 ²	
Suicide:	38,364
Motor vehicle accidents	35,332
Homicide:	16,259

- Suicide is the third leading cause of death for 10 to 24 year-olds;³
- Like the rest of the nation, the largest number of suicide deaths occurs among our workforce, primarily men ages 35–64;⁴
- The highest rate (measured in number of suicides per 100,000 population) is among our oldest male residents.⁵

There are many populations at risk for suicide and suicidal behavior within Michigan and the nation. This plan is meant to encompass all of these populations and address suicide risk across the lifespan. However, it does

not include specific objectives for each special population. We continue to seek new and emerging practices that have potential for inclusion in future versions of this plan. The focus of this version is on continuing to build the infrastructure necessary to support prevention efforts across the state and aligning our work with the recommendations set forth in the 2012 revision of the *National Strategy for Suicide Prevention*. Every effort has been made to assure that Michigan’s strategy remains:

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

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

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

In addition to effective implementation, it is essential that we systematically track and evaluate our progress toward the goals. This will enable us to provide accurate feedback to government leaders, policy makers, organizations, advocates, and all those involved in implementation of the Michigan Plan for Suicide Prevention 2014. It will also provide the information needed to revise objectives over time, enabling the Michigan Plan to evolve as goals are reached and new “best practices” information becomes available. Thus, all objectives in the Michigan Plan include measurable outcomes or targets that specifically identify what is to be achieved. All objectives in the Michigan Plan indicate the data source for monitoring progress, and one set of objectives is dedicated solely to improving and expanding state surveillance systems related to suicide prevention so the best possible data for the state is available.

We Present ...

The *Suicide Prevention Plan for Michigan 2014*, which reflects in many instances the 2012 *National Strategy for Suicide Prevention*, the input of dozens of people from across the state garnered in the development of the original plan, the results of the state plan evaluation completed in 2012, and even some of the work from the state’s first effort in the 1990s at developing a plan. It is based on the most valid information we now have about how to reduce suicide deaths and attempts using a community-based, public health approach.

SUICIDE AS A PUBLIC HEALTH PROBLEM IN THE UNITED STATES

Suicide has been one of the leading causes of death in the United States for decades. Rates of suicide remained relatively constant for many years, but appear to be slowly increasing (see Table 1). The nation experiences more than 33,000 suicide deaths each year, and an estimated 959,100 attempts.⁶ These numbers may be artificially low according to the U.S. Centers for Disease Control and Prevention because suicide is under-reported. The cost in terms of pain and suffering, loss of life, medical payouts and lost productivity, and the impact upon the survivors of suicide, is immeasurable.

Survivors⁶

- *It is estimated that each suicide death intimately affects at least six other people.*
- *Based on the more than 796,672 suicides from 1986 through 2010, there are at least 4.78 million survivors in the U.S. (1 of every 65 Americans in 2010).*
- *In 2010 alone, that number grew by at least 230,184.*
- *There is a suicide—and six new survivors created—every 13.7 minutes.*

• **IMPACT**

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

• **RISK FACTORS**

While suicide is closely correlated with mental illnesses (studies indicate that in well over 90% of all suicide deaths, there is a diagnosable and treatable illness of the brain present^{7,8}), there are

other risk factors that contribute to suicide deaths and attempts as well. For example, elderly males who live alone, with a diagnosable and treatable mental illness and a substance abuse problem, are a very high risk population.

Those incarcerated in jails are also one of the populations at highest risk for suicide in the United States with rates of 36 per 100,000 (the national average ~12 per 100,000).⁹ Another very high risk group are gay, lesbian, bisexual, transgender, and questioning/queer (LGBTQ) youth. Studies have shown that LGBTQ youth have suicide attempt rates of 3.6–7.1 times higher than their heterosexual peers.^{10,11} There are multiple other groups at elevated risk for suicide across the life span. Untreated or under-treated depression is highly correlated with suicide. Around a third of those who die by suicide have an identifiable diagnosis of clinical depression at the time of death.⁸ Other mental illnesses also are associated with increased risk including, among others, schizophrenia, bi-polar disorder, some anxiety disorders, and borderline personality disorder.^{7,8} Co-morbidity with other psychiatric diagnoses is known to increase risk for suicide.

Table 1. US Suicide Rates, 2000–2010⁶
(rates per 100,000 population)

Age/Group	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
10-14	1.5	1.3	1.2	1.1	1.3	1.3	1.0	1.0	1.0	1.3	1.3
15-24	10.4	9.9	9.9	9.7	10.3	10.0	9.9	9.7	10.0	10.1	10.5
25-34	12.8	12.8	12.6	12.7	12.7	12.4	12.3	13.0	12.9	12.8	14.0
35-44	14.6	14.7	15.3	14.9	15.0	14.9	15.1	15.6	15.9	16.1	16.0
45-54	14.6	15.2	15.7	15.9	16.6	16.5	17.2	17.7	18.7	19.3	19.6
55-64	12.3	13.1	13.6	13.8	13.8	13.9	14.5	15.5	16.3	16.7	17.5
65-74	12.6	13.3	13.5	12.7	12.3	12.6	12.6	12.6	13.9	14.0	13.7
75-84	17.7	17.4	17.7	16.4	16.3	16.9	15.9	16.3	16.0	15.7	15.7
85+	19.4	17.5	18.0	16.9	16.4	16.9	15.9	15.6	15.6	15.6	17.6
65+	15.3	15.3	15.6	14.6	14.3	14.7	14.2	14.3	14.8	14.8	14.9
Total	10.7	10.8	11.0	10.8	11.0	11.0	11.1	11.5	11.8	12.0	12.4
Men	17.5	17.6	17.9	17.6	17.7	17.7	17.8	18.3	19.0	19.2	20.0
Women	4.1	4.1	4.3	4.3	4.6	4.5	4.6	4.8	4.9	5.0	5.2
White	11.7	11.9	12.2	12.1	12.3	12.3	12.4	12.9	13.3	13.5	14.1
Non-white	5.9	5.6	5.5	5.5	5.8	5.5	5.5	5.6	5.7	5.8	5.8
Black	5.6	5.3	5.1	5.1	5.2	5.1	4.9	4.9	5.2	5.1	5.1

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

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

• PREVENTION

While there are few research based suicide prevention programs that are proven to reduce suicidal behaviors, several are worth noting. Approaches that utilize integrated suicide prevention efforts that include education, increased identification and referral, increased access to care, reduction of stigma, and the application of effective clinical interventions have been shown to reduce deaths and attempts and are promising for the future. A major United States Air Force study¹² and multiple school evaluations have demonstrated positive results at the community level. Other major studies are currently underway to evaluate and replicate programs with potential. One-time and isolated prevention efforts may have some value, but have not demonstrated sustainable positive impact on suicide behaviors. Recent evidence suggests that effective suicide prevention programs also reduce other violent behaviors. Some interventions have shown promise for the treatment of depressed, despondent or suicidal individuals;

however, major efforts are necessary to implement quality care throughout the healthcare delivery system from general medical practice to professional mental health practices. Standards of care for the treatment of disorders with high suicide risk are not clearly defined, disseminated, or widely practiced across the nation.

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

Anonymous - letter to a crisis line

- **MEANS OF DEATH**

In the U.S., the method used in more than 50% of suicide deaths is firearms. The 2010 data in Table 3 is consistent with data over the past decade. Some studies have demonstrated that voluntary removal of firearms from homes of persons at risk has a positive impact on suicide rates and that substitution of methods does not necessarily occur.

Table 3. Suicide Methods, United States, 2010⁶

<i>Suicide Method</i>	<i>No.</i>	<i>Rate</i>	<i>% of total</i>
Firearms	19,392	6.3	50.5
Suffocation/Hanging	9,493	3.1	24.7
Poisoning	6,599	2.1	17.2
Falls	740	0.3	2.3
Cut/Pierce	673	0.2	1.8
Drowning	409	0.1	1.1
Fire/burn	150	0.1	0.5
All other	775	0.3	2.5
Total	30,622		100.0

SUICIDE AS A PUBLIC HEALTH PROBLEM IN MICHIGAN

Did You Know?

It is estimated that over 7,500 people became suicide survivors in Michigan in 2012

Did You Know?

Michigan Deaths In 2012¹³

Suicide	1,255
Motor vehicle accidents	1,042
Homicide	737

What is a public health problem? It is anything that affects or threatens to affect the overall health and well-being of the public. Compared to causes of death such as heart disease or cancer, suicide as a manner of death is a relatively rare event. And yet, on average, more than 1,200 Michigan residents take their lives each year (see Table 4). Suicide was the tenth leading cause of death in the state for 2012. For some groups, such as white males ages 10–34 years, suicide is the second or third leading cause of death. In this state, suicide is fourth leading causes of years of potential life lost below age 75.^{a,14}

Suicide rates, methods, risk factors and at-risk populations in Michigan closely parallel national trends and statistics (see Figure 1). Annual estimated economic costs^b associated with completed and attempted suicide in Michigan are over \$1.1 billion annually.¹⁵

The average annual suicide rate^c for the state remained relatively flat for more than a decade, but has been slowly on the rise since 2010. Males account for 61% of suicides deaths in Michigan. The highest suicide rate per capita (33.9 per 100,000) is actually among white males ages 40–44. Other groups of men with high rates are white males ages 50–54 (32.7/100,000), age 75+ (32.3/100,000), 55–59 (29.2/100,000), 50–54 (32.7/100,000), and 35–39 (30.6/100,000). The lowest suicide rate is for among black women, at 3.8 per 100,000 persons.

An analysis of the 2011 Michigan Youth Risk Behavior Survey data found that 16% of Michigan's 9th–12th graders seriously considered attempting suicide at some point during the 12 months preceding the survey.¹⁶ About one in every 12 students indicated they actually attempted suicide during that time. The number of young people in the state who die by suicide increases dramatically over the adolescent years (see Figure 2).

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

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

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

Table 4.

**Average Annual Number of Suicides
By Age, Race, Hispanic Ethnicity, and Sex
Michigan Residents, 2007-2010**

Age	White, non-Hispanic			Black, non-Hispanic			Hispanic			All Races/Ethnicities		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
<1	-	-	-	-	-	-	-	-	-	-	-	-
1-4	-	-	-	-	-	-	-	-	-	-	-	-
5-9	-	-	-	0	-	0	-	-	-	0	-	0
10-14	3	2	4	1	2	4	0	-	0	5	4	9
15-19	36	7	43	8	1	9	3	1	4	50	10	60
20-24	57	11	68	7	2	9	2	1	2	69	14	83
25-29	56	12	68	8	1	9	3	1	4	68	15	83
30-34	59	10	69	6	2	8	4	1	5	71	14	85
35-44	155	44	199	15	5	20	4	1	5	177	51	228
45-54	204	62	266	10	5	16	2	1	2	221	70	290
55-64	120	36	156	5	3	8	2	0	2	128	40	167
65-74	67	15	83	4	1	4	1	-	1	73	16	89
75+	75	9	83	4	1	4	0	-	0	79	9	88
Total	832	207	1,039	68	22	90	20	5	25	940	242	1,181

Includes ICD-10 codes: X60 - X84, Y870

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

Source: Division for Vital Records and Health Statistics, MDCH

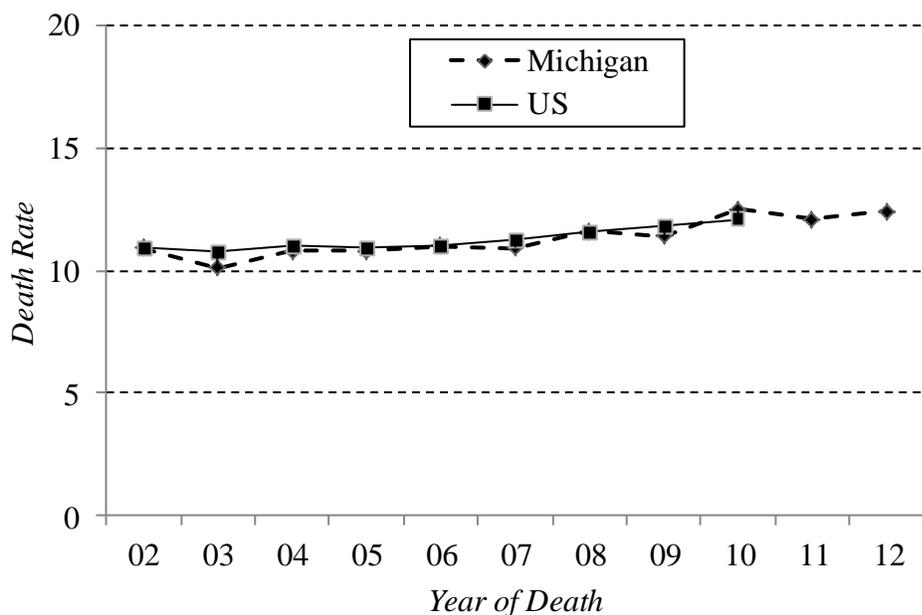


FIGURE 1. Suicide rates (age-adjusted), Michigan and U.S. Residents, 2002-2012¹⁷

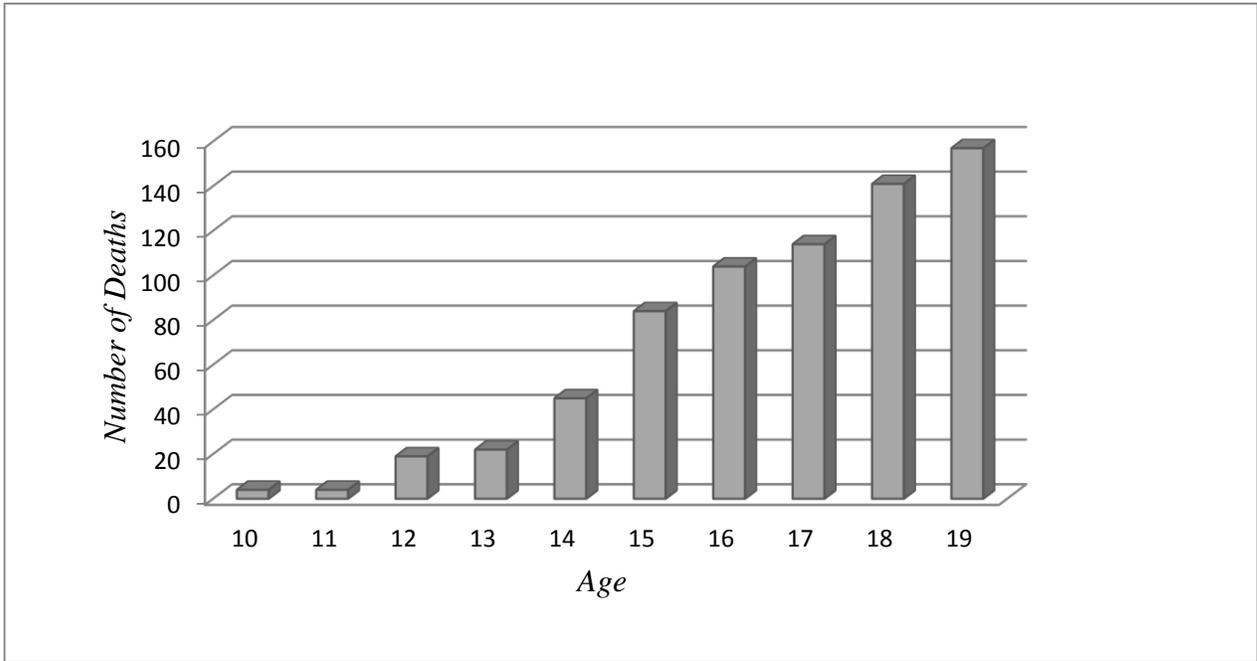


Figure 2. Adolescent suicide deaths, Michigan, 2003–2012¹⁸

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¹⁸ Michigan Department of Community Health, Injury and Violence Prevention Section. Unpublished data.

GOALS AND OBJECTIVES

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

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

Goal #1

Reduce the Incidence of Suicide Attempts and Deaths Across the Lifespan

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

DATA SOURCE: Youth Risk Behavior Survey results; hospital discharge data.

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

DATA SOURCE: Michigan Department of Community Health vital records; Michigan Violent Death Reporting System data

Goal #2

Integrate and Coordinate Broad-based Support of Suicide Prevention Activities

Objective 2.1 The Michigan Association for Suicide Prevention (MASP) will work with Michigan Department of Community Health (MDCH), the state's existing Community Collaboratives, and Local or Regional Suicide Prevention Coalitions

to seek broad and diverse participation in suicide prevention programs at the local level.

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

Objective 2.2 MASP, in collaboration with MDCH and local coalitions, will utilize broad based public-private support and establish effective, sustainable, and collaborative suicide prevention programming at the county and local levels.

DATA SOURCES: Record of MDCH and local initiatives involving public/private support for prevention strategies and programs

Objective 2.3 MASP, in collaboration with MDCH and local planning efforts, will utilize broad based public-private support to seek additional funds to develop, sustain and strengthen collaborations across state and local agencies in order to advance suicide prevention efforts.

DATA SOURCES: Record of MDCH and/or community collaboratives that seek funding, and which result in the receipt of funds for suicide prevention.

Objective 2.5 MDCH will compile and make publicly available a Resource Directory that includes state and community resources to enhance suicide prevention in relevant health care reform efforts.

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

Goal # 3

Increase Knowledge by Implementing Research-informed Communication Efforts to Promote Awareness and Reduce Stigma

Objective 3.1 MDCH will coordinate with public and private sectors and assist in local efforts to reach all Michigan citizens by implementing campaigns promoting awareness that suicide is a preventable public health problem and that recovery from mental and substance use disorders is possible for all.

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

Objective 3.2 MDCH will develop and implement a public awareness campaign that will be designed to reach defined segments of the population while promoting the concept that suicide is preventable and that also focuses on reducing the stigma of mental illness and improving help seeking behaviors.

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

Objective 3.3 MDCH will partner with the MASP and other public and private entities to implement and monitor for communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.

DATA SOURCES: Evaluation of online messages

Objective 3.4 MASP and local coalitions will encourage and recognize news organizations that develop and implement policies and practices addressing the safe and responsible reporting of suicide and other related behaviors; assist with educating the media on their critical role in suicide prevention, including mental illness and substance abuse; and collaborate to ensure responsible media practices in the coverage of these topics. Use of the nationally recognized *Reporting On Suicide: Recommendations for the Media* (U.S. Centers for Disease Control and Prevention) will be encouraged.

DATA SOURCES: Documentation of dissemination of media guidelines; documentation of how media outlets are recognized for their good reporting practices

Objective 3.5 MASP, MDCH, and their public and private partners will increase the awareness of policy makers by educating officials on the impact that suicide, mental illnesses, and substance abuse have on other policy areas, such as health care, law enforcement, and education.

DATA SOURCES: Documentation of dissemination of education materials to policy makers.

Goal #4

Develop and Implement Community-Based Suicide Prevention Programs

Objective 4.1 MASP will work with MDCH and community partners to develop (or adopt) a resource guide or method to provide technical assistance that will help coalitions systematically implement a community assessment as a part of suicide prevention planning. The assessment should include establishment of baseline information, quantify the problem, identify gaps, evaluate plan effectiveness, and examine the usefulness and quality of suicide-related data.

DATA SOURCES: The resource guide and publicly available information on how it can be accessed.

Objective 4.2 MDCH will identify and support the efforts of local and/or regional suicide prevention collaboratives to strengthen the coordination, implementation and evaluation of comprehensive suicide prevention programming.

DATA SOURCES: Annual reports from MDCH of Community Collaborative involvement.

Objective 4.3 Through collaboration and partnerships, MDCH will increase the number of and provide support to existing communities or counties that are implementing an evidence-based early intervention strategy for children who have experienced significant childhood traumas.

DATA SOURCES: State mental health agency records on the number of communities initiating implementation of such strategies

Objective 4.4 MASP will encourage and assist communities to develop guidelines for effective comprehensive support programs for survivors of suicide. These support services provide early intervention to reduce suicidality in this population, which is at an increased risk for suicide themselves.

DATA SOURCES: Annual community, suicide prevention coalition survey

Goal #5

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

Objective 5.1 MASP, in collaboration with the MDCH and appropriate professional organizations, will increase the proportion of primary care clinicians, other health care providers, and health and safety officials who routinely assess for the presence of lethal means (including firearms, drugs, and poisons) in the home and be able to educate about actions to reduce associated risks.

DATA SOURCES: Establish baseline data for at least one category of health provider, enabling an evaluation of outcomes for this group(s).

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

DATA SOURCES: Record of penetration of public information campaigns

Objective 5.3 MASP, in collaboration with MDCH and local suicide prevention efforts, will partner with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.

DATA SOURCES: Records of partnerships developed and activities undertaken

Goal #6

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

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

6.1.1 Within three years, MDCH will expand the number of gatekeepers.

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

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

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

Objective 6.2 Within one year the MASP will identify and distribute guidelines for suicide risk screening to primary care settings, emergency departments, mental health and substance abuse settings, senior programs, and the corrections system.

DATA SOURCE: Publicly available copies of materials and distribution lists

Objective 6.3 Within three years, the Michigan Department of Corrections will adopt and disseminate system wide policies and practices for suicide prevention in accordance with the American Correctional Association Standards for Emergency Care and Training, or the National Commission on Correctional Health Care.

DATA SOURCE: Record of policies and practices for suicide prevention

Objective 6.4 Within three years, the state legislature will require that all state funded colleges and universities develop suicide prevention policies and implement one or more prevention strategies patterned after evidence-based approaches

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

Objective 6.5 Within two years, MDCH will require Community Mental Health programs to implement suicide prevention training for all direct service personnel. They will also adopt policies and practices for suicide prevention/intervention including identification, intervention, discharge, and tracking of outcomes.

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

Goal #7

Expand and Encourage Utilization of Evidence-based Approaches to Treatment

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

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

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

DATA SOURCE: Evidence of distribution

Objective 7.3 Within 18 months, MDCH, in collaboration with the Michigan Association of Community Mental Health Boards (MACMHB), will assure that the Zero Suicide approach promoted by the National Action Alliance for Suicide Prevention, is incorporated into protocols and practices of the state managed care plans.

DATA SOURCE: Documentation of implementation of the strategy within the identified organizations

Goal # 8

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

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

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

Objective 8.2 Within each of the next five years, increase the number of communities promoting the awareness and utilization of 24-hour crisis intervention services that provide full range crisis and referral services. These services may be locally based or linked to the national hotline. It is desirable that these services be AAS certified. Once the baseline is established the annual cumulative goal increases will be as follows:

2015	60%
2016	65%
2017	70%
2018	75%
2019	80%

DATA SOURCE: MDCH mental health services audit

Goal #9

Improve and Expand Surveillance Systems

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

DATA SOURCE: MDCH reports

Objective 9.2 The use of standardized protocols for death scene investigations throughout Michigan should be promoted.

DATA SOURCE: MDCH implementation report

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

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

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

DATA SOURCE: Report of YRBS results and records of dissemination

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

DATA SOURCE: Copies of written plans and evaluation reports.

Goal #10

Support and Promote Research on Suicide and Suicide Prevention

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

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

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

DATA SOURCE: Evidence of collaborative efforts to seek funds

Objective 10.3 MDCH will determine the social and economic costs of untreated mental illnesses and substance abuse in the state, and support strategies for reducing these costs.

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

DATA SOURCE: Publicly available report on social and economic costs

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

DATA SOURCE: Publicly available cost benefit report

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

DATA SOURCE: The MASP's annual reports

RECOMMENDED RESOURCES

The American Association of Suicidology: www.suicidology.org

American Foundation for Suicide Prevention: <http://www.afsp.org/about-afsp>

The Canadian Association for Suicide Prevention: <http://www.suicideprevention.ca/>

Centers for Disease Control and Prevention:
<http://www.cdc.gov/violenceprevention/suicide/index.html>

Children's Safety Network: <http://www.childrenssafetynetwork.org/>

Children's Safety Network, Economics & Data Analysis Resource Center:
<http://www.edarc.org/>

Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE (eds.). *Reducing Suicide: A National Imperative*. Washington, D.C.: The National Academies Press, 2002.

Michigan Department of Community Health, Vital Records:
<http://www.mdch.state.mi.us/pha/osr/index.asp?Id=4>

Michigan State University, School of Journalism. Victims and the Media Program:
<http://victims.jrn.msu.edu/>

2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, D.C.: U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012. www.samhsa.gov/nssp

U.S. Centers for Disease Control and Prevention. *Web-based Injury Statistics Query and Reporting System (WISQARS)*: <http://www.cdc.gov/injury/wisqars/index.html>

National Commission on Correctional Healthcare: <http://www.ncchc.org/>

American Foundation for Suicide Prevention, American Association of Suicidology, Annenberg Public Policy Center. *Recommendations for Reporting on Suicide*:
http://www.suicidology.org/c/document_library/get_file?folderId=236&name=DLFE-336.pdf

National Institute of Mental Health—Suicide Prevention:
<http://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml>

Mental Health Foundation of New Zealand, New Zealand Suicide Prevention Strategy 2006-2016: <http://www.spinz.org.nz/page/29-new-zealand-suicide-prevention-strategy-2006-2016>

Schneidman, Edwin. *The Suicidal Mind*. New York: Oxford University Press, 1996.

Suicide Prevention Action Network USA (SPAN USA) is the public policy division of the American Foundation for Suicide Prevention: <http://www.afsp.org/advocacy-public-policy/become-an-advocate/suicide-prevention-advocacy-network>

Suicide Prevention Resource Center: <http://www.sprc.org/>

World Health Organization. *SUPRE—the WHO worldwide initiative for the prevention of suicide*: http://www.who.int/mental_health/prevention/suicide/supresuicideprevent/en/

APPENDIX A:
SENATE RESOLUTION NO. 77^d

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

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

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

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

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

Resolved by the Senate, That we

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

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

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

APPENDIX B:

MICHIGAN SUICIDE PREVENTION COALITION 2005

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

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

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

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

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

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

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

The Michigan Department of Health and Human Services elects not to respond to this requested, but not required, section.

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁹⁷

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

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC: States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*⁹⁸

⁹⁷<http://beta.samhsa.gov/grants/block-grants/resources>

⁹⁸There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:



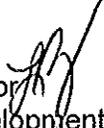
STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

JAMES K. HAVEMAN
DIRECTOR

November 9, 2012

To: Council Members

From: Lynda Zeller, Deputy Director 
Behavioral Health and Developmental Disabilities Administration

Re: Behavioral Health Advisory Council

The Behavioral Health and Developmental Disabilities Administration (BHDDA) of the Michigan Department of Community Health (MDCH) will file a joint mental health and substance use disorder block grant application for fiscal years 2014 and 2015 (FY14-15). The joint application will require the development of a Behavioral Health Advisory Council (Council). The Council will serve to advise and make recommendations to the BHDDA Deputy Director concerning the activities carried out by and through the administration, and the policies governing such activities. I am pleased to inform you that you are being considered as a possible candidate to serve as a member of the Council. After a final decisional process, this would involve a two-year term of service, beginning January 1, 2013.

The overall mission of the Council is to improve the behavioral health outcomes of the citizens of the State of Michigan by:

- Providing expert advice to BHDDA to develop state prevention and treatment systems for behavioral health services;
- Involving consumers and families fully in orienting the behavioral health system toward recovery;
- Improving access to quality care that is culturally competent;
- Developing and coordinating federal prevention and treatment policies and programs for mental health and substance use disorders;
- Eliminating disparities in behavioral health services;
- Encouraging and assisting local entities to achieve these goals and priorities.

The duties of the Council members will include the review of plans for Michigan's use of Federal Block Grant resources allocated to MDCH, and the submission of recommendations to modify these plans as needed. The Council may also serve to advocate for adults with serious mental illnesses and/or substance use disorders, children with severe emotional disturbances, and other individuals with mental illnesses or emotional problems. Lastly, the Council shall monitor, review and evaluate the allocation and adequacy of behavioral health services within the state of Michigan at least once each year.

Meetings will take place quarterly with the potential for additional sessions depending on the work and will of the group. All meetings will be centrally located with the option for in-person participation and/or "attendance" through electronic means, such as teleconferencing and/or webinar options.

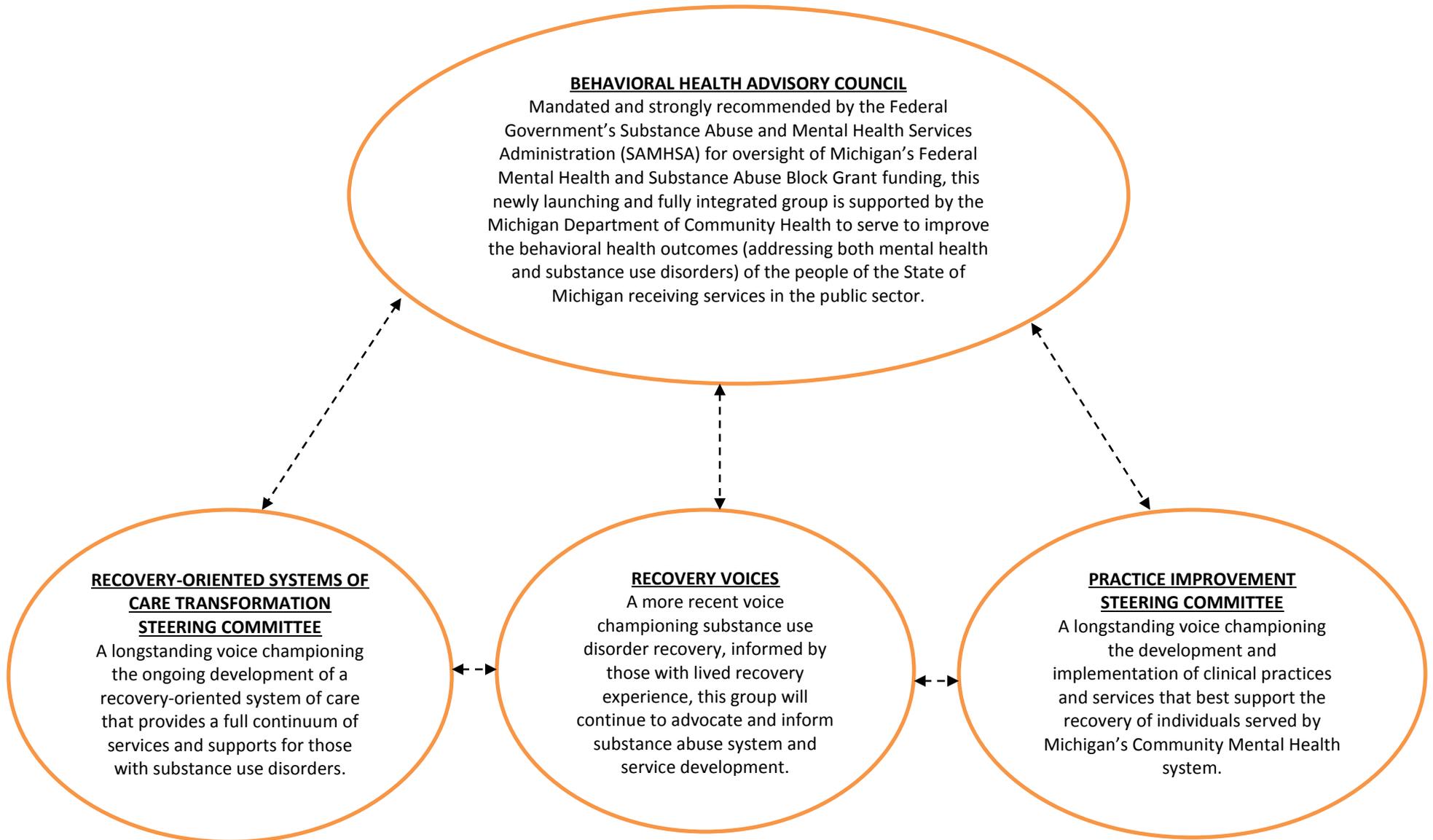
Council Members
November 9, 2012
Page Two

I ask that you consider indicating your candidacy and willingness to participate in the very important work that is involved with being a member of the Council. Please contact Karen Cashen at cashenk@michigan.gov with your decision by December 3, 2012. If you accept this invitation, please supply her with your contact information (name, e-mail address and phone number), as well as indicating which of the roles/positions on the attached chart you would be interested in fulfilling, either in a primary or alternate status. You may also contact Karen with any questions you may have.

Enclosure

COORDINATED ADVANCEMENT OF RECOVERY IN MICHIGAN

As we move forward into an increasingly integrated system of care, the following is a coordinated means for advancing recovery for those receiving public sector mental health and/or substance abuse services within the State of Michigan. Tremendous effort has been expended by various groups, which at times has been duplicative or less than fully integrated. It is the intent and desire of this proposed structure, including the establishment of active communication channels (signified by the dotted lines), to advance the critically important focus of Recovery in a manner that is as effective and well-coordinated as possible, for the benefit of those we serve.



**Behavioral Health Advisory Council
Meeting Minutes
March 20, 2015**

Members Present: Raphael Rivera (Lionetta Albright), Erin Emerson (Amy Allen), Julie Barron, Joeline Beckett (webinar), Linda Burghardt, Karen Cashen, Elmer Cerano, Mary Chaliman, Becky Cienki, Michael Davis, Norm DeLisle, Mary Beth Evans (webinar), Kevin Fischer, Benjamin Jones, Jane Regan (Lauren Kazee), Tina Louise, Kevin McLaughlin, Paula Nelson, Chris O'Droski, Stephanie Oles, Marcia Probst (webinar), Ben Robinson, Kim Rychener (Lori Ryland) (webinar), Kristie Schmiege, Terri Henrizi (Jane Shank), Brian Wellwood, Jeff Wieferich

Members Absent: Marlene Lawrence, Kevin O'Hare, Jamie Pennell, Neicey Pennell, Mark Reinstein, Patricia Smith, Sally Steiner, Cynthia Wright.

Others Present: Kathy Bennett, Carlisle Beauchene, Emily Jarvis, Naomi Snyder. Larry Scott, Jennifer Stentoumis, Lynda Zeller

Welcome and Introductions – Chris O'Droski

Review and Approval of Minutes - Elmer moved/Becky seconded, minutes approved unanimously

BHDDA Updates – Jeff Wieferich

- Medicaid Health Plan rebid planning continues. Group concerned about MH/BH services not getting enough attention in requirements.
- Healthy Michigan - over 588,000 people enrolled currently. April is time to renew, so will have some enrollees who will not renew and will lose their coverage.
- Health Homes - 475 people enrolled in two sites. Working on streamlining eligibility (FQHC and Tribal Health Centers Health Homes project is a separate project that has just started). Housing, transportation and other services and supports are all a part of the considerations of this project.
- PIHP dashboards – working with MPHI to finish these. Target date October 1.
- Children's Behavioral Action Team – contract awarded to the Guidance Center, started March 1st.
- Mental Health and wellness recommendations – BHAC made some recommendations, projects are not finalized.
- Lori Ryland will serve as the liaison to the Diversion Council for the BHAC.
- State Innovation Model – not coming out of BHDDA. sim@mailmihealth.org for more info.
- MiHealth Link – 100-200 people enrolled in two sites. PIHPs and ICOs working together to serve people. There has been some confusion about Medical necessity and in the functioning of the call centers the State is continuously working on clarifying things and making sure people are getting correct information.
- DCH/DHS Merger – go-live date is April 10th. There is not a lot of concrete information about this at this time. More details will be released in the next two months. Employees have been asked for their thoughts and recommendations to try to streamline the process as much as possible. The new department will be called the Department of Health and Human Services.

FY 16-17 combined MH & SA Block Grant Application – Internal meetings at BHDDA are beginning on March 31st. Combined both grants bring in about \$70 million block grant dollars into the State. The app is due September 1st, but the feds encourage submission much before that. Karen presented some select sections of the FY 14-15 application to the group to begin the discussion for FY 16-17. All application documents are available on the MDCH website. Karen asked the group for input on unmet service needs for adults with SMI, Children with SED and individuals with SUD. Becky Cienki indicated that a thorough needs assessment would be helpful. Jeff indicated that CMHs submit annual needs assessments to BHDDA, but additional work could be done there.

Ideas suggested by the group: There is a large gap in access for comprehensive community-based services for people with only Medicare; spend down issues impacting access to community-based services; access to community-based services prior to urgent/emergent situations; more residential options for people who are discharged from inpatient settings but not yet ready to go back to the community; training on MH for corrections and court staff; alternatives for kids who are waiting for an inpatient bed; lack of child psychiatrists; lack of understanding of Medication Assisted Treatment for pregnant women; housing support services; street outreach to people with SMI; making people aware of available services; reducing stigma; people who cannot access the level of service needed due to ineligibility for CMH services, inadequate insurance coverage, etc.; training for recovery coaches and follow-up services.

Larry reviewed the SUD unmet needs that were included in the FY14-15 application for the group. Jennifer reviews the children's SED section and Karen reviewed the adult SMI section. Karen reviewed the performance indicators from the FY 14-15 application. Karen asked the BHAC to review the application online and asked Chris to facilitate a discussion with the group about how they would like to participate in the development of the application.

Subcommittee of the BHAC to review needs was suggested.
Subcommittee Volunteers: Norm, Ben, Becky, Tina, Julie, Linda, Jane, Stephanie, Kevin, Brian, Marcia, Norm will set up a meeting wizard and a teleconference to start the discussion.

Joe Longcor gave a presentation on the Freedom to Work/Medicaid Buy-In revisions. A handout was provided. He also spoke about the ABLE ACT and a handout was provided about that as well.

Department of Corrections Peer Support Specialist Initiative – Mike Davis explained that the DOC is in the process of initiating this project and working on a grant application with DCH to support this. There are plans for two pilot sites – one female and one male. They are looking at training peers and recovery coaches.

Consumer Run Drop-In Center Presentation – Justice in Mental Health Organization staff presented info on consumer run drop-in centers. Multiple handouts were provided. Go to www.JIMHO.org for more information.

Mental Health Association Update – Linda Burkhardt reported that there was a Partners in Crisis Coalition meeting in December to discuss advocacy and policy issues to focus on. Parity study – 88 health plans were reviewed online and most were found to not be compliant with mental health parity. They are now moving forward with a survey to determine people's experiences with their own insurance coverage. Any agency that would like to help disseminate this survey to the people their agency services, contact Linda at lburchardt@comcast.net

Recovery Voices – Chris O. reported that RV is still expanding its memberships. They are putting together a workshop on Multiple Pathways to Recovery that they are proposing to various conferences. They hope to provide technical assistance across the state to assist communities in developing these recovery oriented services on their own. Kevin M. explained how RCOs are trying to find their focus amid the ever changing landscape of recovery. April 21st is Michigan Advocacy Day.

Recovery Oriented System of Care – Kristie Schmeige reported on the meeting. Pam Werner from DCH reported on the group that is moving forward on the integrated peer curriculum looking at peer support specialist, recovery coaches and wellness coaches and community health workers. There is a credentialing subcommittee meeting at the end of March. There was a lot of discussion about the new Medication Assisted Treatment guidelines.

Karen reminded the group that the BHAC currently has one vacancy for an individual from an agency that provides services to special populations. We need to ensure that we have adequate diversity on the council. If anyone has a nomination, contact Karen. She reminded the group of the future meeting dates.

Future Presentations – Chris O suggested a presentation from a group that does peer prison re-entry. The BHAC was receptive to seeing a presentation. Other ideas: Mental Health First Aid, Recovery College, Prison-based Peer Support, DCH/DHS merger, Michigan Housing and Recovery Initiative, SEDW and DHIP, Foster Care Psychotropic Medication Monitoring, Mental Health and Drug Courts, Tribal Youth Suicide Prevention and Early Intervention grants funded by Garrett Lee Smith Memorial Act Funds, Unified SA Credentialing, Seclusion and Restraint in schools, NAMI Stigma and Youth Presentations.

Public Comments

- Jane Regan DOE – Gov. Snyder moved the school reform office out of DOE and moved it to DTMB effective May 1st. Mike Flannigan is retiring and will be replaced by Brian Winston as State Superintendent.
- NAMI State Conference May 14th and 15th – go to NAMI website for more info.
- SUD Conference will be held in September. Dates not confirmed yet.
- Michigan Campaign to end Homelessness has achieved a state-level committee to continue to working on ending homelessness. MSHDA and DCH were awarded a joint grant from HUD.
- Recovery Walk in Ann Arbor on May 30th. Go to www.homeofnewvision.org for info.
- ACMH Conference on May 4th. Go to www.ACMH-mi.org for more info.

Brian moved to adjourn the meeting, Kristi seconded. Meeting adjourned at 3:00 pm.

The next meeting will be June 12, 2015.

**Behavioral Health Advisory Council
Meeting Minutes
June 12, 2015**

Members Present: Raphael Rivera (for Lonna Albright), Amy Allen, Julie Barron, Joeline Beckett, Linda Burghardt, Karen Cashen, Elmer Cerano, Ashley Willis (for Mary Chaliman), Becky Cienki, Michael Davis, Norm DeLisle, Kevin Fischer, Jane Regan (for Lauren Kazee) Tina Louise, Dan Faylor (for Kevin McLaughlin), Paula Nelson, Chris O'Droski, Stephanie Oles, Jamie Pennell, Neicey Pennell, Marcia Probst, Mark Reinstein, Lori Ryland, Kristie Schmiege, Terri Henrizi (for Jane Shank), Patricia Smith, Sally Steiner

Members Absent: Mary Beth Evans, Benjamin Jones, Arlene Kashata, Marlene Lawrence, Kevin O'Hare, Ben Robinson, Brian Wellwood, Jeff Wieferich, Cynthia Wright

Others Present: Kendra Binkley, Erin Emerson, Deborah Hollis, Jeff Patton, Larry Scott, Jennifer Stentoumis, Lynda Zeller

Welcome and Introductions – Chris O'Droski at 10:17 am

Review and Approval of Minutes - Kevin moved/Linda seconded – amended as written below: Page 3, under future presentations, should read: State and Tribal Youth Suicide Prevention and Early Intervention Grants funded by Garrett Lee Smith Memorial Act Funds. Minutes approved with that amendment.

CCBHC Grant – Jeff Patton and Lynda Zeller

Certified Community Behavioral Health Clinics Planning Grant opportunity is currently available. Michigan is applying for this grant. This is the one year planning grant application, the next phase will be implementation and hopefully Michigan will be one of eight states selected. The CCBHC Grant committee would like to engage the BHAC to provide input when data is gathered for the application. The planning grant application is due August 5th and the state is looking for a letter of support from the BHAC as well. This project will go hand in hand with the duals project, parity, the SIMS project and the Health Homes project. Plan is to use existing CMHSP structure and maybe other clinics to expand in certain ways in certain locations to meet all the requirements for CCBHCs to be a true safety net for behavioral health. If awarded, planning will begin in January. CCBHCs will have to serve all comers meaning have no geographic restrictions, serve all insurances or no insurance, and serve all populations. These will be serving people who are not being served successfully elsewhere. The planning grant application will be sent out to the BHAC for review. Jeff Patton is also looking for any needs assessment documents different agencies or departments may have available – send any info to Karen and she will pass it along. Public comment will be required during the planning phase, but not for the planning grants application. Mark moved to provide a letter of support of the CCBHC grant application, Elmer seconded. The BHAC members unanimously approved. Letter will be provided.

BHDDA Updates – Lynda Zeller

SIM Project – there is an FAQ section on the SIM website and there is info on CMHs directly on the website.

Defending Childhood Initiative – multisystem group, including governor's office reps, looking at increasing screening to identify trauma in children and increase further assessment of need and increase access to treatment. More info next time as this effort is just getting started.

Prescription Drug and Opioid Abuse – There is another multi-agency effort called for in the Governors State of the State that will likely need to include state police, Department of Education, Board of Pharmacists, BHDDA, etc. to come up with a Michigan plan to address this issue long-term.

Medicaid Health Plan Re-Bid – There is a lot of good integration and peer involvement included in the re-bid. There are also combined metrics being proposed that both Medicaid Health Plans and Prepaid Inpatient Health Plans would be jointly responsible for.

Joint MSHDA/BHDDA HUD grant award – Michigan won this grant to expand housing support and options.

TTI Grant for Peers in Prison – DOC and BHDDA jointly applied and were awarded a \$75,000 grant to train peers in prison. One female facility (Huron Valley) and one male facility (Adrian) were selected. The goal is to train up to 40 peers to begin providing Peer Support by mid-September. Chris suggested a joint presentation between this group and the group who is working on developing peers that work with prisoners who are re-entering the community.

DCH/DHS Merger – There have been some changes that impact BHDDA. The purpose of the merger is to treat the whole person and making it easier for people to get on the path of self-sufficiency. The Mental Health Services to Children and Families Section was moved to the Children's Services Agency under Steve Yager. The purpose of this is to develop mental health services leadership and strategy of the MHSCF into the entire Children's services system. There are still local decisions that impact how agencies operate locally. If anyone notices or hears that MDHHS services are harder for people to access than they were before – let BHDDA Leadership know as quickly as possible! This should not be the case. The State Medicaid Director, Steve Fitton, is retiring at the end of June. Kathy Stiffler is the interim Director. The search is on for a new Director.

Block Grant Needs Workgroup – Norm DeLisle

There was a two hour brain storming teleconference by the subcommittee on May 8th. The group came up with six recommendations and a handout was provided. Norm also attended a conference in Atlanta on using health equity to improve outcomes in behavioral health and found it to be very informative and is willing to share the materials. Additional input can be sent to Karen or Norm.

Fiscal Year 2016-17 State Block Grant Application Planning Discussion:

The draft documents were sent out prior to the meeting. The BHAC members made some suggestions for clarifications in the draft documents. Members with suggestions for specific language changes or factually inaccurate statements that require changes should e-mail those changes to Karen so accurate info can be included in the application. There was discussion about identifying unmet needs and various sources where needs assessment data are available. If anyone has needs assessments info or sources, please send to Karen. "People First" language should be used throughout. Outcomes should be measurable. Any additional input or comments should be emailed to Karen. The Block Grant application for fiscal year 2014-15 is on the MDHHS website and Karen will send the link out to the group. Please read the additional narrative sections to determine if individuals can assist with any info for any sections. Contact Karen if you have anything else to contribute.

Mental Health and Wellness Commission Recommendations – Mark Reinstein

Mark reported on some issues on which the BHAC had made recommendations. The common formulary recommendation has been moving forward and the BHAC has not been involved in this issue thus far even though this issue was one of the items the BHAC mentioned to the Department when asked what the BHAC wanted to be involved in. The other two issues were – Recipient Rights offices being independent of CMHs and interim residential beds for kids and adults, neither of which have been moving forward. Mark moved and Norm seconded that the BHAC send a letter to Director Lyon stating the BHAC would like to be involved in the common formulary issue and will be asking for a meeting about it. BHAC voted unanimously to send the letter. All State employees abstained from voting.

NAMI – Kevin Fisher

Kevin provided a NAMI brochure and discussed some other NAMI programs like programs for young people with friends experiencing mental health issues, faith-based programs and additional family to family programs. Visit www.namimi.org for more info. The NAMI Walk is on September 26, 2015 at 10:00 am at Belle Isle. Registration starts at 8:00 am.

Mental Health Association in Michigan Modified Consumer Survey – Mark Reinstein

By the end of next week the survey instrument should be ready to go. It will be on a survey monkey and will be sent out to all BHAC members and disseminated to other agencies as well. Stay tuned!

Review/Updates for State Councils and Committees:

Recovery Voices - Chris O'Droski

Peer Conference and Recovery Coach Curriculum = there has been a lot of activity in these areas. The Peer Conference went very well. The Recovery Coach Curriculum advisory group is meeting again next week and hopefully the curriculum will be finalized soon after. Dan Faylor who works for NEMSAS reported on his activities in the Gaylord area regarding multiple pathways. NEMSAS has 130 coaches in their region (a very large region from Clare to the bridge). They also have a community speakers bureau and other comprehensive services. Recovery Voices is also keeping an eye on SUD related legislation.

ROSC Steering Committee – Kristie Schmiede

The Department gave updates (opioid initiative, peer activities, new DOC member gave info on contracting for SUD services); discussed the focus of the committee ongoing, Phil Chvojka informed the group on the TEDS system and how it is expanding into the behavioral health TEDS; Colleen Jasper gave an update on trauma initiatives; Becky Cienki gave a presentation about health centers and behavioral health activities; PA2 dollars were discussed; and a workgroup was created to discuss access management for SUD in light on the integration of CAs into PIHPs.

Future Presentations – Chris O'Droski

For the September meeting:

State/Tribal Youth Suicide Prevention and Early Intervention Grants funded by the Garrett Lee Smith Memorial Act – Patricia Smith

To discuss at the September meeting:

Forced outpatient treatment and pending legislation – Elmer Cerano will send info out to group.

For the November meeting:

Peers in Prison and Peers in re-entry combined presentation - Mike Davis and Chris O'Droski
Families aging out of TANF services – Terry Beurer, MDHHS.

Michigan Housing and Recovery Initiative – Stephanie Oles will locate presenters
Seclusion and Restraints in schools – Elmer Cerano
Mental Health First Aid – Julie Barron
Recovery school/colleges – Chris is looking for suggestions for presenters.
Mental Health and Drug Courts – Cheryl Kubiak or SCAO could present.
Foster care psychotropic medication management – Dr. Scheid, MDHHS
SEDW and DHIP – Mary Chaliman, MDHHS

Public Comment –

Norm DeLisle – September 17th 11:00 am to 2:00 pm Anniversary of ADA at the Capitol.
Linda Burkhardt – The concerns MHA in MI had about two budget bills were resolved by advocacy.

Stephanie Oles – John Loring, a champion for homeless people in Washtenaw County, died. He was a wonderful asset to his community.

Elmer Cerano – Director of Information and Referral position at MPAS is still open. Contact Elmer.

Chris O’Droski – Rally at Home of New Vision Resource Center in Jackson. June 26th at 5:00 pm to prepare for a walk. Chris has an Elvis tribute band – they are playing in Grand Rapids.

Karen Cashen – Annual SA Conference is in late September. Go to MACMHB website for more info.

Glenn Cornish – Glenn informed the group of changes in Medicaid payments for substance abuse treatment. He works on policy issues regarding SUD treatment, medication treatment and payment issues.

Meeting dates are on the bottom of all agendas.

Becky moved to adjourn the meeting, Kristi seconded. Meeting adjourned at 3:08 pm.

The next meeting is September 11, 2015.



Behavioral Health Advisory Council

Bylaws

ARTICLE I

Name

1. The name of this unincorporated association shall be the Behavioral Health Advisory Council.

ARTICLE II

Function

1. The purpose of the Behavioral Health Advisory Council shall be to only advise the Michigan Department of Community Health (MDCH) concerning proposed and adopted plans affecting both mental health and substance use disorder services provided or coordinated by the State of Michigan and the implementation thereof.
2. The Council's responsibilities as defined in the applicable federal law include, but are not limited to:
 - a. Improve the behavioral health outcomes (addressing both mental health and substance use disorders) of the people of the State of Michigan receiving behavioral health services.
 - b. Assist the Department of Community Health in planning for community-based programs targeted to persons with behavioral health issues.
 - c. Advocate for improved services to persons with behavioral health problems.
 - d. Monitor and evaluate the implementation of the applicable federal law.
 - e. Advise the Director of the Department of Community Health as to service system needs for persons with behavioral health problems.
3. The Director of the Department of Community Health may assign additional areas of responsibilities to the Council.

ARTICLE III

Members

1. Members shall be appointed by the Director of the Michigan Department of Community Health in accordance with the requirements of the applicable federal law.
2. Council member composition shall follow the guidelines set forth in the applicable federal law and any subsequent regulations pertaining to council membership.
3. The Council shall have a maximum of 40 members.



Behavioral Health Advisory Council

Bylaws

- a. More than 50% of the members shall be consumers/clients/advocates.
 - b. Every effort shall be made to assure the composition of the Council reflects the social and demographic characteristics of Michigan's population.
4. Members shall be appointed for 2 year terms and may be re-appointed.
 5. Each member may designate to the Department an alternate to represent the member at Council meetings. The officially designated alternates attending as representatives of members shall be given voting privileges at the Council meeting.
 6. Attendance:
 - a. Members shall be excused by notifying Council staff when unable to attend a scheduled meeting.
 - b. Absent members who do not notify staff to be excused from a meeting and do not send an alternate shall be noted as un-excused.
 - c. Two un-excused absences during a members term shall trigger an interview of the member by the executive committee to determine the member's continued status on the Council
 - d. Three absences (excused or un-excused) during one year shall trigger an interview of the member by the Executive Committee to determine the member's continued the member's status on the Council.
 7. Vacancies: Vacancies on the Council shall be filled by appointment by the Director of the Department of Community Health in accordance with the applicable federal law.
 8. The department director may remove any member from the Council if the department director determines the member has not fulfilled his or her council responsibilities in a manner consistent with the Council's or departments best interests. If exercising this authority, the department director shall inform the removed member and the Council Chairperson of the reason(s) supporting such action.

ARTICLE IV

Officers

1. The Council shall use the calendar year for appointments and terms of officers. Officers serve for one calendar year. The officers of the Council shall consist of Chairperson, Vice-Chairperson, and Recording Secretary, who shall be elected by the Council.



Behavioral Health Advisory Council

Bylaws

2. The Chairperson shall be responsible for conducting the meetings. The Chairperson shall be an ex-officio member of all committees formed by the Council. As the ex-officio member the Chairperson shall have no voting rights in said committees. The Chairperson shall serve for a 1 year term with a maximum of 2 consecutive terms.
3. The Vice-Chairperson shall act in the absence of the chair. The Vice-Chairperson shall serve for a 1 year term with a maximum of 2 consecutive terms.
4. The Recording Secretary shall be responsible for assuring that minutes are recorded, recording attendance, and working with the other officers. The recording secretary shall serve for a 1 year term with the maximum of 2 consecutive terms.
5. Vacancies among officers: A vacancy shall exist when an officer resigns from the office held or ceases to be a member of the Council. In the event the position of the Chairperson becomes vacant, the Vice-Chairperson shall perform the duties and exercise the powers of the Chairperson for the remainder of the term. The Council shall fill vacancies in the offices of Vice-Chairperson and Recording Secretary for the remainder of the term.
6. Nominations shall be submitted to Council staff for specific officer positions. Individuals can nominate themselves as well as any other member of the Council. Those who are nominated have the opportunity to decline to take part in the election process.

ARTICLE V

Meetings

1. The regular meetings of the Council will occur no less than 4 times per calendar year.
2. Notice of the dates, time, location, and agenda of regular meetings of the Council shall be distributed in accordance with the Open Meetings ACT (P.A. 267 of 1976). In addition, notice of dates, time, location, and agenda of regular meetings shall be posted publicly at least 3 days prior to any meeting of the Council.
3. The Director of the Department of Community Health, Council Chairperson or a minimum of 6 members may call a special meeting of the Council as necessary.
4. A quorum shall be more than $\frac{1}{2}$ of the number of members serving on the Council at the time of the vote.



Behavioral Health Advisory Council

Bylaws

5. Council action is determined by a majority vote. A majority vote is defined as a majority of those members present.
6. The current edition of Robert's Rules of Order shall govern the conduct of all meetings.
7. Electronic meetings, using telephone conference calls, or video conferencing are allowed when circumstances require Council action or to establish a quorum.

ARTICLE VI

Executive Committee

1. The Council's Executive Committee shall consist of the Chairperson, Vice-Chairperson, Recording Secretary, and immediate past Chairperson, if still a Council member. If none of the described positions includes a consumer/client/advocate, then a consumer/client/advocate member will be added to the Executive Committee as a Member at Large through the same nomination and election process used for Council Officers
2. The Executive Committee may draft and finalize letters and communications on behalf of the Council as directed by the Council.
3. The Executive Committee members may represent the Council in meetings with state and federal government officials within the scope of the Council's business. The Executive Committee may act on behalf of the Council when it is in the Council's best interests to do so. Any action by the Executive Committee shall be subject to subsequent ratification by the Council.
4. Any other duties, tasks, or responsibilities assigned to the Executive Committee shall be delegated by official Council action at a Council meeting.

ARTICLE VII

Committees/Workgroups

1. The Council or its Chairperson may create special committees/workgroups for a specific period of time. The Council Chairperson shall designate the members of a special committee/workgroup and assure each committee/workgroup has representation from at least



Behavioral Health Advisory Council

Bylaws

one primary consumer/client, and at least one family member of an adult with serious mental illness or substance use disorder, or one parent/caregiver of a minor with serious emotional disturbance or substance use disorder. The nature of the committee shall dictate the type of consumer/client/family member representation that is needed. The Director of the Department of Community Health may appoint persons to serve as ex-officio members, without voting rights, of Council special committees. The Council Chairperson may serve as the committee chair or designate a committee chairperson.

2. The scope and tenure of special committees shall terminate when the designated period of time has lapsed or the task is completed.
3. Special committees shall report on the committee's work to the Council. The establishment and dissolution of special committees shall be noted in the Council minutes.
4. A special committee may request the invitation of technical resource persons to provide information and answer questions, or the Council Chairperson may appoint persons outside the Council to serve on a committee.

ARTICLE VIII

Amendments

1. These bylaws shall be amended by a two-thirds vote of the Council at a regularly scheduled meeting following a 30-day review period of the proposed amendments and enacted with the concurrence of the Director of the Department of Community Health.
2. A committee of the Council shall review these bylaws not less than every four years.
3. These bylaws were last amended by the Behavioral Health Advisory Council at its regular meeting held on June 28, 2013.



Behavioral Health Advisory Council
State of Michigan

August 10, 2015

Nick Lyon, Director
Michigan Department of Health and Human Services
201 Townsend Street
Lansing, MI 48913

Dear Mr. Lyon:

The state's Behavioral Health Advisory Council (BHAC) met on March 20 and June 12, 2015 to discuss and plan for Michigan's Fiscal Year 2016-2017 Block Grant Application.

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

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

The council looks forward to our continued advisory role relating to the state's behavioral health activities. We have been given the opportunity to review, make suggestions, and approve the content of the information to be submitted to the Substance Abuse and Mental Health Services Administration. We are optimistic that this submission will be met with favorably by the federal government.

Sincerely,

Mark Reinstein, Chair
Behavioral Health Advisory Council
Telephone: (734) 646-8099
E-mail: msrmha@aol.com

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).

Michigan's Behavioral Health Advisory Council (BHAC) met on March 20 and June 12, 2015, to discuss and plan for the combined FY16-17 Block Grant Application. Questions were asked, lively discussions took place, and several members submitted language for inclusion in various sections of the application.

Michigan made the public aware of the application process by posting information for the Substance Abuse and Mental Health Block Grant application and a copy of the guidance on our state's website. Included with this is a standing invitation for public review and comment as well as a link to the State Planner's e-mail that allows individuals to provide comments, suggestions, or questions. In addition, all meetings of the BHAC are open to the public for individuals to attend, ask questions, and provide comments.

2. What mechanism does the state use to plan and implement substance abuse services?

The state developed and published an Office of Recovery-Oriented Systems of Care (OROSC) Strategic Plan (FY13 – FY15), that includes priority focus areas including: 1) Establishing a recovery-oriented system of care; 2) Reducing Underage Drinking; 3) Reducing prescription drug and over-the-counter drug abuse; 4) Expanding integrated behavioral health and primary care to persons at risk for substance abuse and mental health disorders; and 5) Reducing pathological gambling. For FY16-18, OROSC has developed an updated Strategic Plan inclusive of the following strategic priorities: 1) Reducing prescription and over the counter drug abuse; 2) Reducing misuse of alcohol, opioid medications and illicit drugs; 3) Reducing underage drinking; 4) Reducing youth access to tobacco and illegal sales to minors; and 5) reducing fetal alcohol spectrum disorder births. All five priority focus areas were selected based on severity of the problem as documented in state and local level epidemiological data including mortality, morbidity, incidence, prevalence, social indicator and trend data. Key informant interviews and focus groups with administrators, providers, coalitions and consumers were held. In addition, all of the focus areas include goals, objectives and strategies with time lines, metrics and outcomes.

Public Act 500 of 2012 requires regional community mental health entities to develop action plans for the provision of substance abuse prevention, treatment and recovery services at the local level. OROSC provides action plan guidelines to the regional entities for the development of the plans, based on the epidemiological data collected and extrapolated for the development of the OROSC Strategic Plan.

3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

MDHHS developed an integrated Behavioral Health Advisory Council (BHAC), effective January 1, 2013. For more information regarding the BHAC, please see the November 9, 2012 letter announcing the formation of the BHAC, a sample reappointment letters, and a copy of the bylaws that were last amended on June 28, 2013.

4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

The BHAC has diverse representation of the service area population that meets the examples above.

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The duties and responsibilities of the BHAC are included in the bylaws that have been uploaded as an attachment to this section. The BHAC membership includes people in recovery, family members, advocates, and other individuals who are important to this diverse council.

If additional input is requested or needed from other individuals, the BHAC may create special committees or workgroups with persons appointed to serve who are outside the Council membership. The BHAC is also listed on the department's website with meeting dates, copies of the minutes, and contact information for the BHAC liaison. All meetings of the BHAC are open to the public, which creates another avenue for individuals to provide input.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year:
 End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Lonnetta Albright	Others (Not State employees or providers)	Great Lakes Addiction Technology Transfer Center	1640 W. Roosevelt Road, Suite 511 Chicago, IL 60608 PH: 312-996-4450	lalbrigh@uic.edu
Linda Burghardt	Others (Not State employees or providers)	Mental Health Association in Michigan	27655 Middlebelt, Suite 170 Farmington Hills, MI 48334 PH: 248-473-3143	lburghardt@comcast.net
Elmer Cerano	Others (Not State employees or providers)	Michigan Protection and Advocacy Services	4095 Legacy Parkway, Suite 500 Lansing, MI 48911 PH: 517-487-1755	ecerano@mpas.org
Rebecca Cienki	Others (Not State employees or providers)	Michigan Primary Care Association	7215 Westshire Drive Lansing, MI 48917 PH: 517-827-0474	rcienki@mpca.net
Kevin Fischer	Others (Not State employees or providers)	NAMI - Michigan	401 S. Washington Avenue, Suite 104 Lansing, MI 48933 PH: 517-485-4049	kfischer@namimi.org
Benjamin Jones	Others (Not State employees or providers)	National Council on Alcoholism and Drug Dependence	2400 E. McNichols Detroit, MI 48212 PH: 313-868-1340	president@ncadd-detroit.org
Mark Reinstein	Others (Not State employees or providers)		27655 Middlebelt, Suite 170 Farmington Hills, MI 48334 PH: 248-473-3143	mrmha@aol.com
Ben Robinson	Others (Not State employees or providers)		5130 Rose Hill Boulevard Holly, MI 48442 PH: 248-634-5530	brobinson@rosehillcenter.org
Jane Shank	Others (Not State employees or providers)	Association for Children's Mental Health	6017 W. St. Joe Highway, Suite 200 Lansing, MI 48917 PH: 231-943-0368	acmhjane@sbcglobal.net
Amy Allen	State Employees	Michigan Department of Health and Human Services	400 S. Pine Street Lansing, MI 48933 PH: 517-241-8704	allena7@michigan.gov
Karen Cashen	State Employees	Michigan Department of Health and Human Services	320 S. Walnut, 5th Floor Lansing, MI 48933 PH: 517-335-5934	cashenk@michigan.gov
Mary Chaliman	State Employees	Michigan Department of Health and Human Services	Grand Tower, Suite 1514 Lansing, MI 48909 PH: 517-335-4151	chalimanm2@michigan.gov
Michael Davis	State Employees	Department of Corrections	9036 East M-36 Whitmore Lake, MI 48189 PH: 734-449-3897	davism24@michigan.gov

Lauren Kazee	State Employees	Department of Education	Street, 2nd Floor Hannah Building Lansing, MI 48933 PH: 517-241-1500	kazeel@michigan.gov
Stephanie Oles	State Employees	Michigan State Housing Development Authority	735 E. Michigan Avenue, P.O. Box 30044 Lansing, MI 48912 PH: 517-241-8591	oless@michigan.gov
Patricia Smith	State Employees	Michigan Department of Health and Human Services	P.O. Box 30195 Lansing, MI 48909 PH: 517-335-9703	smithp40@michigan.gov
Sally Steiner	State Employees	Michigan Department of Health and Human Services	300 E. Michigan Avenue, P.O. Box 30676 Lansing, MI 48909 PH: 517-373-8810	steiners@michigan.gov
Jeffery Wieferich	State Employees	Michigan Department of Health and Human Services	320 S. Walnut, 5th Floor Lansing, MI 48913 PH: 517-335-0499	wieferichj@michigan.gov
Cynthia Wright	State Employees	Michigan Department of Health and Human Services	201 N. Washington Square, P.O. Box 30010 Lansing, MI 48909 PH: 517-281-2738	wrightc1@michigan.gov
Paula Nelson	Providers	Sacred Heart Rehabilitation Center, Inc.	400 Stoddard Road Memphis, MI 48041 PH: 810-392-2167	pnelson@sacredheartcenter.com
Lori Ryland	Providers	Southwest Michigan Behavioral Health	5250 Lovers Lane, Suite 200 Portage, MI 49002 PH: 269-979-9132	lori.ryland@swmbh.org
Kristie Schmiege	Providers	Gateway Community Health	1333 Brewery Park Boulevard Detroit, MI 48207 PH: 810-965-2675	kschmiege@gchi.org
Arlene Kashata	Federally Recognized Tribe Representatives		2815 Hilltop Court #204 Traverse City, MI 49686	a_kashata@hotmail.com
Tina Louise	Federally Recognized Tribe Representatives	American Indian Health and Family Services of Southeastern Michigan, Inc.	4880 Lawndale Detroit, MI 48210 PH: 313-846-3718	tlouise@aihfs.org
Joelene Beckett	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		31900 Utica Road Fraser, MI 48026 PH: 586-218-5283	joeli44@wowway.com
Norm DeLisle	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		780 W. Lake Lansing Road, Suite 200 East Lansing, MI 48823 PH: 517-333-2477	ndelisle@mymdrc.org
Mary Beth Evans	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		101 Vienna Court Houghton Lake, MI 48629 PH: 231-394-1873	maibie_twins_two@yahoo.com
Marlene Lawrence	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		5271 Horizon Drive, Apt. 2 Battle Creek, MI 49015 PH: 269-209-9748	marlenelawrence2000@yahoo.com
Kevin McLaughlin	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		321 Fuller Avenue, N.E. Grand Rapids, MI 49503 PH: 616-262-8531	kevin@recoveryallies.us

Chris O'Droski	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	3800 Packard, Suite 210 Ann Arbor, MI 48108 PH: 734-975-1602	codroski@homeofnewvision.org
Kevin O'Hare	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	2763 22nd Street Wyandotte, MI 48192 PH: 734-309-3091	commdrkev@yahoo.com
Neicey Pennell	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	2018 Lyons Street Lansing, MI 48910 PH: 517-894-7055	ncypennell@gmail.com
Marcia Probst	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	1020 S. Westnedge Avenue Kalamazoo, MI 49008 PH: 269-343-6725	mprobst@recoverymi.org
Julie Barron	Family Members of Individuals in Recovery (to include family members of adults with SMI)	812 E. Jolly Road, Suite G-10 Lansing, MI 48910 PH: 517-346-9600	barron@ceicmh.org
Brian Wellwood	Family Members of Individuals in Recovery (to include family members of adults with SMI)	520 Cherry Street Lansing, MI 48933 PH: 517-371-2221	brwellwood@yahoo.com
Jamie Pennell	Parents of children with SED	211 Butler Street Leslie, MI 49251 PH: 517-589-9074	jpennell00@yahoo.com

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	36	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	9	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED*	1	
Vacancies (Individuals and Family Members)	<input type="text" value="0"/>	
Others (Not State employees or providers)	9	
Total Individuals in Recovery, Family Members & Others	21	58.33%
State Employees	10	
Providers	3	
Federally Recognized Tribe Representatives	2	
Vacancies	<input type="text" value="0"/>	
Total State Employees & Providers	15	41.67%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="3"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="5"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	8	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="12"/>	

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

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

Michigan's Behavioral Health Advisory Council (BHAC) met on March 20, 2015, and June 12, 2015, to discuss and plan for the combined FY16-17 Block Grant Application. Questions were asked, lively discussions took place, and several members submitted language for inclusion in various sections of the application.

Footnotes:

JUL 7 2015

Ms. Lynda Zeller
Behavioral Health and Developmental
Disabilities Administration
320 South Walnut Street, 5th Floor
Lansing, MI 48933

Dear Ms. Zeller:

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy of the authorizing legislation (42 USC § 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/Territory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment of the FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BGAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regarding the September 1 receipt date.

Page – 2 Ms. Zeller

Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the “Application Complete” function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA’s block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, “Management’s Responsibility for Internal Controls,” and one of the controls involves a review of how SAMHSA ensures states’ and jurisdictions’ compliance with the statutory receipt dates as described in sections 1917(a)(1) and 1932(a)(1) of Title XIX, Part B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

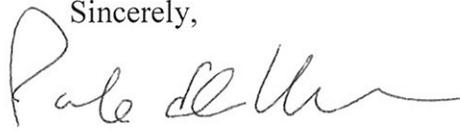
Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857
TEL. (240) 276-1422

Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state’s chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BGAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state’s chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 7-1109
Rockville, Maryland 20850
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respective State Project Officer within CMHS’s Division of State and Community Systems Development. Enclosed is a State project officer directory.

Sincerely,

A handwritten signature in black ink, appearing to read "Paolo del Vecchio". The signature is fluid and cursive, with a large initial "P" and a long horizontal stroke at the end.

Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

cc: Karen C. Cashen
Jennifer Stentoumis
Marcia Probst

Enclosures:
2016 MHBG Prospective Allotments
MHBG Project Officer Directory



STATE OF MICHIGAN
EXECUTIVE OFFICE
LANSING

RICK SNYDER
GOVERNOR

BRIAN CALLEY
LT. GOVERNOR

August 13, 2015

The Honorable Sylvia Mathews Burwell
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Burwell:

As the federal and state governments are working together to implement federal mental health and substance abuse block grants, this letter designates Nick Lyon, Director of the Michigan Department of Health and Human Services, as Administrator of the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant on behalf of the state of Michigan. Mr. Lyon may function as my designee for all activities related to these block grants.

We continue to look forward to our work with you and your staff during the implementation of these federal block grants.

Sincerely,

A handwritten signature in cursive script that reads "Rick Snyder".

Rick Snyder
Governor

cc: Virginia Simmons, Grants Management Specialist
Nick Lyon, Director
Lynda Zeller, Deputy Director