Michigan

UNIFORM APPLICATION
FY 2016/2017 - STATE BEHAVORIAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 08/31/2015 12.52.36 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

State SAPT DUNS Number

Number 113704139

Expiration Date 9/30/2016

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

Agency Name Michigan Department of Health and Human Services

Organizational Unit Behavioral Health and Developmental Disabilities Administration

Mailing Address 320 S. Walnut Street, 5th Floor

City Lansing

Zip Code 48913

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Thomas

Last Name Renwick

Agency Name Michigan Department of Health and Human Services

Mailing Address 320 S. Walnut Street, 5th Floor

City Lansing

Zip Code 48913

Telephone 517-373-2568

Fax 517-335-5376

Email Address renwickt@michigan.gov

State CMHS DUNS Number

Number 113704139

Expiration Date 9/30/2016

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

Agency Name Michigan Department of Health and Human Services

Organizational Unit Behavioral Health & Developmental Disabilities Administration

Mailing Address 320 S. Walnut Street, 5th Floor

City Lansing

Zip Code 48913

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Thomas

Last Name Renwick

Agency Name Michigan Department of Health and Human Services

Mailing Address 320 S. Walnut Street, 5th Floor

City	Lansing
Zip Code	48933
Telephone	517-373-2568
Fax	517-335-5376
Email Address	renwickt@michigan.gov

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

From	
To	

IV. Date Submitted

Submission Date	
Revision Date	

V. Contact Person Responsible for Application Submission

First Name	Karen
Last Name	Cashen
Telephone	(517) 335-5934
Fax	(517) 335-5376
Email Address	cashenk@michigan.gov

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
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Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPMâ€™s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for childrenâ€™s services and that all sub-recipients shall certify accordingly.

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

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Rick Snyder

Signature of CEO or Designee[1]: _____

Title: Governor _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2016

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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Governor Rick Snyder

Signature of CEO or Designee[1]: Rick Snyder

Title: Governor- State of Michigan Date Signed: 8/13/2015 (mm/dd/yyyy)

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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Governor Rick Snyder

Signature of CEO or Designee[1]: Rick Snyder

Title: Governor- State of Michigan Date Signed: 8/13/2015 (mm/dd/yyyy)

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State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

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Signature of CEO or Designee[1]: _____

Title: Governor _____ Date Signed: _____

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State Information

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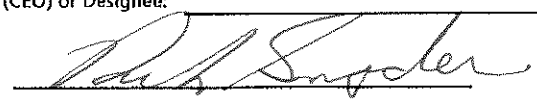
Name of Chief Executive Officer (CEO) or Designee: Governor Rick Snyder

Signature of CEO or Designee[1]: 

Title: Governor- State of Michigan Date Signed: 8/13/2015

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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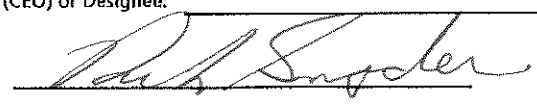
Signature of CEO or Designee[1]: 

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State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name	Nick Lyon
Title	Director
Organization	Department of Health and Human Services

Signature: _____ Date: _____

Footnotes:

Planning Steps

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

Narrative Question:

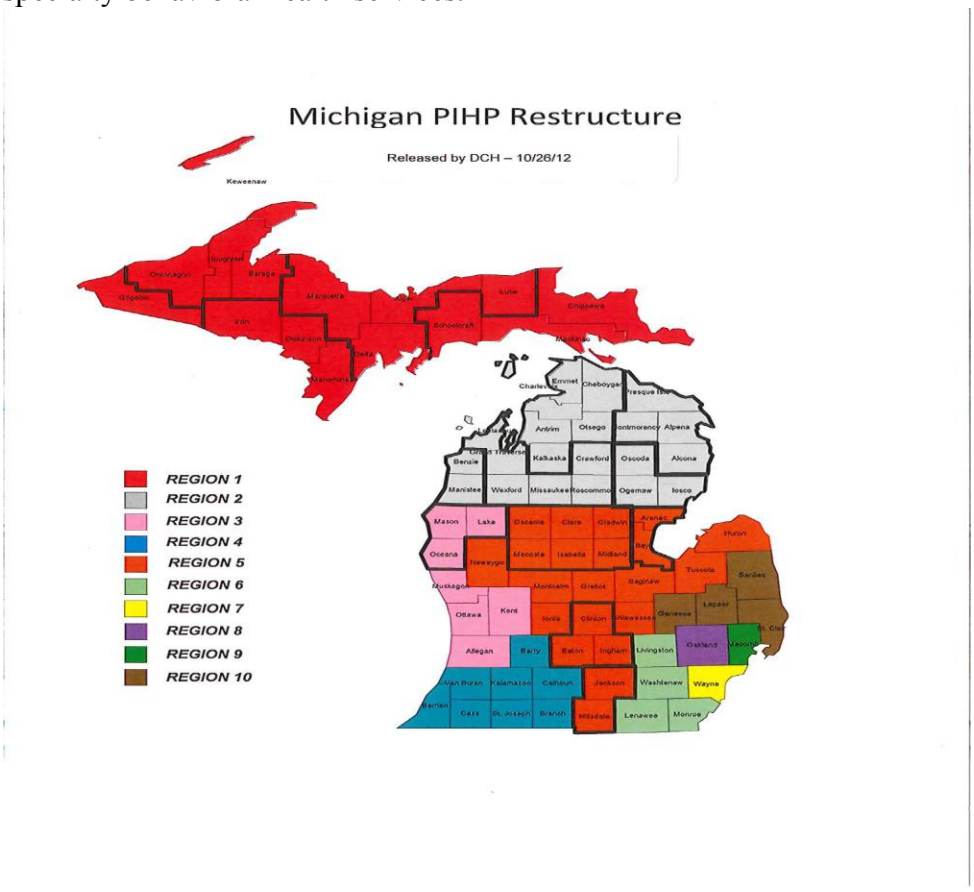
Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should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

Footnotes:

OVERVIEW

In Michigan, behavioral health prevention, early identification, treatment, and recovery support systems are the primary responsibility of the State's mental health and substance use disorder services authorities, collectively known as the Behavioral Health and Developmental Disabilities Administration (BHDDA), located within the Michigan Department of Health and Human Services (MDHHS). MDHHS, one of the largest of the 17 departments in Michigan's State government, is responsible for health policy and management of the State's publicly-funded health and human service systems. The new MDHHS, created in April 2015, replaces the former Michigan Department of Community Health (MDCH), which was created in 1996 by consolidating the Department of Public Health (now the Public Health Administration), the Department of Mental Health (now BHDDA), and the Medical Services Administration (MSA-the state's Medicaid agency).

MDHHS contracts with 10 Prepaid Inpatient Health Plans (PIHPs) to manage Medicaid funded specialty services and supports. Specialty behavioral health is carved out from the Medicaid Health Plans managed care system, and first opportunity for the sole source management of these services is available to be earned by the 46 Community Mental Health Services Provider (CMHSP) system through state defined PIHP regions. Additionally, Medicaid Health Plans manage comprehensive physical health services inclusive of outpatient mental health for the mild to moderate population. There is also a fee-for-service outpatient mental health benefit for Medicaid beneficiaries with a physician or psychiatrist for the very small number of persons not yet in a Medicaid Health Plan (mostly persons in nursing home settings or persons awaiting choice of or assignment to a Medicaid Health Plan). The map below outlines the state defined regions; each represented by one PIHP which contracts with MDHHS to manage the carved-out specialty behavioral health services.



Three of the ten PIHPs are single county CMHSPs. The remaining seven PIHPs are regional entities representing all CMHSPs within a state defined region. Regional entities are defined in the Michigan Mental Health Code (Public Act 258 of 1974).

CMHSPs provide Medicaid, state general fund, block grant, and locally funded services to children with serious emotional disturbance (SED), adults with serious mental illness (SMI), and children and adults with intellectual/developmental disabilities (I/DD).

For Medicaid, each region and each CMHSP provider system is required to have a comprehensive array of services that allows for maximizing choice and control on the part of individuals in need of service. Requirements for priority populations and mandatory services for state general funds are also defined in Public Act 258 of 1974. With the CMHSP system, individual plans of service are developed using a person-centered planning process for adults and a family driven/youth guided process for children.

Since submission of the FY15 block grant application, Public Act 500 and 501 of 2013 were signed into law. Public Act 500 and 501 required the full integration of the Substance Abuse Coordinating Agencies (CAs) into the same statewide network of PIHP managing entities that were already responsible for Medicaid funded substance use disorder prevention and treatment services. The result is the PIHP, in close collaboration with CMHSPs within the region, are responsible for the full range of behavioral health and intellectual/developmental disabilities services, regardless of the public payer source (state general fund, Medicaid, block grant, etc.).

In April 2014 Michigan expanded Medicaid by offering of the Healthy Michigan Plan. As of this writing, more than 590,000 previously uninsured persons are enrolled in the Healthy Michigan Plan receiving both comprehensive physical and mental health outpatient services through the Medicaid Health Plans. These people also have access to the full continuum of specialty behavioral health services available as needed through the PIHPs and CMHSPs. Formerly, these services were supported by block grant funding, state general fund and local funds, none of which were entitlements and all of which were prioritized within a capped amount of resources available.

The array of Medicaid mental health specialty services and supports provided through PIHPs under Michigan's 1915b/c capitated managed care waiver includes: Applied Behavioral Analysis, Assertive Community Treatment, Assessments, Child Therapy, Clubhouse Psychosocial Rehabilitation Programs, Crisis Interventions, Crisis Residential Services, Family Therapy, Health Services, Home-Based Services, Individual/Group Therapy, Intensive Crisis Stabilization Services, Medication Administration, Medication Review, Nursing Facility Mental Health Monitoring, Occupational Therapy, Personal Care in Specialized Settings, Physical Therapy, Speech, Hearing and Language, Substance Abuse (including outpatient, approved pharmacological supports, residential and sub-acute detoxification services), Targeted Case Management, Telemedicine, Transportation, Treatment Planning, Partial Hospitalization, and Inpatient Psychiatric Hospitalization. The specialty services and supports known as (b)(3) services which are included in the MDHHS contract include: Assistive Technology, Community Living Supports, Enhanced Pharmacy, Environmental Modifications, Family Support and Training, Housing Assistance. Peer-Delivered or Operated Support Services, Prevention-Direct Service Models, Respite Care Services, Skill-Building Assistance, Support and Service Coordination, Supported/Integrated Employment Services, Children's Serious Emotional Disturbance Home and Community-Based Services and Fiscal Intermediary Services.

The BHDDA requires that PIHPs have recovery-oriented services available for substance use disorder support and services. These consist of outpatient services (including intensive outpatient), residential services, sub-acute detoxification, medication-assisted treatment, case management, early intervention, peer recovery and recovery support, prevention, and integrated treatment for co-occurring mental health and substance use disorders. BHDDA has been expanding and improving integrated treatment for persons with co-occurring mental health and substance use disorders. This has been a focus of improvement over the last several years, occurring in partnership with the public mental health system. This process has been impacted at the state level through the statewide Practice Improvement Steering Committee and a group of specially trained clinicians (Michigan Fidelity Assessment Services Team) who conduct fidelity reviews of various organizations to ensure that evidence-based practices that support co-occurring disorder services and other practices, are being provided appropriately and that necessary ongoing education and training are provided. The steering committee is comprised of state level staff, PIHP representatives, stakeholders from local agencies and persons in recovery.

MDHHS has a number of mechanisms in place to provide leadership in the coordination of mental health services within the broader system. The PIHP contracts currently describe the PIHPs' responsibilities and deliverables. These contracts place a heavy emphasis on customer service, uniform data collection and encounter data reporting, fiscal management, quality assessment, and utilization.

This past year much progress has been made providing tools and information to support integration of physical health with the behavioral health systems of care. One example is the new tool called Care Connect 360, which provides a comprehensive overview of a person's claims and encounter history, including chronic conditions indicated by that activity. The tool also provides population level reporting options to identify lists of persons who are at high risk such as those with frequent utilization of inpatient or emergency room. Care Connect 360 is available to care coordinators in both PIHP/CMHSP and MHP systems, as the consumer has consented and as consistent with all privacy and security laws.

Also to support integration and good collaboration, each PIHP is required to have agreements in place with Medicaid Health Plans and human services agencies that serve people in the mental health system. In the upcoming contract year, both Medicaid Health Plan and PIHP contracts will have key common indicators of population health that are shared. The quality withhold and financial incentive systems for both PIHPs and Medicaid Health Plans will incorporate the common metrics that both Medicaid Health Plans and PIHP are accountable together for, as well as the metrics that are unique to the PIHP and Medicaid Health Plans' quality systems.

Through September 30, 2014, BHDDA coordinated substance use disorder treatment, prevention, and recovery services through sixteen Coordinating Agencies. As noted earlier in this overview, the coordination of substance use disorder treatment and prevention systems of care are now administered through the same entities that manage and deliver mental health services (PIHPs and CMHSPs). Each PIHP is also required to have a specific substance use disorder advisory and policy board that monitors prevention, treatment and recovery functions of the PIHP to ensure these services continue to be evidenced based, and result in positive outcomes.

The Public Health and Community Services Administration (PHCS) within MDHHS is responsible for behavioral health promotion and early intervention activities and other activities which complement the behavioral health services offered by BHDDA. The PHCS is also responsible for statewide suicide prevention planning and activities, maternal, infant and early

childhood programs that include behavioral health screenings and referrals, tobacco use prevention and treatment programs, fetal alcohol syndrome prevention programs, the coordinated school health program, chronic disease prevention and management programs and health integration activities.

The MDHHS is one of 17 departments of state government, responsible for health policy and management of the states publicly funded health service systems. The Michigan Public Health Code, Public Act 368 of 1978 (as amended) Sections 6201 and 6203, and Public Act 500, establishes the state substance abuse authority (SSA) and its duties. BHDDA functions as the Michigan SSA and duties include the administration and coordination of public funds such as Substance Abuse Prevention and Treatment (SAPT) Block Grant for the prevention and treatment of substance abuse and gambling addictions.

ADULTS WITH SERIOUS MENTAL ILLNESS (SMI)

As early as 2001, the National Institute of Medicine's report brief entitled, Crossing the Quality Chasm – A New Health System for the 21st Century highlighted the finding that, *"Scientific knowledge about best care is not applied systematically or expeditiously to clinical practice. It now takes an average of 17 years for new knowledge generated by randomized controlled trails to be incorporated into practice, and even then application is highly uneven. The committee therefore recommends that the Department of Health and Human Services establish a comprehensive program aimed at making scientific evidence more useful and more accessible to clinicians and patients."*[1]

Additional calls for systems transformation came in 2003 with the President's New Freedom Commission on Mental Health report, in 2004 with the State of Michigan's Mental Health Commission final report, and in 2006 with another National Institute of Medicine report on Improving the Quality of Care for Mental and Substance-Use Conditions. As recently as 2009, Proctor et al noted that, *"One of the most critical issues in mental health services research is the gap between what is known about effective treatment and what is provided to and experienced by consumers in routine care in community practice settings."*[2]

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

Assisted by available block grant resources, Michigan has continued to make strides in improving our system of care to include the availability and delivery of many of these recommended practices. Among the strengths demonstrated across our State, efforts have continued to progress in the development and implementation of a range of SAMHSA-endorsed

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

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

evidence-based practices (EBPs) and cross-cutting initiatives across our CMHSP provider system, including block grant-supported projects targeting the following adult service practice areas. As many of these practices are only partially implemented and/or are encountering sustainability challenges, they also continue to represent ongoing needs for the coming Fiscal Year 2016-17 grant cycle:

Assertive Community Treatment

The 90+ community-based Michigan Assertive Community Treatment (ACT) teams engage and work with adults who experience the most severe and troubling symptoms of serious mental illness. Firmly embedded in the public mental health system and a Medicaid covered service, ACT uses proactive engagement to provide continuous, rapid, flexible, twenty-four hour a day, seven days a week, three hundred and sixty-five days a year treatment. Although there is a well-established 20 year history of ACT, assuring the necessary skills and information in workforce development and support of this very high intensity evidence-based practice remains a priority. An ACT specific training is required annually.

ACT-specific training is required by Medicaid, and the Quality Management Site Review Team emphasizes adherence to Medicaid. A quality improvement tool, the Field Guide to ACT was created, adopted and is used today to support ACT teamwork addressing Medicaid, the sponsoring organization, in consumer relations and satisfaction and outcomes.

As the fixed point of responsibility, the ACT team consists of multi-disciplinary mental health professionals that most often include a peer. Responsible for working with ACT consumers to develop the person-centered treatment plan and for supporting consumers in all aspects of community living, ACT assists consumers to live in the most independent setting possible, while supporting goals focused toward recovery. Consumers receiving ACT services in Michigan typically have needs that have not been effectively addressed by traditional, less intensive services. Additionally, ACT consumers have been asked to participate in the 44 item MHSIP Survey.

Fully integrated into the public mental health system, ACT interfaces with many of Michigan State‘s other supported evidence-based practices such as Integrated Dual Disorder Treatment and Family Psychoeducation. ACT is represented on the Practice Improvement Steering Committee; the ACT subcommittee has been disbanded and is poised to reconvene when policy and practice issues arise. ACT is one of the evidence-based practices in the www.improvingmipractices.org website and, as such, has a variety of resources and information available to ACT team members, the public, consumers, administrators, and families.

Family Psychoeducation

Family Psychoeducation (FPE) in Michigan is provided through the PIHPs, CMHSPs, and contract agencies for partnering with consumers and families to support recovery. FPE is comprised of three phases: 1) joining sessions, where practitioners and families begin to form a practitioner, consumer-family alliance and learn about the individual families experiences related to mental illness; 2) a structured one day workshop that focuses on the biological causes of mental illness as well as individual needs of families; and 3) multi-family groups focus on a structured problem-solving approach over time, creating a safe environment to experiment, communicate, cope, grow and practice new social skills.

Representation on the Practice Improvement Steering committee (PISC) is consistent. FPE has a strong subcommittee, the Steering Committee, made of dedicated and skilled staff from throughout the state.

Over time a significant structure to support FPE has been achieved. A part-time State Coordinator works with MDHHS and the Steering Committee to plan and implement the Facilitator, Advanced Facilitator and Trainer/Regional Supervisor training. A FPE Sustainability document has been created. Bimonthly Learning Collaboratives focusing on FPE staffs current needs and challenges. Learning Collaboratives are well-attended and have lively participation. In effort to maintain high fidelity, technical assistance/fidelity reviews are offered to PIHPs annually. There are 15 active supervisors/trainers spread regionally to provide regular supervision throughout the State.

Consumers participating in multi-family problem solving groups have shown a decrease in the use of higher intensity mental health services [Crisis Intervention (CI), Crisis Residential (CR), and Inpatient (IP)]. This is an area rich for research but, meanwhile, it looks like FPE can greatly reduce the use of expensive services.

We are in the process of another review of this service similar to what was completed in 2012. That report, a "Point-in-Time Survey" Family Psychoeducation, November 2012, showed very positive results for FPE. Surveys were completed within a two week period by 146 Consumers and 121 Families about their family members. Acceptance, respect, help, hope, and dealing better with daily problems averaged 87% for families and 70% for consumers. 53% of families observed an improvement in physical health. 92% of consumers indicated taking medications on a regular basis. Categories included daily problems, control of life, dealing with crisis, getting along better with family, better social in social situations, taking care of needs, handling things when awry, regular medications, crisis help from natural supports, no police contact or hospitalizations during the past three months averaged 69% improvement.

Co-occurring Disorders (COD): Integrated Dual Disorders Treatment (IDDT)

MDHHS activities for the implementation and sustainability of evidence-based and best practices for addressing co-occurring behavioral health and substance use disorders include:

- Michigan Fidelity Assessment Support Team (MIFAST):
  - Integrated Dual Disorder Treatment (IDDT) readiness assessment, onsite fidelity reviews, and follow-up technical assistance;
  - Dual Disorder Capability in Mental Health Treatment (DDCMHT) onsite reviews and follow-up technical assistance.
- The Performance Improvement Steering Committee;
  - Quarterly meetings of this Committee includes a standing agenda for Co-occurring Competency in both Mental Health and Substance Use Disorder Treatment as well as Integrated Treatment for Co-occurring Disorders (formerly Integrated Dual Disorder Treatment) which is specialized care for Co-occurring disorders at the Assertive Community Treatment (ACT) level.

The MIFAST group reviews programs for the purpose of assisting them in developing and sustaining IDDT teams that practice with a high level of fidelity. MIFAST does this by conducting a technical assistance conference to help agencies develop an implementation plan for IDDT, followed by an onsite visit to determine the degree to which the agency has achieved implementation by fidelity scoring of the 26 scorecard elements, and subsequent provision of

technical assistance to aid in the improvement of areas that are shown to need further development. The MIFAST team has added the DDCMHT site review process to its menu of assistive activities. The MIFAST team underwent formal training through SAMSHA in order to provide system wide review of "dual disorder" treatment capabilities across all programs at the outpatient level of care. For the agencies that request DDCMHT site-reviews of their outpatient treatment programs, each site is provided with a scoring report and a work plan with suggested activities for enhancing supports and services in each area reviewed.

The 2016 plan for MIFAST ITCOD (formerly IDDT) is to ascertain the number of teams practicing across the State of Michigan; determine the number of teams who have had four or more site Reviews since 2006; determine the number of protocols that consistently score above a 4 and organize site reviews to target areas that score below 3.1; provide both review and technical assistance for areas below 3.1 in site reviews and follow-up; initiate site reviews for IDDT teams who have not yet participated or have had <3 reviews; conduct DDCMHT site reviews for all outpatient level of care programs; conduct MIFAST inter-rater reliability enhancement training for veteran and new reviewer team members; and recruit and induct additional peer support specialists or persons with lived experience onto the review team as consultants to MIFAST and as part of the site review process.

The Practice Improvement Steering Committee has goals and objectives for the continuance of implementation, sustainability and improvement of the standards of practice for integrated treatment. The Practice Improvement Steering Committee helps to plan and focus the Co-occurring treatment within the annual statewide Substance Use Disorder Conference, as well as the Co-occurring College. The Co-occurring College is a separate activity which provides focused trainings for providers from various specialized supports and services who want to insure they are able to address comorbidity.

The annual Substance Abuse Conference and its Co-occurring topics are intended to bring together staff from administrative and practice levels and provide them with the best examples of co-occurring mission, vision, policy and practice initiatives, as well training on evidence based practices developed and adapted for co-occurring treatment. The Substance Abuse Conference planning group meets to review submissions from presenters who wish to participate in this conference. Reviews are conducted to determine if presentations meet the goals of the conference for integrated treatment, evidence-based and meet standards for strength-based and recovery characteristics. Plenary speakers are also reviewed and chosen based on their ability to meet the goals of the conference.

Motivational Interviewing

Motivational Interviewing (MI) is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal. MI represents a philosophy as well as a set of skills for effectively engaging and assisting Michigan's behavioral health system's service recipients facing one or more areas of difficult behavior change about which they may be ambivalent.

Goals for 2016-2017 and beyond with regard to Motivational Interviewing include:

- Expanding the Motivational Interviewing internal trainer project by using trainers developed through a state-funded initiative to strengthen Supervisor Skills for observing, coaching and enhancing Motivational Interviewing skills with the people they supervise.

- Complete five additional Modules for the web-based Motivational Interviewing Training on the Improving MI Practices (www.improvingMIpractices.org) website. These modules will be specific to supervisors of contact level staff and intended to teach them how to provide MI skill enhancement supervision, coaching and feedback.
- Begin to recruit and include individuals from provider agencies across the state that wish to become local trainers in the MIMIT project through the regularly scheduled Learn-and-Share project for trainers.

Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. It has become the evidence-based treatment of choice for serving individuals with Borderline Personality Disorder, a population that when untreated/undertreated tends to drive up emergency service/crisis service and psychiatric hospitalization costs.

- With approximately 50 DBT teams delivering services across Michigan's public behavioral health system, each existing PIHP regions feature one or more available DBT team providing this evidence-based treatment to service recipients with Borderline Personality Disorder.
- Ongoing core and refresher training continues to be provided annually to Michigan's public behavioral health workforce, along with evaluation of the effectiveness of the current training approach, using outcomes from training surveys as well as information on the continuing development of the model to make improvements that are cost-effective and help strengthen and sustain program and practitioner skills.
- Increase use of the practice knowledge exam that has been developed to better gauge the level of core knowledge and skills, as well as to inform future training and support for performance quality. The DBT practice knowledge exam is available via the Improving MI Practices (www.improvingmipractices.org) website. Test results are immediately available to MDHHS for aggregation and analysis for the purposes of supporting high-quality service delivery, and to help inform needed training moving forward.
- Statewide efforts to improve and expand the quality and availability of DBT services is being guided by a DBT Subcommittee, led by experienced practitioners from within Michigan's behavioral health service network, which advances the products of its work to the MDHHS-advising Practices Improvement Steering Committee.
- In 2014 the sub-committee was formed into an arm of the Michigan Fidelity Assistance Support Team for DBT. The team trained on the Global Informational Index (GOI) as an on-site evaluation tool and used it in nine site visits to assist teams in identifying the degree to which they have achieved implementation and identify areas for further development. In 2015 the team developed a DBT specific tool and trained for use of the tool along with the GOI for site assistance. In 2016 the goal will be to conduct a minimum of 10 reviews and provide follow-up consulting and training for areas identified by the site visit activity as requiring further development.

Supported Employment / Individual Placement and Support

Michigan presently has 21 Individual Placement and Support (IPS) sites actively providing services and striving to achieve or maintain at least fair fidelity. Another four sites are beginning to provide IPS services. In addition, two more sites are struggling to balance staff and are in

question of continuing to follow the IPS model. One other site chose to stop providing IPS services in FY 2015. These sites represent 13 of the 46 CMHSPs in Michigan and provide these services in 24 of the 83 counties in Michigan. The Upper Peninsula as well as other rural areas struggle with efforts to build and/or follow the IPS model. Several CMHSPs and providers met the summer of FY 2014 and were challenged to determine enough potential candidates to merit a full-time staff. Funding and budgeting for this distinct position is also challenging. Outreach has continued through technical assistance for counties considering the IPS model and led to one site's decision to press forward this fiscal year requesting a fidelity review and expectation of growth.

State-level leadership for IPS transitioned in late 2014. The new State lead met with the Michigan core review team over several months and jointly chose to adopt the Individual Placement & Support (IPS) title instead of the "supported employment" title. This was done to help providers recognize this is truly an evidence-based practice for individuals with mental illness with higher expectations and standards than more generically referenced "supported employment" programs. Training events in FY 2015 have intentionally been by invitation to supervisors, sites and organizations sincerely trying to follow the IPS model.

In fiscal year 2014, approximately 800 individuals with serious mental illness equated to about 900 jobs (some individuals had more than one (1) job during the year) were supported through the Michigan IPS initiative. All of these jobs were reported as competitive, integrated employment. Anecdotally it appears a significant number of these jobs were for over 30 hours a week and individuals earned in access of the Social Security Administration's substantial gainful amount. This has not been well documented but efforts are underway to increase reporting to better track this data, set goals, and promote stronger partnering with vocational rehab for shared successes. Key focus areas to increase quality employment outcomes for FY 2016 and beyond include:

Core Review Team-
In FY 2014, the core review team's participation had fallen to four (4) active reviewers. We have added two (2) new review team members this year and anticipate at least another two (2) new review team members in FY 2016 for a total of eight (8) members. It appears that maintaining eight to ten review members will meet the review needs for the immediate future.

Funding Challenges-
- It's become obvious that there is much variance in the rates and/or staffing costs associated with these 21 plus IPS providers. Four of the IPS providers offer services directly through their CMHSP staff and average costs are clearly more than those providers that are contracted by other CMHSPs to provide the services. Detroit Wayne Mental Health Authority (the CMHSP) is presently working with its current eight IPS sites (soon to be eleven to increase the contract payment amount to much better cover actual program costs.

In addition, it's becoming clear that in order to grow the IPS model in Michigan, a strategy must be developed to not only develop new IPS sites but to provide the framework to support that growth through timely reviews, training events, and even consideration/implementation of incentives to gain heightened provider commitment. Presently, MI supports just over 200,000 individuals with serious mental illness. This equates to about 1,000 employment specialists needed to serve all Michigan citizens with mental illness at the ratio projected by Dartmouth of one (1) employment specialist for each 200 individuals. Presently there are about 50 employment specialists in Michigan with continuing struggles to fund those staff positions. There is clearly much room for growth of the IPS model.

Staff Development/Training Events clearly needed include:

- Enhancing Supervisor Outcomes
- Basic IPS "101" training is needed annually for new staff
- Job Development & Retention
- Increased emphasis on data collection
- Cross-walking effective Motivational Interviewing (MI) with IPS
- Peer Support Specialist's role(s) in IPS
- Benefits Planning for effective IPS
- Seeking out new funding sources such as SSA PASS plans, VR, etc.

The IPS Core Review Team led similar training events in FY 2015 and is planning to lead again in FY 2016 with assistance from topic experts on MI, VR, benefits planning, etc.
NOTE: The lead Michigan staff is also giving consideration to how to best implement training webinars, conferences and other events available through Dartmouth IPS.

Strategic Planning-
Though strategic planning has been included in the past, it has not grown into an accepted component, plan, or roadmap for planned growth and sustainability in Michigan. Efforts are starting now in FY 2015 to establish the best logical roadmap by consensus of the core review team and ideally will be a living instrument reviewed annually and projected for three to five years.

Communications and Michigan Specific Resource Development-
Michigan is working to create a growing on-line presence at www.improvingmipractices.org. This website was established several years ago for other evidence-based practices and now has a section dedicated to IPS with Michigan specific resources available. It is also expected to become the home for tracking ongoing fidelity reviews, calendar of events, IPS webinar events, possibly interactive on-line training, and more.

Documentation and Data Tracking-
Additionally, Michigan is strongly considering implementing a requirement that each CMHSP will report quarterly the number of individuals employed (focus on individual, competitive, integrated employment), average hours and average wage. Establishing these quarterly data is expected to then allow the State to more effectively create policy, procedures and contracts to emphasize IPS. Work is underway at this time to update the Medicaid Provider Manual to clearly include IPS as the lead/preferred employment outcome for persons with serious mental illness and to also require CMHSPs or providers attain State approval to present themselves as an IPS site.

Partnerships with Vocational Rehabilitation is challenging given limited funding and differing philosophies. Past work established an inter-agency joint agreement describing shared roles of each agency. This agreement is being reconsidered primarily due to the release of the Work Innovation and Opportunity Act. Ideally, these efforts will greatly polish Michigan's IPS initiative and provide growing opportunities to increase high quality fidelity and employment outcomes for Michigan citizens.

Older Adults

Older adults are eligible for the same service array as younger adults within the public behavioral health system. In FY 14 over 13,000 older adults (65 and over) received public behavioral health

services, which is approximately 5% of the total number of adults served. Approximately 1,100 of these individuals had both an Intellectual/Developmental Disability and a mental illness and some 3,461 received behavioral health services in a nursing facility. Note: Citizens aged 65 and older make up nearly 14% of Michigan's population according to the 2010 Census, with a projected 36% increase 2010 to 2020. It is expected that there will be twice as many persons aged 65+ in 2030 as 2000, making up 20% of the population by 2030.

MDHHS continues to partner with universities such as Eastern Michigan University's Alzheimer's disease and Education Program, and colleges like Lansing Community College, Mental Health and Aging Project (MHAP), to provide a variety of seminars and workshops related to both mental illness and dementia. An annual Mental Health and Aging Conference and regional seminars focus on the mental health needs of elders. Other partnerships include collaborative work with the Michigan Assisted Living Association, providing materials, curriculum, and training on dementia care to staff of facilities whose residents include over half persons with dementia.

MDHHS continues to work with the Geriatric Education Center of Michigan (GECM) and the Center for Rural Health. Providing behavioral health information through a monthly teleconference called, "grand rounds" has reached new audiences: 50 locations with multiple attendees in primary care, primarily in the Upper Peninsula and upper-lower rural areas, plus presentations on behavioral health for older adults at regional GECM sites. Collaboration with GECM has extended to their "Alzheimer's Disease and Related Disorders Supplemental Training Grant," with enhancements to curriculum and relevant case studies (e.g., cases of persons with physical and mental health issues and accompanying dementia), and expansion of training participation to mental health professionals, which builds on the department's focus on Integrated Health. Upcoming efforts include writing educational modules on co-occurring mental illness and substance abuse for the audience of primary care professionals.

Involvement in the Michigan Dementia Coalition, a grassroots collaboration of representatives of universities, community agencies, and state government units continues. As adjunct members of NASMHPD Older Persons Division, Department staff share state programming information and participate in regular calls regarding services and needs.

Clubhouse

Currently there are 44 Clubhouses that serve over 4,500 consumers in the state. The International Center for Clubhouse Development (ICCD) model programs have been recognized as an evidenced-based practice by the Substance Abuse and Mental Health Services Administration (SAMHSA) since March 2011. Employment outcomes for Clubhouses played a significant role in SAMSHA's decision. Two of the three journal articles used to make the finding focused on employment. Both articles were studies of employment outcomes at a Clubhouse certified by the ICCD.

Accredited Clubhouses follow specific guidelines for employment systems within the clubhouse, and they were able to objectively demonstrate strong effectiveness for this model. Therefore, the ICCD standards on employment should be seen as the most effective method known to secure an array of employment opportunities for clubhouse members. For this reason, fidelity to the ICCD clubhouse standards is strongly encouraged. Michigan clubhouses have made gains in their employment outcomes from.

There are clear differences in outcomes between Clubhouse International (CI)-Accredited clubhouses and non-CI Accredited clubhouses, particularly in transitional employment (TE).

Forty percent of the directors and about one-third of staff have had training from CI. Notably all clubhouses have provided outreach services to members and have been engaged in some form of health and wellness initiative. In keeping with the goal of integrating physical health and behavioral health, clubhouses show an increase of about 8.6% from 2012 to 2013 in engagement with health and wellness initiatives. In the employment arena, it appears that TE is very much associated with CI-Accredited clubhouses with some patterns that CI Accredited clubhouses show better employment outcomes than non-CI-Accredited clubhouses. Independent employment (IE) is the most common form of employment across clubhouses. The correlations between the different types of employment and services extended to clubhouse members reveal a pattern that suggests that the type of employment that a member holds may be related to different services. For example, the number of members connected to Michigan Rehabilitation Services or Michigan Commission for the Blind was significantly related to IE, not to SE or TE. The IE number was significantly related to access to clubhouse activities on weekend, evenings and holidays. Perhaps clubhouses accommodate their members who hold weekday jobs by having other days of access to this group. This was significant only for 2013. Finally the numbers holding SE was related to the number of face-to-face outreach services provided. Clearly the pattern of not seeing any significant relationships with these services and TE employment is notable. Perhaps people in TE are receiving supports from clubhouses through their participation in TE which involves staff who are highly integrated into the core clubhouse activities. A five year survey conducted by Michigan State University and MDHHS provides use with much of the information above.

Comprehensive 2-3 emersion training; In FY14 MDHHS sponsored 15 different Michigan Clubhouses to participate in 2-3 emersion training though-out the United States. The initiative provided funding for Clubhouse colleagues (members & staff) to attend comprehensive trainings at any of the 6 accredited training bases in North America. Comprehensive trainings come in the form of 3-week or 2-week courses. All trainings are for 1 staff and 1 member for the full duration, and one administrator for the final week. The trainings follow a uniquely experiential program where colleagues are immersed in the practices of some of the strongest Clubhouses in the world. Training content includes Employment Development, Education Support, Meaningful Work-Ordered Day & Relationships Opportunities, Physical Wellness and more. In 2011, SAMSHA added the Clubhouse *International* Model to their *Evidenced-Based Practices* list. In the spirit of Evidenced-based practice, programs that follow the model closely will have better outcomes. Many Michigan Clubhouses need assistance to attain model fidelity, and comprehensive trainings like these are a catalyst for strong, positive changes. High Fidelity Clubhouses provide a better experience, significantly improve mental health, and are very cost-effective which is consistent with the department's vision).

Benefits training: Many people with serious mental illness (SMI) do not consider working for fear that they will lose their government benefits (especially Medicaid). The goal of benefits training is to provide high-quality training to CPSSS and PIHP/ CMHSP staff so that they can help people who use CMHSP services and navigate through the complex maze of work incentives available. The main target population was: Certified Peer Supports Specialists, other people with SMI receiving services from PIHPs/CMHPs, as well as other administrators, benefits coordinators, training coordinators ad supports coordinators/case managers from the PIHP/CMHSPs. In FY14, four-two-day trainings with (25-30 participants) were offered thought-out Michigan. In addition, four one- day training events were also provided serving 25-30 individuals as well. Also ongoing Technical assistance was provided to all training participants as needed. Approximately 160 contacts per year are typical in any given year.

Jail Diversion

Through Executive Order 2013-7, Governor Snyder mandated the establishment of the Mental Health Diversion Council within the (then) Michigan Department of Community Health to advise and assist in the implementation of a diversion action plan and to provide recommendations for statutory, contractual or procedural changes to improve diversion efforts statewide. This Council consists of 18 members who have been vetted by the Lt. Governor as agents of their respective fields and include representation from: Michigan Department of Health and Human Services; Michigan Department of Corrections; State Court Administration Office; Medicaid pre-paid inpatient health plan; adult service agencies/providers (CMHSM); Judiciary; prosecutors; community prisoner re-entry; court administrators; county sheriffs; local law enforcement; attorneys representing MI, DD interests; mental health, DD advocate; school administration; juvenile courts; and children's medical psychiatric.

The Council is chaired by the Lt. Governor and meets on a monthly basis to address progress on the Council's Action Plan, which is the framework and blueprint that the Diversion Council is using to help implement systematic, innovative and cost effective methods of diversion throughout the state. The ultimate goals are to: strengthen pre-booking jail diversion for individuals with mental illness; ensure quality, effective and comprehensive behavioral health treatment in jails and prisons; expand post booking jail diversion options for individuals with mental illness; reduce unnecessary incarceration or re-incarceration of individuals with mental illness; and establish an ongoing mechanism to coordinate and assist with implementation of action plan goals and to facilitate needed systems change.

In order to put these major goals in motion, action steps, milestone dates, key responsibilities and deliverable outcomes that help move along the process and act as markers for progress there have been set in place. This is a "living" document that is in constant flux as major/minor goals and action steps get crossed off due to completion and new goals and action steps are added. It's used as a template to visualize the framework of the overall diversion blueprint.

One of the main focuses of the Action Plan has to do with implementing systematic change in communities and how they address jail/law enforcement diversion. These pilot programs are charged with demonstrating the effectiveness of various diversion approaches and help build a case for expansion on a statewide basis. Lessons learned from these programs will be used to inform a broader pilot approach moving forward. To that end the Diversion Council looks at different counties around the state to come up with innovative and cost effective ways to divert MI, DD consumers in a way that could be replicated state wide. Each of the pilot sights would be awarded funding to initiate their process for one year initially (now on a two year cycle) and those broadly considered were based on innovation of program, urban/rural mix and already established community relationships (readiness). Potential pilots would be asked to explain their mode of diversion within their communities with the following considerations being treated as priorities coming out of the Mental Health Diversion Council. Each of these considerations was acknowledged to be some of the most important innovation strategies in an effort to focus on evidence based practices.

Priority Considerations for Pilots:

1. Those agencies seeking to initiate expanded services with law enforcement to include in their communities Crisis Intervention Teams (CIT) that would train local police, first responders and dispatch personnel in the 40 hour CIT training model to help better deal with the mentally ill and developmentally disabled in the field prior to potential incarceration. Further, that police departments would be backfilled while their officers are trained.

2. Those agencies that are exploring the need for a centralized crisis assessment/diversion facility for law enforcement to utilize in lieu of jails.
3. Those agencies that desire to focus on more comprehensive and enhanced mental health treatment for those in jail and transitioning out of jail. Efforts may include access to psychotropic medications in the jail setting as well as easy access to meds upon release, bolstered housing efforts prior to and after release; minimal wait times to see doctors/psychiatrists in and out of jail, increased support systems in place prior to and after release, utilization of educational and vocational opportunities pre and post release.
4. Those agencies looking to initiate or bolster efforts to expand the use of Alternative Outpatient Treatment by way of "Kevin's Law." This consideration has been lessened due to the subsequent formation of the Kevin's Law Panel at the behest of the Mental Health Diversion Council in an effort to address pre-emptive diversion. There is currently legislation pending (provided by the Panel) that would make the existing law more streamlined, easier to understand and implement as well as more "user friendly" for courts, CMH's and family members. This would go a long way in trying to get help for the mentally ill before they become an immediate threat to themselves or others and subsequently have interaction with law enforcement.

The Mental Health Diversion Council has a goal to address diversion at any point in which the mentally ill may come in contact with law enforcement or the criminal justice system. This is referred to as "points of intercept" and the Diversion Council is working diligently in the following areas to fill gaps in communities that may need assistance: 1) Pre-Emptive - Expanded use of Assisted Outpatient Treatment (currently being revamped by the Kevin's Law Panel and the Legislature); 2) Pre-Arrest/Pre-Booking - Law enforcement and emergency services point of contact (CIT), Initial detention; 3) Post Booking – Improve local in jail behavioral health treatment at booking, expand/strengthen mental health courts and mental health resources in criminal probation, greater presence at pre-sentencing/forensic evaluations; 4) Pre-Release – Re-entry from jails, prisons and forensic center; and 5) Post Release – Comprehensive jail in-reach and post release coordination, linkage to community services from probation/parole (housing, treatment, employment, meds).

Data and Evaluation:
The Mental Health Diversion Council has partnered with Michigan State University to supply comprehensive data and evaluation reports for each pilot individually and as a whole. What this means is that the MSU evaluation team will gather data that will be utilized in all the pilots, in essence binding them together to draw certain conclusions as to their effectiveness as a whole. They will also gather and analyze data specific to each individual pilot to determine their effectiveness separately.

Governor Snyder and his administration have committed to making jail diversion efforts around the state a priority and in doing so the Mental Health Diversion Council is changing the way we currently do business in this regard. The Mental Health Diversion Council has become instrumental in its charge of carrying out this administrations edict to come up with efficient, innovative, cost effective and transferable programs that can be replicated state wide once deemed a best practice and to supply comprehensive evaluations of data collected to outline the return on investment. The Mental Health Diversion Council's jail diversion efforts are far reaching and in the process of impacting legislation that would get the mentally ill into treatment before they decompensate and fall in to the revolving door of law enforcement, jail, courts and hospitalization. Finally this body is striving to take steps to improve the current relationships and culture of law enforcement, courts and treatment providers. We are trying to foster an

attitude of shared commitment to a shared challenge that every community faces and in doing so that we may assist and empower those that need our help the most.

Recovery-Oriented Care / Recovery Support Services

Recovery-based services and supports remain a strong foundation of publicly funded behavioral health programs in the state. As part of Michigan's Certified Peer Support Specialist (CPSS) initiative, approximately 1,400 individuals have been trained and certified in the state. Individuals work in a variety of areas including supports coordination, psychosocial rehabilitation programs, access centers, drug and mental health courts, crisis settings, drop-in centers, employment, housing outreach, jail diversion, Assertive Community Treatment, and a variety of other evidence based practices. A strong relationship with the Veterans Administration has led to over 105 Veterans receiving certification working at community mental health programs, provider agencies and VA centers.

A statewide committee of individuals with lived experience from addictions are providing recommendations and developing a curriculum for a statewide certification for peer recovery coaches. The committee has received on going technical assistance from the Center for Social Innovation. The information will be used to develop Medicaid provider requirements and serve as guidance to agencies in the state.

This fiscal year a health coach certification is being developed for both CPSS and Certified Peer Recovery Coaches (CPRC). Approximately 30 individuals will be part of the initial pilot. Ongoing continuing education trainings for peer specialists are provided including Wellness Recovery Action Planning (WRAP), emotional CPR, art and skill of facilitating effective groups, smoking cessation, motivational interviewing, Whole Health Action Management (WHAM), trauma informed care, housing outreach, and development and forensic peer support. Training is focused on developing recovery cultures and practices statewide.

A BRSS TACS grant was awarded in April of 2015 to train 40 individuals in two prisons in the state to become certified as a peer support specialist and/or peer recovery coach. The individuals will receive three Lansing Community College credit hours and additional training that will help with re-entry into their home communities as returning citizens. A Transformation Transfer Initiative grant on implementing Self-Directed Care for persons with mental health conditions was awarded by NASMHPD through SAMHSA. The individuals participating in the project will be part of a 5 year study with the Robert Wood Johnson Foundation and Human Services Research Institute (HSRI).

Integrated Physical & Behavioral Health

Ongoing efforts are underway to better integrate mental health and substance use disorder treatment services with physical health services, in a variety of settings including Federally Qualified Health Clinics (FQHCs), in primary care clinics, and in CMH and other mental health care settings.

A statewide Integrated Health Learning Community is continuing, in partnership with the Michigan Association of Community Mental Health Boards and with continued assistance and coaching calls in conjunction with the National Council for Behavioral Health. A University of Michigan evaluator is also being utilized. Topics of discussion for the Learning Community include: how agencies fund integrated health activities, developing and enhancing clinical services in an integrated health setting, national trends in integrated care, case rate tool kit for integrated care / health homes, what works when working with health plans, hospital and community behavioral health partnerships, federally qualified health care and community health

center providers. Moving forward, the Learning Community continues to provide a forum for integrated care teams to discuss what is working in their area, to assist in working through obstacles and strategies regarding ongoing efforts to be optimally positioned to develop health home models and share accountable care approaches in concert with ongoing healthcare reform.

Trauma-specific and Trauma-informed Services

There is increasing recognition of the high prevalence of historical trauma among many adult services populations, with support for developing and implementing Seeking Safety and Trauma Recovery and Empowerment Model services as part of Co-occurring Disorders treatment, as well as addressing trauma within the context of advanced Dialectical Behavior Therapy for borderline personality disorder with progressive exposure approaches. Additional attention is being given to moving systems of care to becoming more trauma-informed, with assistance from Community Connections consultants, and through the use of their Trauma-informed Self-Assessment framework.

A Trauma Subcommittee has been convened to advance statewide development and implementation of trauma-informed and trauma-specific services. Efforts of this subcommittee (which reports up to the Practice Improvement Steering Committee) included facilitating statewide training to our behavioral health workforce, and conducting a statewide needs-assessment survey to help inform training plans moving forward.

An arm of the Michigan Fidelity Assistance Support Team (MIFAST) has been developed to begin the process of on-site ascertainment of the degree to which agencies have achieved implementation of Trauma Informed Care. A standardized tool for conducting the on-site ascertainment has been chosen and a cadre of staff who are experts in Trauma Informed Care have been selected to form the team of site reviewers/consultants. The team began meeting in May of 2015 to complete training on the standardized tool and achieve inter-rater reliability prior to use with provider agencies. In 2016 it is expected that the Trauma MIFAST will be a part of the building and support for ongoing effective service quality, and a major part of the outcome tracking and analysis to substantiate progress and cost/benefit value.

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

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

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

CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (SED)

The organization of the Michigan's system of care (SOC) for children with SED includes many state and local agencies, advocacy groups, family members, and local providers of services. State agencies in Michigan are organized in such a way that each agency may provide multiple services. As mentioned above, an executive order went into effect in April 2015 that merged the Michigan Department of Human Services and the Michigan Department of Community Health into one department, the Michigan Department of Health and Human Services (MDHHS). Within this new Department, a new Children's Services Administration (CSA) has been established. The CSA is responsible for foster care and adoption, child protective services, juvenile justice services and includes the Mental Health Services to Children and Families Division, which was moved out of the BHDDA into the CSA. The Family Division of County Circuit Courts is responsible for juvenile court services. The Michigan Department of Education (MDE) is responsible for educational services and the implementation of Parts B and C of the Individuals with Disabilities Education Act. The Michigan State Housing Development Authority, a division of the Department of Licensing and Regulatory Affairs, is responsible for housing services. The state level policy direction to the local public mental health and substance use disorder service delivery system is provided by the BHDDA, the Office of Recovery Oriented Systems of Care (OROSC) and the Mental Health Services to Children and Families (MHSCF) Division within MDHHS.

Discussion of the Medicaid State plan and B3 services is mentioned above, however of special note are the additional Medicaid state plan services that were added though the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for youth up to age 21. These additional specialty services and supports include: community living supports, supports coordination, supported employment, family support and training, peer-directed services, skill-building, wraparound and prevention-direct parent education and services for children of adults with mental illness.

Discussion of SUD and co-occurring services is mentioned above as well, however there are some items specific to youth with co-occurring disorders that are important to recognize. Some PIHPs have continued to focus on training in treatment of co-occurring disorders (COD) in youth and these include Oakland and Central Michigan. Oakland County PIHP has held training in Motivational Interviewing in order to increase engagement of families in treatment, as well as addressing the mental health and substance use issues of adolescents and family members. CMH for Central Michigan also includes a specific COD focus on children/adolescents to assist with meeting goals around reducing their substance use. Several other PIHPs use Multi-Systemic Therapy (MST) as a strategy for addressing co-occurring disorders. In FY15, a new multi-year MST project was established across three CMHSPs and funded with Mental Health Block Grant to obtain training in MST in a regional area and maximize training dollars. Another CMHSP also expanded their MST services using Mental Health Block Grant dollars. There continues to be a need for additional cross-agency cooperation between mental health and substance use disorder service providers with regard to serving youth with co-occurring disorders. The integration of the CAs into the public mental health system statewide provides the opportunity for further growth and integration in this area.

Michigan continues to focus on 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 FY15, 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, specifically for youth also involved with child welfare and/or juvenile justice. Many of these projects will continue into FY16-17. 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 and 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. 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.

Another very exciting initiative that kicked off March 1, 2015 is the implementation of the Children's Behavioral Action Team (CBAT) pilot. The CBAT is responsible for developing successful community-based services which will allow 25 extremely complex children/youth to return home to their families, or if this is not possible, to the most family-like setting. The target population of the C-BAT includes 25 children/youth ages 5 to 18 currently residing in Hawthorn Center, who present with any and/or all of the following challenges: multiple hospitalizations and failed community placements; extensive trauma histories; Fetal Alcohol Spectrum Disorder; Serious Emotional Disturbance (SED); Primary SED with Secondary Intellectual/Developmental Disabilities; as well as other behavioral and physical health needs. The C-BAT works in conjunction with a state-level C-BAT Leadership Team, Hawthorn Center administration and staff, multiple community providers (PIHPs/ CMHSPs, local MDHHS, schools, courts, primary care and other physical health providers, etc.) as well as families/guardians and the children/youth themselves to create unique, individualized community living arrangements and plans for treatment, supports and services to successfully maintain these youth in the community. The team has offices on the Hawthorn Center campus but travel around the state to provide hands-on training and support to the community service providers who will be serving these children/youth long-term. The Guidance Center in Detroit was awarded the contract to provide CBAT services. This initiative was funded by state general fund dollars specifically earmarked for this purpose. The CBAT is overseen by an inter-departmental state leadership team which monitors implementation and assists in barrier busting at the systems level.

Michigan has also successfully utilized the 5% set-aside for First Episode Psychosis services for young adults. There are three pilot sites in Michigan funded utilizing the 5% set- aside currently implementing the RAISE model. These sites began serving people in FY15 and will continue into FY16-17 if funding continues from SAMHSA for this purpose, as proposed. This is another way Michigan is attempting to utilize community based services and supports to maintain youth with SED and young adults with SMI in their homes and communities.

MDHHS has been a leader in increasing collaboration with other state agencies, local communities, and families. MDHHS 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. Michigan has been awarded several collaborative federal grants, including Safe Schools Healthy Students and Project AWARE, in which MDHHS is a partner. Michigan has also maintained an extensive Mental Health First Aid and Youth Mental Health First Aid training initiative through state money and grant funding for the past two years and plans for sustaining this training are currently being developed.

Michigan has achieved some success in creating the foundation for a statewide SOC for children with SED. All public mental health providers in Michigan utilize a standard definition of SED and uniform access standards, as outlined in an attachment to the MDHHS contract with the PIHPs and with the CMHSPs. 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 to7 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. MDHHS 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)[5] and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (Cohen, Mannarino, Deblinger, 2006)[6]. And in fiscal year 2009, the SOC planning process was formally incorporated into the public mental health system through the Program Policy Guidelines (PPGs) through which 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). MDHHS 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 four years. As a result of participation in the February 2009 National Federation of Families for Children's Mental

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[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] 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.

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

Health's Policy Academy on Transforming Children's Mental Health through Family-Driven Strategies and continuing work by that team, an official MDHHS 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 statewide family organization and MDHHS, and training began in 2010 and will continue in FY16-17. MDHHS has also worked with youth and other stakeholders to develop a youth peer curriculum and training protocol for statewide implementation of youth peer support. This has also been added as a Medicaid covered service in Michigan. The trainings will be offered in partnership with the statewide family organization as well and should be rolled out in early FY16.

Another key component of SOC that has been addressed recently is cross-system funding. Previously MDCH and MDHS (Now MDHHS) committed to a collaborative partnership which has expanded the SEDW DHS pilot to 36 counties, including current and former SAMHSA SOC grantee sites in Michigan. The waiver sites provide comprehensive mental health services, including wraparound, to children in foster care. This initiative provided the impetus for further collaboration between MDCH and MDHS (now MDHHS) to provide services to additional children in the child welfare system who may not meet the criteria for the SEDW but who still require specialized mental health services. MDHHS provides the state match to Medicaid for both these projects in order to increase access to mental health services through CMHSPs/PIHPs for children in foster care and child protective services levels 1 and 2. Also in the past, Mental Health Block Grant funds were used as seed money to establish SEDW Access positions, located at the local MDHHS office, at SEDW sites to provide mental health screening, assessment and liaison functions to facilitate children being identified and enrolled in appropriate mental health services. These efforts have been integral in assisting MDHHS in responding to the consent decree that was the result of the Dwayne B. v. Granholm (2006) lawsuit (that requires, among other things, MDHS to provide improved screening and access to mental health services for children in foster care) and will continue to assist in the response to the revised consent decree Dwayne B. v. Snyder (2011) as well as to sustain a stronger SOC for children in the child welfare system in Michigan. Now that MDCH and MDHS are merged into the same department, the hope is that funding and administration of these types of programs will be streamlined.

MDHHS staff have also worked closely with present and former SAMHSA SOC grantee sites (in Kent County, Saginaw County, Southwest Detroit, Ingham and Kalamazoo counties) to provide leadership in collaborative efforts to develop SOC in their communities and impact state level efforts. MDHHS staff have regular meetings with sites to discuss strategies, progress, outcomes and sustaining the gains made during the grant period. The lessons learned by these sites provide a wealth of knowledge about what has been successful and what has been challenging in implementing SOC at a local level. Also, Detroit Wayne Mental Health Authority in partnership with the American Indian Health and Family Services was awarded a SOC expansion grant in FY14 that is ongoing. Some of the very important goals of this project are to strengthen, expand and sustain the SOC values and principles; to develop sustainable sources of funding; and to offer culturally and linguistically relevant services to children/youth with SED in Wayne County, specifically Native children, youth and families who are "out of balance and challenged by spiritual unrest. This is a unique project in the state and Michigan hopes to utilize lessons learned through this process to enhance services to minority youth and family populations statewide.

INDIVUDALS WITH SUBSTANCE USE DISORDERS (SUD)

The BHDDA currently allocates Substance Abuse Prevention and Treatment (SAPT) Block Grant funding through the 10 regional PIHPs, whose responsibilities include planning, administering, funding and maintaining the provision of substance abuse treatment and prevention services for Michigan's 83 counties. All PIHPs have Prevention Coordinators (PCs), who receive input from and empower local communities in their response to substance abuse prevention needs. The PIHPs are required to provide outpatient services (including intensive outpatient), residential services, medication-assisted treatment, case management, early intervention, peer recovery and recovery support, prevention, and integrated treatment for co-occurring mental health and substance use disorders.

In FY09, BHDDA embarked on a recovery oriented system of care (ROSC) transformational change initiative. This initiative changes the values and philosophy of the existing substance use disorder (SUD) delivery system from an acute crisis orientation to a long term stable recovery orientation. Michigan's ROSC definition was adopted on September 20, 2010 as follows: *Michigan's recovery oriented system of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The opportunities established through collaboration, partnership and a broad array of services promote life enhancing recovery and wellness for individuals, families and communities.*

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

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

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

PIHPs are expected to employ the six Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP) strategies to engage

individuals and the community to effect population-based change. This multi-component and strategic approach should cover all age groups including support for children, senior citizens, all socio-economic classes, diverse cultures, minority, and under-served populations, service men and women, gender-specific, and targeted high-risk groups. As part of the BHDDA strategic plan, the following has been identified as prevention priorities through FY2016.

1. Reduce childhood and underage drinking.
2. Reduce prescription drug and opioid abuse/misuse.
3. Reduce youth access to tobacco (Synar and Synar-related activity).
4. Address an identified local priority based on epidemiological evidence.

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

Early Identification

Screening, Brief Intervention and Referral to Treatment (SBIRT), an evidence-based practice used to identify, reduce and prevent problematic use, abuse, and dependence on alcohol and illicit drugs will be further developed and implemented in Michigan as part of early identification efforts. The SBIRT model was incited by an Institute of Medicine (IOM) recommendation that called for community-based screening for health risk behaviors, including substance use. Three major components are involved in SBIRT: (1) Screening—a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools; (2) Brief Intervention—a health care professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice; and (3) Referral—a healthcare professional provides referral to additional services, if needed. SBIRT has more recently been applied to identify and prevent risky substance use among adolescents, and has been shown to be effective in reducing substance abuse in this population. Many components of SBIRT models are also applicable to prevention strategies that address Problem Identification and Referral (PIR). Community coalitions across the state have been collaborating with primary care entities such as Federally Qualified Health Centers (FQHCs) and other primary care agencies, such as hospitals, local public health departments (LPHDs) clinics and school-based health centers to: employ SBIRT to youth and young adults at risk for substance use disorders; refer youth and young adults to evidence-based practices proven to be effective in reducing substance use disorders, primarily, underage drinking and prescription drug and illicit opioid misuse and abuse; to administer evidence-based practices. These efforts will be expanded not only geographically in Michigan, but also to include adults.

Treatment is intended to assist those individuals identified as having a substance abuse or dependence diagnosis. Each regional PIHP utilizes an Access Management System (AMS) that acts as a gatekeeper to publicly funded services in their region. Through the AMS, individuals and their families are screened and referred to services at the appropriate level of care, and the provider of their choice. Just as the SSA maintains contracts with the regional PIHPs, the PIHPs maintain contracts with their provider panel for publicly funded services to ensure that policies and procedures are followed and a baseline for services is maintained statewide. As indicated, there is a baseline expectation for service provision statewide, however, services above the baseline vary by region and are frequently based on the identified needs of the region's

population. Each region is required to maintain and adhere to a cultural competency plan that includes population demographics, hiring expectations and practices at the PIHP and provider level based on the demographics of the regional population, practices that are in place to ensure appropriate cultural training for staff and culturally appropriate resources for the individuals accessing services. The service delivery system is the same for adults and adolescents, and an adolescent or parent would contact the AMS to initiate services for the adolescent.

Recovery Support Systems are a network of supports put into place to assist an individual in maintaining their recovery or sobriety. These supports can be in the form of, but not limited to, peer mentors, recovery coaches, aftercare programming, employment assistance, housing assistance, educational counseling, supportive housing and a commitment to supporting an individual throughout their recovery journey. Recovery supports are organized at the regional level, and vary by PIHP. Michigan has developed a Recovery Coach Technical Advisory for the SUD field and a Recovery Coach Curriculum and Credentialing Advisory group has been convened for the purpose of developing recommendations for state certification. The group has been meeting on an ongoing basis. We are receiving technical assistance from SAMHSA and about Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) with a national consultant from the Center for Social Innovation. Training opportunities for peer recovery support specialists and coaches were offered regionally in FY 2013 and 2014.

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

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

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

Children and youth who are at risk for mental, emotional and behavioral disorders, including but not limited to addiction, conduct disorder and depression: This population is not served through the SUD treatment system, but can access prevention and mental health services.

Women who are pregnant and have a substance use and/or mental disorder: Pregnant women, as a priority population, have immediate access to SUD treatment services. Specialty services for pregnant and parenting women are available at all levels of care, and children entering treatment with their mothers are also assessed for needs. Referrals to appropriate services are made and followed up on to ensure that family needs are being met. Many programs that offer SUD services to pregnant women are also considered to be co-occurring capable and can address most mental health needs. If a pregnant woman is not able to participate in treatment services

immediately, she is offered interim services and connected with the regional women's treatment coordinator for follow up.

Parents with substance use and/or mental disorders who have dependent children: There is one residential program in Michigan that is able to accommodate an entire family (both parents and children) in SUD treatment. Several other residential programs are able to accommodate women and their children, and at the outpatient level, ancillary services such as child care are offered both to mothers and fathers who are primary caregivers. Michigan law ensures parents at risk of losing their children to the child welfare system are a priority population in Michigan and are able to access SUD treatment services immediately.

Military personnel (active, guard, reserve and veteran) and their families: Military personnel without other resources are able to access the publicly funded system as needed. To date, there are no specially focused programs to meet their needs, but regions are working to train clinical staff in the needs of the military population and the challenges they face. As often as possible, we encourage those military personnel with benefits to access services through the Veteran's Administration.

American Indians/Alaska Natives: There are twelve federally recognized tribes in Michigan. Each tribe provides substance abuse services to the tribal citizens residing in their specified tribal service area. The array of services provided by each tribe is variable, ranging from limited outpatient services to a more comprehensive array of prevention and treatment services. The Indian Health Services does provide limited resources to Michigan tribes for substance abuse services through PL 93-638 contracts and compacts. However, many tribal citizens reside outside the tribal service areas in urban communities. For these citizens, the American Indian Health and Family Services provides outpatient treatment and prevention services to the Detroit American Indian community and the Grand Rapids community receives limited services from the Grand Rapids office of the Nottawaseppi Huron Band of the Potawatomi.

Citizens of Michigan tribes experience health disparities unlike any other population in Michigan with higher rates of substance use disorders amongst youth, chronic alcohol and drug use, Fetal Alcohol Spectrum Disorder, suicide rates, as well as depression and --PTSD. Tribal citizens face unique challenges in their efforts to access effective substance abuse services. These challenges include; limitations on the array of services available from tribes and tribal organizations, limitations on the availability of non-tribal culturally competent services, limited access to funding, over-reliance on grant funding, and geographic barriers.

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

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

Persons with or at risk for HIV/AIDS and who are in treatment for substance abuse: Each PIHP must assure staff knowledge and skills in the provider network are adequate and appropriate for

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

Although not required, targeted services are also provided for the following populations:

- Individuals with mental and/or substance use disorders who are homeless or involved in the criminal or juvenile justice systems.

- Individuals with mental; and/or substance use disorders who live in rural areas.

- Underserved racial and ethnic minority and Lesbian, Gay, Bisexual, Transgendered, and questioning (LGBTQ) populations.

- Persons with disabilities.

- Community populations for environmental prevention activities, including policy changing activities, and behavior change activities to change community, school, family and business norms through laws, policy and guidelines and enforcement.

- Community settings for universal, selective and indicated prevention interventions, including hard-to-reach communities and “late” adopters of prevention strategies.

Planning Steps

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

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

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

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative[18] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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[18] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

ADULTS AND CHILDREN WITH SUBSTANCE USE DISORDERS

Implemented as part of the Strategic Prevention Framework/State Incentive Grant (SPF/SIG), Michigan continues to maintain a functioning epidemiological workgroup. The State Epidemiological and Outcomes Workgroup (SEOW) is a standing workgroup under the auspices of the Recovery Oriented System of Care (ROSC) Transformation Steering Committee (TSC). The chairperson of the SEOW (or his/her designee) attends TSC meetings to not only provide input into the overall ROSC efforts from a SEOW perspective, but also to be available as a resource to the TSC if data needs are identified. Recommendations from the SEOW will be made to the TSC, which in turn will make recommendations to OROSC for ultimate decisions. The project director for the SEOW is an OROSC staff member, as are the SEOW epidemiologist and the SEOW liaison.

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

The primary activities of the SEOW for FY 2015-2016 will be to: 1) expand the scope of the SEOW to include treatment and recovery (not just prevention) and to include mental health disorder prevention and treatment, as well as mental health promotion; 2) continue to gather new data as it becomes available, particularly around prescription and over-the-counter drug abuse; 3) analyze data being gathered, and serve as a resource for both the state and local Community Epidemiology Workgroups (CEWs); 4) continue work on establishing a web-based central data repository for Michigan that can be easily accessed and updated; and 5) evaluate and prioritize continued data gaps, and develop plans for filling these gaps.

The SEOW is chaired by the Provider Network Administrator of the Mid-State Health Network Regional Prepaid Inpatient Health Plan (PIHP), Community Mental Health Authority of Clinton, Eaton, and Ingham Sub Regional Entity (CMHA-CEI SRE). Membership on the SEOW includes representatives of various state-level departments including Michigan Department of Education, Michigan State Police, and various divisions and administrations within MDHHS including epidemiology, local health services, mental health, and SUD treatment. In addition, community coalitions, and the Michigan Primary Care Association are represented on the SEOW. As of January 31, 2015, the following are SEOW members:

Member Name	Organization	Workgroup Affiliation
Elizabeth Agius	Wayne State University	Member/Evaluator
Dr. Lorri Cameron	MDHHS, Division of Environmental Health	Member
Rebecca Cienki	Michigan Primary Care Association	Member
Lisa Coleman	Region 10 PIHP: Genesee Health System	Member
Denise Herbert	Network 180	Member
Joel Hoepfner	Community Mental Health Authority of Clinton, Eaton, and Ingham Sub Regional Entity (CMHA-CEI SRE)	Member/Chairperson
Charlotte Kilvington	Michigan State Police	Member
Kim Kovalchick	Michigan Department of Education	Member
Mary Ludtke	MDHHS, Mental Health	Member
Dr. Corinne Miller	MDHHS, Bureau of Disease Control, Prevention, and Epidemiology	Member
Dr. Su Min Oh	MDHHS/BHDDA (Prevention)	Member/SEOW Epidemiologist/Staff Liaison
Larry Scott	MDHHS/BHDDA (Prevention)	Member/SEOW Project Director
Angela Smith-Butterwi	MDHHS/BHDDA (Treatment)	Member
Brenda Stoneburner	MDHHS/BHDDA (Prevention)	Member

The following represent data sources used by the SEOW:

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

Based on the 2012-2013 NSDUH, an estimated 784,000 individuals aged 12 or older in Michigan needed treatment for an illicit drug or alcohol use problems (9.4% of the population aged 12 or older). Among the 784,000 individuals 12 or older who needed treatment for an illicit drug of alcohol use problem, an estimated 95,000 individuals received treatment at a specialty facility. This means that 689,000 individuals needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty facility in the past year. An estimated 49,000 adolescents aged 12 to 17 needed treatment for an illicit drug or alcohol use problem, 2,000 adolescents (4.2%) received treatment at a specialty facility. Among the 47,000 adolescents aged 12 to 17 who were classified as needing substance use treatment but did not receive treatment at a specialty facility in the past year, 1,000 (1.9%) reported that they perceived a need for treatment for their illicit drug or alcohol use problem. An estimated 736,000 individuals aged 18 or older needed treatment for an illicit drug or alcohol use problem, 93,000 (12.6%) received treatment at a specialty facility. Of the 643,000 individuals aged 18 or older who were classified as needing substance use treatment but did not receive treatment at a specialty facility, 15,000 (2.3%) reported that they perceived a need for treatment for their illicit drug or alcohol use problem.

According to TEDS, the number of persons reporting opiates as primary drug of substance at admission to publicly funded programs increased over the last 10 years, it peaked in 2011 and has not reached that level since. In 2013, among those reporting opiates other than heroin as the primary drug of substance at admission, 47% were adults aged 26 to 35 and 23% were young adults aged 18 to 25. Similarly, the number of persons reporting heroin as primary drug of substance increased steadily during the past decade, from 7,935 in 2003 to 13,641 in 2013. Of the 13,641 admissions, 39% were adults aged 26 to 35 and 23% were young adults aged 18 to 25.

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

The findings for Michigan youth include:

- Between 2004 and 2013, alcohol-related traffic crashes involved at least one driver, aged 16-20, who had been drinking, caused an annual average of 158 deaths and serious injuries.
- In 2013, underage alcohol use cost Michigan taxpayers $1.9 billion dollars.
- In 2013, 1,149 youth, 16-20 years-of-age, were admitted for alcohol as the primary drug of abuse in Michigan, accounting for 22.1.8% of all substance abuse treatment admissions.
- In 2013, 11.8% of Michigan 9 through 12thth grade students smoked cigarettes on one or more of the past 30 days and 7.1% of students had smoked daily.
- In 2013, 14% of Michigan youth reported having seriously considered suicide and 9% students reported having attempted suicide one or more times.
    - In comparison, 43% of Sexual Minority Youth in Michigan reported having considered attempting suicide; 32% had made a suicide attempt; and 12% had made a suicide attempt that needed to be treated by a doctor or nurse in the prior 12 month period.

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

- Between 2004 and 2013, alcohol-related traffic crashes involving at least one driver, 21 years of age or older, who had been drinking, caused an average of 1,107 deaths and incapacitating injuries.

- In 2013, an estimated 6.2% of individuals over the age of 18 years old were heavy drinkers and 18.9% of them were binge drinkers.
- In 2012, the prescription drug overdose death rate was the highest for adults 35 to 54 years of age.
- In 2013, prescription drugs totaled 8,464 treatment entrances for individuals 21 years of age of older, accounting 9.2% of all substance abuse treatment admissions.
- Between 2003 and 2012, young adults 18 to 25 years of age in Michigan, had higher rates of nonmedical use of pain relievers, compared to youth 12 to 17 years of age and adults 26 years of age or older.
- Between 2011 and 2012, 7.4% of adults 18 years of age and older reported experiencing major depressive episode and 4.5% of adults reported serious mental illness.
- In 2013, Michigan's age-adjusted suicide rate was 12.9 per 100,000 with the rate of death for males, four times higher than for females (20.7 and 5.6 respectively).

Primary indicators used in assessing community needs include: nonmedical use of pain relievers, level of past 30 day use of alcohol and binge drinking among youth aged 12 to 20, alcohol involved death and serious injuries, past year psychological distress, past year major depressive episode, and age adjusted suicide rates.

As a result of this work, unmet service needs and critical gaps have been identified as follows:
- Reducing childhood and underage drinking
- Reducing prescription drug and over-the-counter (RxOTC) misuse and abuse
- Reducing opioid abuse
- Reducing youth access to tobacco
- Reducing suicide
- Greater collaboration between primary care and prevention providers, including coalitions.
- Greater collaboration between Tribal entities in the collection of data relevant to the severity, incidence, prevalence and trends related to substance use and mental health disorders.
- Training and technical assistance in implementing evidence-based practices effective in reducing childhood and underage drinking, youth access to tobacco, prescription and over-the-counter drug misuse and abuse, and suicide.

In addition to the above unmet service needs and critical gaps, based on recent data and changes occurring in Michigan, the following issues are being added as priorities:

1. Identify current and improve data collection among LGBT populations and evaluation of programs and practices targeted toward LGBT populations, as well as mainstream programs that serve LGBT clients.
   According to the Institute of Medicine (IOM) (2011), LGBT populations are at substantially greater risk for substance abuse and mental health problems. LGBT people are more likely to use alcohol and drugs and to continue heavy drinking into later life. In addition, they are more likely to have higher rates of substance use disorders and less likely to abstain from using alcohol and drugs. Gay men, lesbians and male-to-female transgender persons experience methamphetamine use as a significant problem. A multistate study of high school students found a greater likelihood of engagement in unhealthy risk behaviors such as tobacco use, alcohol and other drug use, suicidal behaviors and violence among LGB students. Current known data sources are limited in

Michigan. There is a need and desire to improve data collection, as well as identify and implement evidence based programs and practices to address this target population.

2. Adolescent Treatment
   The current system of care reflects poor penetration rates for the treatment of adolescents with less than 10% of those with an identified need, receiving substance use disorder (SUD) treatment services. In addition, there is no identified mechanism for conducting effective outreach to this population, direction for collaboration with referral sources, or linking to resources. There is also low use of integrated treatment and recovery support services for this population. Approximately 40% indicate a co-occurring substance use and mental health disorder. In order to be effective, more providers should be utilizing co-occurring treatment services to treat the population. In addition, the longer this population and their families are involved in services, the better their recovery potential. Due to only a small number of providers utilizing recovery supports, approximately 4%, families do not have access to services after formal treatment ends.

3. Recreational Marijuana
   There is no state legalization bill currently in play, but 15 Michigan cities, including Detroit and Lansing (the state capital) have already legalized the possession of small quantities of pot for private use. Nationally, perceived risk of marijuana use among students in 8th, 10th, and 12th grades decreased by 38% over the last 10 years. Fewer teens now believe using marijuana is harmful. Coinciding with the declining perceived risk nationally, marijuana use in the last 30 days among high school students increased, from 20.2% in 2005 to 23.4% in 2013. During this time period, the prevalence of marijuana use among Michigan high school students remained the same at 18 percent. Laws legalizing recreational marijuana can lead to easier access of marijuana by children and youth. There is a need to keep marijuana out of hands of children and youth and implement strategies to prevent marijuana use among minors given current movement of legalized marijuana.

4. Increase in Prescription Opioid Use
   Data from the death certificates file indicate that, from 2002 to 2013, deaths due to heroin and prescription opiate overdose rose from 213 to 840 (rates of 2.1 to 8.5 per 100,000 population.). Recent NSDUH surveys (2012-13) reported that 4.8% of Michigan residents, 12 or older, reported nonmedical use of pain relievers in the past year. Drawing upon these NSDUH surveys, the estimated prevalence of illicit drug dependence or abuse in the past year for Michigan was 3.0% among persons aged 12 or older. The Medication Assisted Treatment (MAT) workgroup was created to address issues related to opiate use, abuse, and addiction within the OROSC. In 2014, the MAT workgroup enhanced and refined the SAMHSA's Guidelines for the Provision of Medication Assisted Treatment Services for Opiate Use Disorders to be specific to Michigan. However, some areas of the state require more time to fully implement these guidelines.

CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

According to 2014 US Census figures, Michigan is the 10th most populous state in the United States with an estimated population of 9,909,877, with approximately 2,246,890 of those residents being children ages 0-17. Prevalence data supplied by the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2013 National Outcome Measures Prevalence Report suggests 6-12% of the 1,184,104 children from ages 9 to 17 in Michigan could be identified as having a serious emotional disturbance (SED). That means anywhere from 71,046 to 142,092 children ages 9 to17 might have been eligible for services in the public mental health system in 2013 alone. However, data compiled by MDHHS for FY13 indicates 42,789 children (ages 0 through 17) with SED were served in the public mental health system in Michigan. Improvement in identifying and engaging children who may be in need of mental health services in Michigan is needed.

In March 2015, 13,201 children were residing in out-of-home foster placements per MDHHS. According to the Michigan Department of Education (MDE) the statewide high school drop-out rate in 2014 was 9.61%, which has shown steady improvement over the past 4 years but continues to be higher than desired. According to the Michigan Council on Crime and Delinquency, Michigan ranks 2nd highest in the country for juvenile life without parole sentences, with over 350 inmates sentenced to die in prison for crimes they committed when they were children. Data reported on the National Center for Children in Poverty website (http://nccp.org/publications/pub_687.html#26) indicates nationally that up to 44% of youth with mental health problems drop-out of school; up to 50% of children in the child welfare system have mental health problems; and 67 to 70% of youth in the juvenile justice system have a diagnosable mental health disorder. Finally, 75 to 80% of children and youth with mental health problems do not receive needed services nationwide. When considering this national data, it is clear that a significant percentage of the children and youth represented in the Michigan education, child welfare and juvenile justice statistics have SED and are not receiving needed services. A collaborative approach to addressing the needs of these children/youth and families is needed to achieve better outcomes for the children/families involved.

Michigan's fiscal climate has shown some improvement in the last few years. According to the State of Michigan's "Mi Dashboard" (http://www.michigan.gov/midashboard/0,1607,7-256-58012---,00.html) the unemployment rate in Michigan was 6.7% in November 2014 which was better than previous years but remained 0.9% above the national average of 5.8% for that same time. According to the Michigan League for Public Policy's 2015 Kids Count in Michigan Data Book, (http://www.mlpp.org/misc/KidsCount2015_FINAL_RGB_WEB.pdf) child poverty actually worsened in Michigan as the state was experiencing economic recovery. In 2013 one of every four children in the state lived in a family with income below the poverty level and half of these children live in extreme poverty (income less than half the poverty level). According to information provided by SAMHSA in the 2013 National Outcome Measures Prevalence Report, Michigan is 29th in the national poverty ranking. MDHHS' May 2015 Medicaid enrollment data indicated that 1,688,402 Michigan residents were eligible for Medicaid in that month. Of those eligible residents, 926,359 or 54.87% were children ages 0-17. Medicaid births in Michigan are now approximately 50% of all births. According to the Child Trends Data Bank (http://www.childtrends.org/?indicators=children-in-poverty,) poverty is related to increased

risks of negative health outcomes for young children and adolescents. When compared with all children, poor children are more likely to have poor health and chronic health conditions. As adolescents, poor youth are more likely to suffer from mental health problems, such as personality disorders and depression. Moreover, in comparison to all adolescents, those raised in poverty engage in higher rates of risky health-related behaviors, including smoking and early initiation of sexual activity. Poverty in childhood and adolescence is also associated with a higher risk for poorer cognitive and academic outcomes, lower school attendance, lower reading and math test scores, increased distractibility, and higher rates of grade failure and early high school dropout. Poor children are also more likely than other children to have externalizing and other behavior problems, or emotional problems, and are more likely to engage in delinquent behaviors during adolescence. Poverty continues to be a major issue for children in Michigan. It is prime time for partnerships to be forged to attempt to meet the needs of Michigan's children and families collaboratively on a larger scale.

The recent dire fiscal climate in Michigan resulted in fewer resources for all child-serving systems and the funding and support for such resources has not bounced back. This is unfortunate, but helped to create an environment where the former MDCH and MDHS (now MDHHS) were open to collaborating and matching funds which resulted in the SEDW pilot project. The project has helped the child welfare system to realize that the expertise of the mental health system may assist them in their vision of better outcomes for children. It also has helped the mental health system develop a sense of responsibility for children that are in the child welfare system. There are opportunities to improve fiscal efficiencies and to re-direct dollars from ineffective, costly out-of-home models into effective community-based models inherent in this partnership. The MDHHS SEDW Pilot continues to demonstrate fiscal saving and better outcomes for children and families which has acted as a catalyst for other collaborative projects. And now that the two departments have merged, there is hope that administrative and fiscal barriers may be reduced.

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

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

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

ADULTS WITH SERIOUS MENTAL ILLNESS (SMI)

Michigan's estimated population was around 9,891,487 persons from 2012 to 2013 as reported by the United States Census Bureau. Of that number 77.1% were over the age of 18, constituting an estimate of 7,631,788 adults. Per the 2012-2013 data set provided by the National Survey on Drug Use and Health (NSDUH), 4.14% of all American adults (approximately 12.8 million) were estimated to have serious mental illness. The NSDUH is also a source of estimating the prevalence, or total number of Michigan adults for the period of 2012-2013 with serious mental illness. According to the survey, 4.69% of Michigan's adult population have serious mental illness, with the confidence interval range between 4.06% and 5.42%, and predictive of a Michigan's adult SMI population between 401,594 and 536,118.

These figures suggest a significant gap between the prevalence of serious mental illness estimated in Michigan's adult population and the penetration of public sector mental health services. It is unlikely that the differential can be fully accounted for by the cohort of SMI adults served in the private-sector, or via other systems. Clearly, improvement in identifying, engaging, and serving adults who may be in need of public sector mental health services in Michigan is needed. This gap between prevalence and service penetration continues to support the global need for greater availability of and access to care for Michigan's adult serious mental health population. There are needs that block grant resources can assist in meeting.

There were 167,931 adults served through Michigan mental health services in 2013, and nearly 60% of them met the federal definition of having a serious mental illness. In each NSDUH survey asked from 2009 to 2013, more than half (56.5%) of about 648,000 Michigan adults with any mental illness did not receive treatment or counseling in the year prior to data collection. Of persons with serious mental illness, 37.1% (2012) and 31.5% (2013) of the adult Michigan respondents did not receive mental health counseling or treatment.

The 2012-2013 NSDUH revealed that a greater proportion of young adults (ages 18 to 25) in Michigan (5.35%) suffered serious mental illness than in the nation overall (4.17%). Estimates for Michigan's adults aged 26 and older suggest slightly higher serious mental illness within the prior year (4.58%) when compared to the national average (4.14%) as well. At the national level, higher proportions of women have been experiencing serious mental illness than men during young adulthood and throughout the adult age ranges, only declining after age 60 to proportions lower than male counterparts.

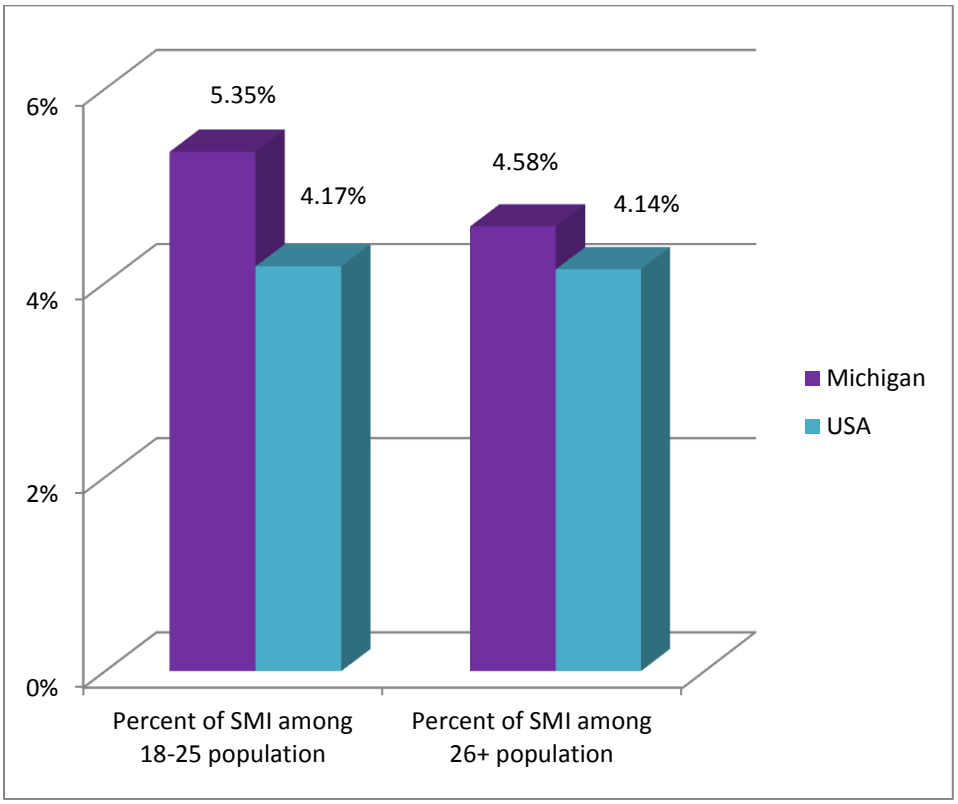


Figure 1 Proportions of Serious Mental Illness in Michigan and the United States, 2012-2013

According to 2012-13 NSDUH findings regarding any mental illness experienced within the prior year, Michigan's young adults in the 18-25 age range were comparable, but slightly higher in proportion(21%%) to the national average (19%%) . Findings of any mental illness for Michigan adults aged 26 and older were similar (19.9%) when compared to the national average (18.3%).

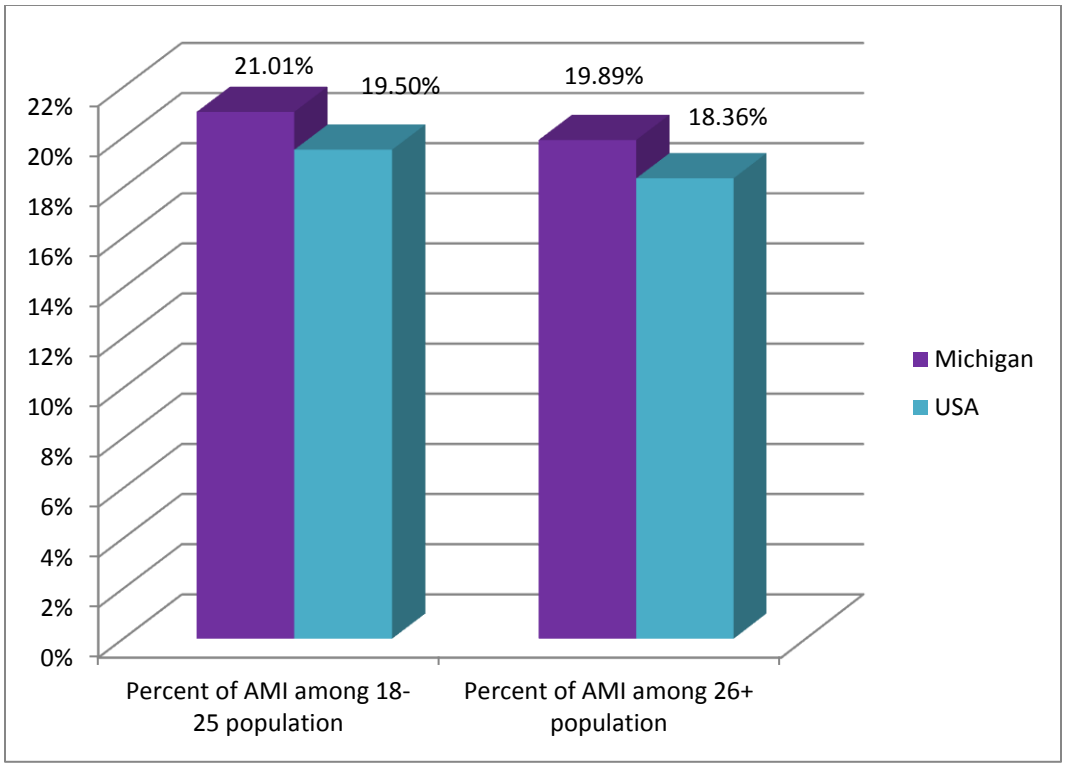
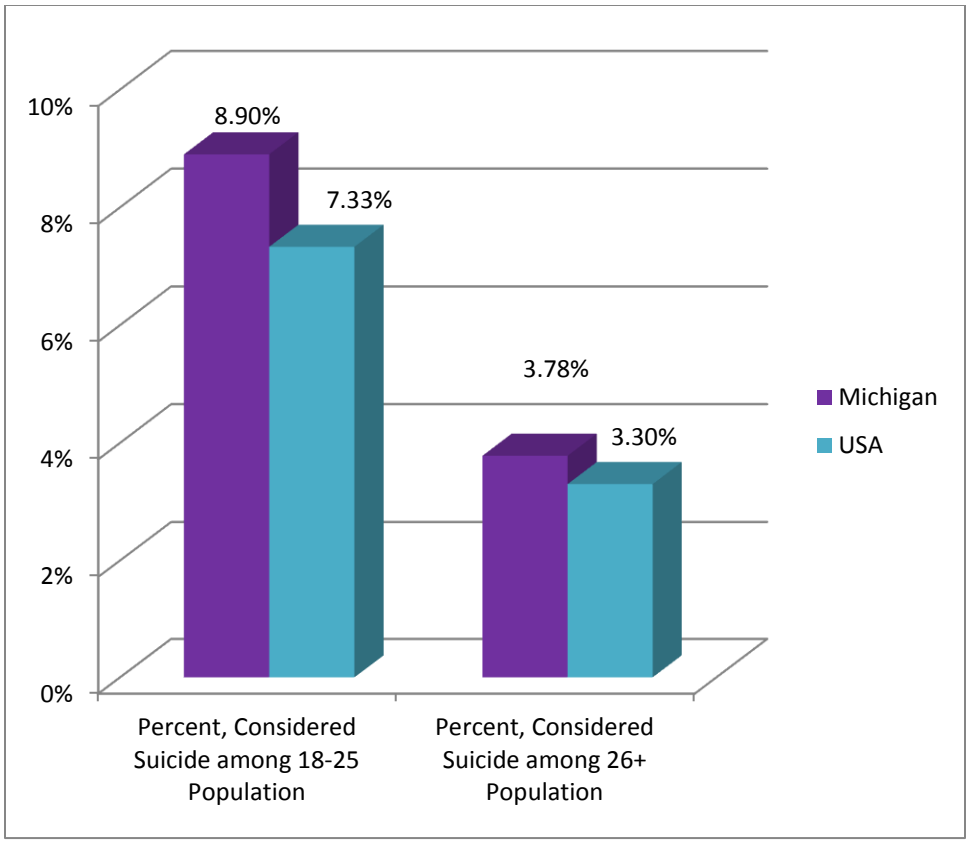


Figure 2 Proportion of Any Mental Illness, by Age, Michigan and United States, 2012-2013

An additional indicator that demonstrates the need for public mental health services in Michigan is suicidality. More Michigan citizens than other national respondents to the NSDUH reported having past-year suicidal thoughts from 2009 to 2013. More than 4% (4.2, 4.5, 4.4, and 4.5% in the respective survey years) of all Michigan adults had considered suicide. According to data provided by the Michigan Division for Vital Records & Health Statistics, Michigan's 2013 age-adjusted suicide rate was 12.9 per 100,000 individuals, where the figure has hovered since 2010 and demonstrates an increase from the 2009 rate of 11.3 per 100,000. As is true with national tendencies, more Michigan deaths confirmed as suicide have been male. Of 1,296 suicides for all ages in 2013, 78% (1,013) of the decedents were male and 22% (283) were female. In 2013, intentional self-harm or suicide was the tenth leading cause of death in Michigan and in the nation.



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

Data supplied by SAMHSA's 2011 Mental Health National Outcome Measures report appears to indicate that Michigan continues to lag behind the reported national average in each of the following areas of adult evidence-based practice (EBP) delivery:

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

This may serve as one indicator of needful additional service development and implementation, and/or improvement in service reporting processes moving forward. For example, it is acknowledged that significant progress has been made in the development of a Medications Algorithm to guide the prescription practices of psychotropic medications, as a pilot project funded by Flinn Foundation grant resources. In the provider clinics that have adopted this or similar tools, positive outcomes are being reported, yet since this has not yet been adopted/implemented on a statewide basis, no standardized data has been available to include in SAMHSA's Mental Health NOMs report. In somewhat similar fashion, although a formal Illness Self-management practice (like the SAMHSA-endorsed Illness Management and Recovery model) has not been uniformly adopted in Michigan, illness self-management concepts and practices have been and are being adopted in a non-standardized fashion in various areas of the State, but not in a manner that is conducive to uniform reporting. Some of these methods include the use of peers to support self-management and the use of technology based processes that can be used through smart phone applications.

Family Psychoeducation continues to be utilized in areas around the state. Widespread implementation and ongoing use of this practice has been problematic, especially in the rural areas of the state. Budget constraints and staff turnover have made it difficult for providers to commit resources to the developing this program when other support services can be provided/offered to families. Michigan continues to support the development of this program by offering needed trainings and certification in this model of treatment.

Although the means currently exist to accurately capture the delivery of the IDDT-level of intensive Dual Diagnosis Treatment services, Michigan still has room to grow in working out improved identification, delivery, and capture of co-occurring disorder treatment services at lower levels of intensity. Michigan uses the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) and the Dual Diagnosis Capability in Addiction Treatment (DDCAT) to review program readiness and supporting the continued development and implementation of Dual Diagnosis Treatment services across the entire continuum of service type and intensity of need. Michigan utilizes a fidelity review support team to survey organizations and to offer ongoing technical assistance as the agencies seek to further develop their capacities to provide services. We further the support co-occurring disorder treatment by providing Motivational Interviewing training that is specific to the working with the co-occurring disorder population.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at http://www.samhsa.gov/data/quality-metrics/block-grant-measures. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

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:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

   Michigan's community behavioral health system has been collecting HIPAA compliant 837 encounter data as well as demographic data statewide since 2003. This behavioral health information is reported for the individual client, the providers as well as the program. Since 1992, Michigan's publicly-funded substance use disorder service delivery system has been collecting and reporting Treatment Episode Data SETS (TEDS) at the client and provider level. In 2010, a web-based data collection system for TEDS was developed to allow submitters to track submissions, fix errors, and monitor reported admissions and discharges. It currently operates on a batch production model, but there are plans to develop real time, HL7 updates of individual records.

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

   Michigan's behavioral health encounter and demographic information is housed with the state's Medicaid encounter system. The web-based, stand-alone application (referenced above under #1) is separate from Medicaid and will be expanded to collect demographic data on all persons receiving behavioral health services (MH and SUD). This application currently serves as a data collection system for all SUD TEDS records.

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client identifying information)?

   Yes, Michigan's collection of encounter and demographic data is at the individual level. Michigan's substance use disorder information is currently reported to SAMHSA via the TEDS data collection system at the client level. Michigan's mental health and SUD demographic data are being incorporated into SAMHSA's Behavioral Health (BH) TEDS for reporting to SAMHSA.

4. If not, what changes will the state need to make to be able to collect and report on these measures?

   Michigan is currently developing the collection and reporting systems to report BH-TEDS files to SAMHSA by December 2015. Specifications for these enhancements can be found on the MDHHS Reporting Requirements web site:

   http://www.michigan.gov/mdch/0,4612,7-132-2941_38765---,00.html

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: System of Care for Children/Youth with Serious Emotional Disturbance (SED) and Their Families

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Treatment outcomes for children/youth with SED and their families improve statewide.

Objective:

Outcomes are improved for children/youth with SED and their families through participation in a statewide SOC demonstrated by the measurable strategies below.

Strategies to attain the objective:

1. Develop a structure to expand the availability and access to a statewide comprehensive system of care (SOC) for children/youth and their families that includes improved treatment outcomes, using block grant funding in addition to other resources.

2. Engage system partners and stakeholders in the process of developing a statewide SOC.

4. Utilize block grant funding to support system improvement activities such as statewide PMTO and Trauma Informed Initiative for children with SED, state supported training and technical assistance in targeted areas such as co-occurring treatment, wraparound, home-based services, early childhood screening and assessment, family-driven and youth-guided service provision and peer-to peer parent and youth support activities.

5. Utilize block grant funding to support projects identified by CMHSPS to fill gaps in their local systems of care for services that improve outcomes for children/youth with SED and their families.

6. Utilize data to inform policy and program decision making and improvements.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percent of children assessed with the CAFAS statewide who demonstrate at least a 20 point (statistically significant) reduction in their overall CAFAS score from intake to discharge will increase in FY16 and again in FY17 from a baseline average obtained in FY14.

Baseline Measurement: FY14 Baseline = 56% of children assessed

First-year target/outcome measurement: FY16 Target = 58% of children assessed

Second-year target/outcome measurement: FY17 Target = 60% of children assessed

Data Source:

John Carlson, PhD and the Michigan Level of Functioning Project.

Description of Data:

Statewide aggregate CAFAS data

Data issues/caveats that affect outcome measures::

The data collection for this indicator will be changed in FY16 and we are hoping to see a more accurate representation of the progress children/youth make in treatment. Previously, we have only been analyzing data from one fiscal year at a time, however, treatment episodes from intake to discharge for many children/youth cross fiscal year boundaries. In FY16 we will be able to analyze data across fiscal years.

Indicator #: 2

Indicator: The number of children/youth with SED served in the public mental health system that receive wraparound services will increase in FY16 and again in FY17 from a baseline of number served in FY14.

Baseline Measurement: FY14 Baseline = 1,457 children served by Wraparound

First-year target/outcome measurement: FY16 Target = 1,500 children served by Wraparound

Second-year target/outcome measurement: FY17 Target = 1,550 children served by Wraparound

Data Source:

MDHHS Division of Quality Management and Planning state Fingertip Report.

Description of Data:

Numbers served in wraparound

Data issues/caveats that affect outcome measures::

None

Indicator #: 3

Indicator: The number of children/youth with SED served in the public mental health system that receive PMTO will increase in FY16 and again in FY17 from a baseline of number served in FY14.

Baseline Measurement: FY14 Baseline = 1,394 children received PMTO

First-year target/outcome measurement: FY16 Target = 1,410 children received PMTO

Second-year target/outcome measurement: FY17 Target = 1,430 children received PMTO

Data Source:

MDHHS Division of Quality Management and Planning state Fingertip Report

Description of Data:

Numbers served in PMTO

Data issues/caveats that affect outcome measures::

None

Indicator #: 4

Indicator: The number of children/youth with SED served in the public mental health system that receive Trauma-Focused Cognitive Behavior Therapy (TFCBT) will increase in FY16 and again in FY17 from a baseline of number served in FY14.

Baseline Measurement: FY14 Baseline = 635 children received TFCBT

First-year target/outcome measurement: FY16 Target = 650 children received TFCBT

Second-year target/outcome measurement: FY17 Target = 665 children received TFCBT

Data Source:

MDHHS Division of Quality Management and Planning state encounter data.

Description of Data:

Number served in TFCBT

Data issues/caveats that affect outcome measures::

None

Indicator #: 5

Indicator: The number of certified Parent Support Partners trained to work in the public mental health will increase in FY16 and again in FY17 from a baseline of number trained in FY14.

Baseline Measurement: FY14 Baseline = 85 Parent Support Partners certified

First-year target/outcome measurement: FY16 Target = 100 Parent Support Partners certified

Second-year target/outcome measurement: FY17 Target = 115 Parent Support Partners certified

Data Source:

Michigan Parent Support Partner Training Project

Description of Data:

Number of Parent Support Partners trained

Data issues/caveats that affect outcome measures::

None

Priority #: 2

Priority Area: Enhanced Partnerships

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Enhanced partnerships exist to serve children/youth with SED and their families, including traditionally underserved populations, using block grant funds and other resources; that reduce duplication of efforts.

Objective:

The number of children/youth with SED and their families effectively served by collaborative projects will increase in FY16 and again in FY17 from FY14 baseline.

Strategies to attain the objective:

1. Continue to support the SED Waiver (SEDW).

2. Continue to support joint projects and foster the relationship between MDHHS child welfare, juvenile justice, child mental health, child and family health, MDE, State Court Administrative Office and other child serving systems to encourage more collaborative work.

3. Continue to pursue and support integrated physical health and behavioral health initiatives for children and youth with SED and their families.

4. Continue to utilize the 5% set-aside for integrated first episode psychosis services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of children enrolled in the SEDW will increase in FY16 and again in FY17 from FY14 baseline.

Baseline Measurement: FY14 Baseline = 621 children served by the SED Waiver

First-year target/outcome measurement: FY16 Target = 650 children served by the SED Waiver

Second-year target/outcome measurement: FY17 Target = 670 children served by the SED Waiver

Data Source:

SEDW Pilot Specialist

Description of Data:

Number of children enrolled in SEDW

Data issues/caveats that affect outcome measures::

None

Indicator #:	2
Indicator:	The number of youth who are involved in the juvenile justice system and need mental health services will be identified and served by the public mental health system.
Baseline Measurement:	FY14 Baseline = 1,729 youth served
First-year target/outcome measurement:	FY16 Target = 1,740 youth served
Second-year target/outcome measurement:	FY17 Target = 1,760 youth served

Data Source:

MDHHS Division of Quality Management and Planning state full 404 Report.

Description of Data:

Number of children served by mental health and juvenile justice system.

Data issues/caveats that affect outcome measures::

None

Indicator #:	3
Indicator:	The number of children served in integrated physical and mental health projects will increase in FY16 and again in FY17 from FY14 baseline.
Baseline Measurement:	FY14 Baseline = 857 children served
First-year target/outcome measurement:	FY16 Target = 880 children served
Second-year target/outcome measurement:	FY17 Target = 900 children served

Data Source:

Michigan Child Collaborative Care Project data

Description of Data:

Number of children served by integrated physical and mental health projects.

Data issues/caveats that affect outcome measures::

None

Indicator #:	4
Indicator:	The number of youth receiving co-occurring services will increase in FY16 and again in FY17 from FY14 baseline.
Baseline Measurement:	FY14 Baseline = 2,421 children served
First-year target/outcome measurement:	FY16 Target = 2,460 children served
Second-year target/outcome measurement:	FY17 Target = 2,470 children served

Data Source:

MDHHS Division of Quality Management and Planning Encounter data

Description of Data:

Number of children receiving co-occurring services

Data issues/caveats that affect outcome measures::

None

Indicator #: 5

Indicator: A baseline of young adults receiving RAISE model services through the 5% set-aside pilots will be obtained in FY16 and the number served will increase in FY17.

Baseline Measurement: FY16 Baseline = 75 young adults served

First-year target/outcome measurement: FY16 Baseline = 75 young adults served

Second-year target/outcome measurement: FY17 Target = 85 young adults served

Data Source:

5% set-aside contract manager

Description of Data:

Number of young adults receiving RAISE model services

Data issues/caveats that affect outcome measures::

None

Priority #: 3

Priority Area: Provide integrated treatment to adult SMI service recipients with co-occurring mental health and substance use disorders.

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

To improve the penetration of integrated co-occurring mental health and substances use disorder treatment services within the adult CMHSP provider network.

Objective:

Improvement in integrated treatment.

Strategies to attain the objective:

1. Continue to provide training to the CMHSP workforce on co-occurring disorders treatment knowledge and skills, including motivational interviewing, and other IDDT and/or DDCMHT framework domains areas.

2. Continue to provide IDDT and/or DDCMHT program site reviews and subsequent associated technical assistance/coaching input for advancing service development and implementation.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of program fidelity and ascertainment reviews will increase in FY16 and FY17 from its current level in FY15.

Baseline Measurement: FY15 Baseline = 22 reviews

First-year target/outcome measurement: FY16 Target = 24 reviews

Second-year target/outcome measurement: FY17 Estimate = 26 reviews

Data Source:

Michigan Fidelity Assessment Support Team (MIFAST) data from MDHHS Specialist tracking the number of reviews taking place.

Description of Data:

Reflects the number of reviews conducted that are monitoring the implementation and ongoing use of practices and/or readiness.

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: The number of behavioral health consumers receiving treatment services for co-occurring mental health and substance use disorders will increase in FY16 and FY17 from its current level in FY15.

Baseline Measurement: FY15 Baseline = 60,300

First-year target/outcome measurement: FY16 Target = 61,500

Second-year target/outcome measurement: FY17 Target = 62,750

Data Source:

MDHHS data warehouse, Quality Improvement Data (soon to be Behavioral Health TEDS)

Description of Data:

Count of adults receiving co-occurring disorder services

Data issues/caveats that affect outcome measures::

None

Indicator #: 3

Indicator: The number of CMHSP and/or Primary Care Provider staff receiving training and/or education on integrated behavioral and physical healthcare services will increase in FY16 and FY17 from its current level in FY15.

Baseline Measurement: FY15 Baseline = 560

First-year target/outcome measurement: FY16 Target = 700

Second-year target/outcome measurement: FY17 Target = 850

Data Source:

Integrated health learning community reports and attendance rosters.

Description of Data:

Count of the number of individuals participating in training and activities that are part of the Integrated Health Learning Collaborative

Data issues/caveats that affect outcome measures::

None

Priority #: 4

Priority Area: Promote and protect health, wellness and safety of consumers with serious mental illness who have contact with law enforcement.

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

To increase the safety of consumers with serious mental illness and to gain swifter access to services by means of referral or intervention of police

officers trained in Crisis Intervention Team Training (CIT).

Objective:

The health, wellness and safety of consumers with serious mental illness who have contact with law enforcement will be protected.

Strategies to attain the objective:

1. Leverage monies allocated to the Governor's Mental Health Diversion Council that would support pilots across the State who would use CIT as a model for their communities.

2. Give priority consideration (funding) to those communities that would use CIT as a primary means to help divert the mentally ill from jail on a pre-emptive basis for future pilot sites.

3. Provide support to pilots that have opted to utilize CIT as their primary innovation within their community by means of data sharing, access to resources and networking with other communities that have been successful in their efforts.

4. Utilize the efforts of the data and evaluation team from Michigan State University to analyze the progress of each pilot and note the amount of consumers with serious mental illness being served as a result of CIT intervention.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of CIT trained officers will increase in FY16 and again in FY17 from the FY14 baseline.

Baseline Measurement: FY14 Baseline = 103 officers trained

First-year target/outcome measurement: FY16 Target = 150 officers trained

Second-year target/outcome measurement: FY17 Target = 175 officers trained

Data Source:

MSU data and evaluation team

Description of Data:

Count of police, dispatch, and jail personnel trained from data evaluation team

Data issues/caveats that affect outcome measures::

None

Priority #: 5

Priority Area: Promote and protect health, wellness and safety of consumers with serious mental illness who have interactions with criminal justice systems.

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

To reduce the number of consumers with serious mental illness being arrested or incarcerated and to divert them to treatment.

Objective:

The health, wellness and safety of consumers with serious mental illness who have interactions with criminal justice systems will be protected.

Strategies to attain the objective:

1. Leverage monies allocated to the Governor's Mental Health Diversion Council to bolster efforts statewide in diverting consumers with serious mental illness through innovative, replicative, and cost effective pilots.

2. Provide support to pilots through data sharing, networking and regular contact to promote growth and cohesiveness within individual communities and all stakeholders.

3. Evaluate the effectiveness of pilots through data collection and evaluation efforts with Michigan State University to document success/hurdles.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of statewide pilots initiated through the Mental Health Diversion Council will increase in FY16 and again in FY17 from the FY14 baseline.

Baseline Measurement: FY14 Baseline = 5 statewide diversion pilots

First-year target/outcome measurement: FY16 Target = 6 statewide diversion pilots

Second-year target/outcome measurement: FY17 Target = 7 statewide diversion pilots

Data Source:

MSU data and evaluation team

Description of Data:

Count of pilot programs statewide from project reporting

Data issues/caveats that affect outcome measures::

None

Priority #: 6

Priority Area: Promote Healthy Births

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Healthy births will be promoted.

Objective:

Reduce infant mortality in the target population and increase the incidence of healthy, drug and alcohol free births.

Strategies to attain the objective:

1. Increase outreach to pregnant women to increase the population's access to treatment.

2. Provide extended case management to pregnant women to provide support after the treatment episode in order to promote a healthy birth.

3. Promote recovery support services to extend engagement and support retention.

4. Build capacity to provide trauma-informed care.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of reported drug free births

Baseline Measurement: FY12 Baseline = 200 drug free births reported by programs serving PWWDC

First-year target/outcome measurement: FY16 Target = 210 drug free births

Second-year target/outcome measurement: FY17 Target = 215 drug free births

Data Source:

Women's Specialty Services Report

Description of Data:

Raw count of women who enter treatment pregnant or become pregnant while in treatment and have a subsequent substance free birth, based on the results of meconium testing.

Data issues/caveats that affect outcome measures::

This measure must be tracked by hand and, if a woman leaves treatment unexpectedly, a program may never know if she has a healthy birth. MDHHS has worked diligently to ensure numbers are reported accurately and continue to encourage case management and recovery supports for pregnant women as they exit formal treatment.

Priority #: 7

Priority Area: Reduce IVDU wait times

Priority Type: SAT

Population(s): IVDUs

Goal of the priority area:

IVDU wait times will be reduced.

Objective:

Reduce the percentage of individuals waiting over 10 days to enter treatment by 10%.

Strategies to attain the objective:

1. Encourage case management services for IVDUs entering services to promote sustained recovery and manage the multiple issues that this population experiences when they participate in treatment services.

2. Work with regional Prepaid Inpatient Health Plans to manage wait lists and expand services as needed to limit wait times for methadone treatment.

3. Encourage the use of recovery support services to extend engagement and support retention.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Time to Treatment

Baseline Measurement: FY12 Baseline = 12.1% of individuals waiting over 10 days to enter treatment

First-year target/outcome measurement: FY16 Target = 9.7% of individuals

Second-year target/outcome measurement: FY17 Target = 8.7% of individuals

Data Source:

TEDS treatment admission record will be used to track the elapsed number of days between date of service request and actual services.

Description of Data:

Days of waiting are derived by subtracting the date of first request from the date of admission in the TEDS admission records.

Data issues/caveats that affect outcome measures::

None

Priority #: 8

Priority Area: Increased Access to Treatment

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Access to treatment will be increased.

Objective:

Increase the percentage of parents with dependent children who continue 14 days in residential treatment by 5%.

Strategies to attain the objective:

1. Outreach to collaborative partners to ensure that parents are identified as priority populations.

2. Ensure that programs identified as serving pregnant and parenting women are able to serve the entire family or have agreements for referral to other agencies.

3. Encourage the use of recovery support services to extend engagement and support retention.

4. Encourage case management services.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Parents with Dependent Children Access/Retention in Residential Care
Baseline Measurement:	FY12 Baseline = 36.3% of parents with dependent children who continue 14 days in residential treatment
First-year target/outcome measurement:	FY16 Target = 38.2% of parents with dependent children
Second-year target/outcome measurement:	FY17 Target = 39.2% of parents with dependent children

Data Source:

TEDS treatment admission and discharge data will be used to track the elapsed number of days between admission and discharge. Authorizations for stays less than 14 days would be excluded.

Description of Data:

Matched cases of admission and discharge TEDS data per individual in treatment.

Data issues/caveats that affect outcome measures::

None

Priority #:	9
Priority Area:	Increase the use of integrated services
Priority Type:	SAT
Population(s):	Other (Individuals with Co-occurring Disorders)

Goal of the priority area:

The use of integrated services will be increased.

Objective:

Increase the percentage of integrated treatment expenditures by 10%.

Strategies to attain the objective:

1. Encourage case management when an individual entering treatment is identified as having a co-occurring disorder (COD) to help manage the many issues resulting from their disorder.

2. Encourage regions to provide technical assistance to those agencies working to become co-occurring capable and enhanced.

3. Encourage the use of recovery support services to extend engagement and support retention.

4. Build capacity to provide trauma-informed care.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Percentage of Prepaid Inpatient Health Plan expenditures on integrated services for individuals with co-occurring disorders.
Baseline Measurement:	FY12 Baseline = 13.1% of expenditures
First-year target/outcome measurement:	FY16 Target = 14.4%
Second-year target/outcome measurement:	FY17 Target = 15.1%

Data Source:

Section 408 of the Legislative Report provides information on expenditures for integrated services for individuals with co-occurring disorders. TEDS admission and discharge data indicates those individuals who had HH modified encounters reported.

Description of Data:

Data are selected from line-item block grant expenditures per licensed provider and the integrated service sub-report.

Data issues/caveats that affect outcome measures::

None

Priority #: 10

Priority Area: Underaged Drinking

Priority Type: SAP

Population(s): Other (Adolescents w/SA and/or MH, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Childhood and underage drinking is reduced.

Objective:

Reduce childhood and underage drinking.

Strategies to attain the objective:

1. Increase multi-system collaboration to implement strategies identified in the Underage Drinking Strategic Plan.

2. Reduce adult abuse by engaging all segments of the community in establishing a recovery-oriented system of care and increase the use of brief intervention.

3. Engage parents and other adults in helping reduce underage drinking.

4. Community coalitions will implement at least one environmental or community based process strategy each year.

5. Continue to build and enhance community substance abuse prevention infrastructure and capacity by strengthening collaboration with primary care providers to implement screening, brief intervention and referral (SBIR)

6. Encourage the use of Communities that Care, Community Trials, Strengthening Families and Prime for Life.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Past 30 days use of alcohol among youth 9th - 12th grade will be reduced
Baseline Measurement:	FY11 Baseline = 30.5% of youth
First-year target/outcome measurement:	FY16 Target = 28.0%
Second-year target/outcome measurement:	FY17 Target = 25.0%

Data Source:

Michigan Profile for Healthy Youth (MiPHY); Youth Risk Behavior Survey; National Survey on Drug Use and Health (NSDUH); and Michigan State Police/Office of Highway Safety Planning (OHSP)

Description of Data:

Through the Michigan Department of Education, the MiPHY is administered during the years that the Youth Risk Behavior Survey is not conducted. The survey is intended to secure information from students in grades 7, 9, and 11, regarding health risk behaviors including substance abuse. The MiPHY results are extrapolated at the county level and are useful for data-driven decisions to improve prevention programming performed in the counties.

Data issues/caveats that affect outcome measures::

The limited number of school districts participating in the MiPHY has been a concern. Through efforts of the state and community coalitions and other stakeholders, attention has been given to community readiness and responsiveness to conducting the MiPHY, and the number of school districts now participating has increased substantially.

Priority #: 11

Priority Area: Youth Access to Tobacco

Priority Type: SAP

Population(s): Other (Adolescents w/SA and/or MH, Minors under 18 years)

Goal of the priority area:

Youth access to tobacco will be reduced.

Objective:

Reduce youth access to tobacco.

Strategies to attain the objective:

1. Synar and Non Synar compliance checks to discourage sells to minors - During annual Synar required inspection periods and Non Synar regionally scheduled phases throughout the year.

2. Reduction in the initiation of tobacco use among children, adolescents and young adults – Use of research-based practices and classroom curriculum / Ongoing.

3. Increased vertical driver's license education – Promote "Read the Red" and , Secretary of State awareness website / Ongoing.

4. Encouragement through positive community recognition – Mass media, Associated Food & Petroleum Dealers (AFPD) magazine feature and E-blast acknowledgment / Quarterly.

5. Increased merchant retailer education – OROSC ImprovingMIPractices.org free online certificated training / Ongoing; AFPD tobacco awareness article series / Quarterly; and One hundred percent birthdate and legal awareness signage mailing to all merchants on the state's tobacco Master Retail List / Annually.

6. Increased environmental efforts – "Kick Butts" annual smoking cessation day. Alliance with existing "Do Your Part" campaign using fact sheets, PowerPoint and video resources by developing an attention getting website for educators, merchants, parents and research resources for youth.

7. Increased collaborative enforcement efforts – Violation reports to Michigan Liquor Control Commission to increase licensing consequences and Michigan State Police for follow-up action by Tobacco Tax Enforcement Teams.

8. Sensitivity to cultural diversity - Aggregate information regarding targeted HR, minority and underserved populations from annual plans; Review best practice evidence-based interventions for specific populations; Set minimum state goal that 20% of populations identified by Census data must include HR populations.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Effect a 14% retail merchant sells rate to minors

Baseline Measurement: FY15 Baseline = 18.0% Michigan Retailer Violation Rate

First-year target/outcome measurement: FY16 Target = 16%

Second-year target/outcome measurement: FY17 Target = 14%

Data Source:

Annual Synar Survey

Description of Data:

The state must conduct a formal Synar survey annually to determine retailer compliance with the tobacco youth access law and to measure the effectiveness of the enforcement of the law. The state must achieve and maintain a youth tobacco sales rate of 20% or less to underage youth during the formal Synar survey.

Data issues/caveats that affect outcome measures::

Socio-economic factors that lead to reduced merchant diligence; low perception of law enforcement; low perception of health risk.

Priority #: 12

Priority Area: Health Disparities

Priority Type: SAP

Population(s): Other (LGBTQ)

Goal of the priority area:

Health disparities among LGBTQ youth and young adults will be decreased.

Objective:

Decrease health disparities among LGBT youth and young adults in relation to behavioral health issues.

Strategies to attain the objective:

1. Gather and review data from existing sources to establish baseline indicators on substance abuse and mental health issues among target population.

2. Provide funding to include question on sexual orientation on the 2016 BRFSS; identify other mechanisms to increase sources for data.

3. Once data is identified, prioritize indicators to monitor.

4. Evaluate effective evidence based prevention programs and practices for this target population in anticipation of future pilot projects once data is gathered.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase LGBTQ data sources

Baseline Measurement: TBD in 2016

First-year target/outcome measurement: TBD

Second-year target/outcome measurement: Increase sources for data collection by at least 50% from first year target.

Data Source:

Michigan Profile for Healthy Youth (MiPHY); Youth Risk Behavior Survey (YRBS); Behavioral Risk Factor Surveillance Survey (BRFSS); others to be determined.

Description of Data:

The MiPHY and YRBS have non-public data available on sexual minority youth, which is able to be obtained in summary form through collaboration with Department of Education. A question on sexual orientation has been added to the BRFSS for the coming year.

Data issues/caveats that affect outcome measures::

A limited number of data sources for this target population has been identified by the SEOW as a gap for a number of years. Simply identifying sources to gather and establish baseline data is a priority in 2016.

Priority #: 13

Priority Area: Marijuana Use

Priority Type: SAP

Population(s): Other (Youth)

Goal of the priority area:

Decrease marijuana use and increase awareness.

Objective:

Increase perceived risk of marijuana use and decrease marijuana use.

Strategies to attain the objective:

1. Develop a comprehensive strategic plan to prevent youth marijuana use.

2. Use fact sheets and infographics as a prevention tool to increase awareness of impact of marijuana use.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Perceived risk of marijuana use among 12 to 17 years old

Baseline Measurement: FY13 Baseline = 67.5% of youth among 12 to 17 years old

First-year target/outcome measurement: FY16 Target = 68.5%

Second-year target/outcome measurement: FY17 Target = 70.5%

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

The percentage of youth (12-17 years old) expressed either moderate risk or great risk of smoking marijuana once or twice week.

Data issues/caveats that affect outcome measures::

The availability of public use of NSDUH may hinder the reporting in a timely manner.

Indicator #: 2

Indicator: Past 30 day use of marijuana use among youth

Baseline Measurement: FY13 Baseline = 9.5% of youth among 12 to 17 years old

First-year target/outcome measurement: FY16 Target = 9.0%

Second-year target/outcome measurement: FY17 Target = 8.0%

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

The NSDUH data will be used to track the past 30 day use of marijuana among youth.

Data issues/caveats that affect outcome measures::

The availability of public use of NSDUH may hinder the reporting in a timely manner.

Priority #: 14

Priority Area: Opiate Use

Priority Type: SAT

Population(s): Other (Individuals with opioid use disorders)

Goal of the priority area:

Treatment outcomes will be improved.

Objective:

Improve treatment outcomes for individuals with opioid use disorders.

Strategies to attain the objective:

1. Initiate implementation of new Medication Assisted Treatment (MAT) Guidelines for Opioid Use Disorders.

2. Improve fidelity in the use of behavioral health therapies utilized in the treatment of opioid use disorders.

3. Require the availability of all three FDA approved medications for the treatment of opioid dependency in all publicly-funded opioid treatment programs.

4. Increase the use of peer recovery coaches within treatment settings.

5. Promote the utilization of recovery oriented services and systems to effectively treat the disease of addiction.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of admissions initiated into MAT services with pharmacotherapies approved by the FDA for the treatment of opioid use disorders

Baseline Measurement: FY13 Baseline = 4,627 admissions initiated into MAT services

First-year target/outcome measurement: FY16 Target = 4,673

Second-year target/outcome measurement: FY17 Target = 4,766

Data Source:

TEDS admission. Service category of Detox would be excluded.

Description of Data:

TEDS admission data indicates those individuals who initiated into MAT during the fiscal year.

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: Retention in MAT treatment

Baseline Measurement: FY13 Baseline = 38.1% of individuals who continue 180 days in MAT

First-year target/outcome measurement: FY16 Target = 39.1%

Second-year target/outcome measurement: FY17 Target = 41.0%

Data Source:

TEDS treatment admission and discharge data

Description of Data:

Matched cases of admission and discharge TEDS data per individual in treatment.

Data issues/caveats that affect outcome measures::

None

Priority #: 15

Priority Area: Opiate Use

Priority Type: SAP

Population(s): Other (Individuals in need of primary substance abuse prevention)

Goal of the priority area:

Non-medical use of prescription drugs will be reduced.

Objective:

Reduce non-medical use of prescription drugs, including opiates.

Strategies to attain the objective:

1. Increase multi-system collaboration at state and community levels.

2. Promote to develop leadership structure combining relevant agencies and organizations to oversee surveillance, intervention, education, and enforcement.

3. Promote the use of statewide media campaign entitled: Do your Part: Be the Solution to Prevent Prescription Drug Abuse.

4. Broaden the use of brief screenings in behavioral and primary health care settings.

5. Promote increased access to and use of prescription drug monitoring program.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Past 30 day non-medical use of pain relievers

Baseline Measurement: FY13 Baseline = 2.1% of individuals aged 12 years and older

First-year target/outcome measurement: FY16 Target = 2.0%

Second-year target/outcome measurement: FY17 Target = 1.9%

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

The NSDUH data will be used to track the past 30 day non-medical use of pain relievers.

Data issues/caveats that affect outcome measures::

None

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$83,092,850		$88,207,000	$11,800,272	$58,903,278	$0	$0
a. Pregnant Women and Women with Dependent Children*	$11,244,880		$0	$0	$2,412,768	$0	$0
b. All Other	$71,847,970		$88,207,000	$11,800,272	$56,490,510	$0	$0
2. Substance Abuse Primary Prevention	$22,722,442		$0	$710,860	$157,000	$0	$0
3. Tuberculosis Services	$0		$0	$0	$117,018	$0	$0
4. HIV Early Intervention Services	$0		$0	$0	$0	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	$5,569,226		$0	$1,148,850	$575,984	$0	$0
13. Total	$111,384,518	$0	$88,207,000	$13,659,982	$59,753,280	$0	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$55,199,926	$27,049,496	$384,423,686	$33,742,608	$665,410
6. Other 24 Hour Care		$0	$0	$0	$0	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$0	$0	$0	$891,200	$0	$0
8. Mental Health Primary Prevention**		$0	$0	$0	$0	$0	$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		$1,464,000	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$1,369,734	$0	$0	$0	$0	$0
13. Total	$0	$2,833,734	$55,199,926	$27,049,496	$385,314,886	$33,742,608	$665,410

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	$	$
General and specialized outpatient medical services;		
Acute Primary Care;		
General Health Screens, Tests and Immunizations;		
Comprehensive Care Management;		
Care coordination and Health Promotion;		
Comprehensive Transitional Care;		
Individual and Family Support;		
Referral to Community Services;		
Prevention Including Promotion	$	$

Screening, Brief Intervention and Referral to Treatment ;		
Brief Motivational Interviews;		
Screening and Brief Intervention for Tobacco Cessation;		
Parent Training;		
Facilitated Referrals;		
Relapse Prevention/Wellness Recovery Support;		
Warm Line;		
Substance Abuse Primary Prevention	$	$
Classroom and/or small group sessions (Education);		
Media campaigns (Information Dissemination);		
Systematic Planning/Coalition and Community Team Building(Community Based Process);		
Parenting and family management (Education);		
Education programs for youth groups (Education);		
Community Service Activities (Alternatives);		
Student Assistance Programs (Problem Identification and Referral);		

Employee Assistance programs (Problem Identification and Referral);		
Community Team Building (Community Based Process);		
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);		
Engagement Services	$	$
Assessment;		
Specialized Evaluations (Psychological and Neurological);		
Service Planning (including crisis planning);		
Consumer/Family Education;		
Outreach;		
Outpatient Services	$	$
Individual evidenced based therapies;		
Group Therapy;		
Family Therapy ;		
Multi-family Therapy;		

Consultation to Caregivers;		
Medication Services	$	$
Medication Management;		
Pharmacotherapy (including MAT);		
Laboratory services;		
Community Support (Rehabilitative)	$	$
Parent/Caregiver Support;		
Skill Building (social, daily living, cognitive);		
Case Management;		
Behavior Management;		
Supported Employment;		
Permanent Supported Housing;		
Recovery Housing;		
Therapeutic Mentoring;		
Traditional Healing Services;		

Recovery Supports	$	$
Peer Support;		
Recovery Support Coaching;		
Recovery Support Center Services;		
Supports for Self-directed Care;		
Other Supports (Habilitative)	$	$
Personal Care;		
Homemaker;		
Respite;		
Supported Education;		
Transportation;		
Assisted Living Services;		
Recreational Services;		
Trained Behavioral Health Interpreters;		

Interactive Communication Technology Devices;		
Intensive Support Services	$	$
Substance Abuse Intensive Outpatient (IOP);		
Partial Hospital;		
Assertive Community Treatment;		
Intensive Home-based Services;		
Multi-systemic Therapy;		
Intensive Case Management ;		
Out-of-Home Residential Services	$	$
Crisis Residential/Stabilization;		
Clinically Managed 24 Hour Care (SA);		
Clinically Managed Medium Intensity Care (SA) ;		
Adult Mental Health Residential ;		
Youth Substance Abuse Residential Services;		
Children's Residential Mental Health Services ;		

Therapeutic Foster Care;		
Acute Intensive Services	$	$
Mobile Crisis;		
Peer-based Crisis Services;		
Urgent Care;		
23-hour Observation Bed;		
Medically Monitored Intensive Inpatient (SA);		
24/7 Crisis Hotline Services;		
Other	$	$
Total	$0	$0

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

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$41,746,917
2 . Substance Abuse Primary Prevention	$11,160,729
3 . Tuberculosis Services	$0
4 . HIV Early Intervention Services**	$0
5 . Administration (SSA Level Only)	$2,784,613
6. Total	$55,692,259

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy	IOM Target	FY 2016
		SA Block Grant Award
Information Dissemination	Universal	$494,913
	Selective	$61
	Indicated	$700
	Unspecified	$0
	Total	$495,674
Education	Universal	$2,414,782
	Selective	$1,438,839
	Indicated	$306,486
	Unspecified	$0
	Total	$4,160,107
Alternatives	Universal	$759,877
	Selective	$66,866
	Indicated	$0
	Unspecified	$0
	Total	$826,743
Problem Identification and Referral	Universal	$168,633
	Selective	$372,392
	Indicated	$164,290
	Unspecified	$0
	Total	$705,315

Community-Based Process	Universal	$2,525,637
	Selective	$63,635
	Indicated	$6,930
	Unspecified	$0
	Total	$2,596,202
Environmental	Universal	$856,038
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	$856,038
Section 1926 Tobacco	Universal	$818,222
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	$818,222
Other	Universal	$168,633
	Selective	$372,390
	Indicated	$161,405
	Unspecified	$0
	Total	$702,428
Total Prevention Expenditures		$11,160,729
Total SABG Award*		$55,692,259
Planned Primary Prevention Percentage		20.04 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	$4,114,533	
Universal Indirect	$4,092,202	
Selective	$2,314,183	
Indicated	$639,811	
Column Total	$11,160,729	
Total SABG Award*	$55,692,259	
Planned Primary Prevention Percentage	20.04 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Targeted Substances	
Alcohol	þ
Tobacco	þ
Marijuana	þ
Prescription Drugs	þ
Cocaine	¢
Heroin	¢
Inhalants	¢
Methamphetamine	¢
Synthetic Drugs (i.e. Bath salts, Spice, K2)	¢
Targeted Populations	
Students in College	þ
Military Families	¢
LGBT	þ
American Indians/Alaska Natives	¢
African American	¢
Hispanic	¢
Homeless	¢
Native Hawaiian/Other Pacific Islanders	¢
Asian	¢
Rural	¢
Underserved Racial and Ethnic Minorities	þ

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$0	$0	$0	$0
2. Quality Assurance	$0	$0	$0	$0
3. Training (Post-Employment)	$101,610	$405,428	$507,038	$1,014,076
4. Education (Pre-Employment)	$0	$0	$0	$0
5. Program Development	$0	$0	$0	$0
6. Research and Evaluation	$0	$0	$0	$0
7. Information Systems	$0	$0	$0	$0
8. Total	$101,610	$405,428	$507,038	$1,014,076

Footnotes:

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	$7,060,744
MHA Planning Council Activities	$18,000
MHA Administration	$1,369,734
MHA Data Collection/Reporting	$1,178,390
MHA Activities Other Than Those Above	
Total Non-Direct Services	$9626868

Comments on Data:

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[26] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[27] It has been acknowledged that there is a high rate of co- occurring mental illness and substance abuse, with appropriate treatment required for both conditions.[28] Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The Framingham Heart Study produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence–based practices[29] [30] that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[31] Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.[32] In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.[33] Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.[34] Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.[35] In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[36]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[37] Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.[38] Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[39] and ACOs[40] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.[41] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[42]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[43] Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[44] SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.[45] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.[46] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.[47] It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.[48]

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[49] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[50]

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.[51] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

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

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

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
    - Regular screening with a carbon monoxide (CO) monitor
    - Smoking cessation classes
    - Quit Helplines/Peer supports
    - Others_____
11. The behavioral health providers screen and refer for:
    - Prevention and wellness education;
    - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
    - Recovery supports

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

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[50] About the National Quality Strategy, http://www.ahrq.gov/workingforquality/about.htm; National Behavioral Health Quality Framework, Draft, August 2013, http://samhsa.gov/data/NBHQF

[51] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/cciio/resources/letters/index.html; Affordable Care Act, Indian Health Service, http://www.ihs.gov/ACA/

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

Footnotes:

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

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

Agreeing that this is a critical concern, MDHHS has developed a cooperative alliance with the Michigan Association of Community Mental Health Boards (MACMHB), and contracted with The National Council for Behavioral Healthcare. MDHHS has supported a variety of efforts achieved through mental health block grant funding and technical assistance.

MDHHS has partnered with MACMHB and the National Council for the last 3 years to support a statewide Integrated Primary and Behavioral Healthcare Learning Community. Any Michigan community mental health agency or partnering primary care health center is encouraged to participate. Quarterly activities (team planning and technical assistance including coaching reviews of IH work plans) have had outstanding participation in a non-competitive and supportive environment.

a. Discussion forums on a designated website (www.improvingmipractices.org) that allows all partners to provide and discuss concerns and information.
b. Additional resources may be shared, provided or gathered in areas such as Financing & Sustainability, Clinical Practices, Administration Health Information Management and the IH Workforce are readily accessible to those seeking further information on www.improvingmipractices.org
c. Webinars on topics pertinent to IH development such as 'Evolving Models of Integration' and 'Health Information Technology and Quality Improvement.' This first effort drew 85 participants. The last Integrated Healthcare Learning Community quarterly meeting drew almost 200 participants.

Representatives have given positive comments regarding the effectiveness of sharing available materials, perusing through multiple agencies for inspiration, ideas and self-comparisons. This approach has been touted as original, innovative, efficient and constructive.

1. **Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?**

   Michigan has a very robust and mature Medicaid managed care system for both physical health services and specialty behavioral health services. In addition, Michigan is a Medicaid expansion state which has allowed approximately 600,000 more people access to the established behavioral health service system. Michigan's Medicaid system (including expansion) currently covers and will continue to cover the following services/service categories from Table 3:

   - All services in the Healthcare Home/Physical Health category
   - Prevention Including Promotion
     - Parent training (variety)
     - Relapse Prevention/Wellness Recovery Support
   - All services in the Engagement Services Category
   - Outpatient Services
     - Individual evidenced based therapies
     - Group therapy
     - Family therapy
     - Multi-family therapy
   - All services in the Medication Services category
   - Community Support (Rehabilitative)
     - Parent/caregiver support
     - Skill building
     - Case management
     - Behavior management
     - Supported employment
   - All services in the Recovery Supports category
   - Other Supports (Habilitative)
     - Personal care
     - Respite
     - Transportation
     - Assisted living
   - All services in the Intensive Support Services category
   - Out-of-Home Residential Services
     - Crisis residential/stabilization
     - Clinically managed 24 hour care (ASAM level residential services)
     - Youth substance abuse residential services (ASAM levels)
     - Therapeutic foster care
   - Acute Intensive Services
     - Mobile crisis
     - Medically monitored Intensive Inpatient (SA) – physical health care benefit
     - 24/7 Crisis hotline services (required of all community mental health programs – not a Medicaid benefit)

2. **Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?**

   Access to care and outreach activities informing the public on how and where to access services are part of the contractual requirements of each PIHP (Attachment P4.1.1). Each PIHP region is required to have an access system that does the following:

   - Welcome all individuals by demonstrating empathy and providing opportunity for the person presenting to describe situation, problems and functioning difficulties, exhibiting excellent customer service skills, and working with them in a non-judgmental way.
   - Screen individuals who approach the access system to determine whether they are in crisis and, if so, assure that they receive timely, appropriate attention.
   - Determine individuals' eligibility for Medicaid specialty services and supports, MIChild or, for those who do not have any of these benefits as a person who's presenting needs for mental health services make them a priority to be served.
   - Collect information from individuals for decision-making and reporting purposes.
   - Refer individuals in a timely manner to the appropriate mental health practitioners for assessment, person-centered planning, and/or supports and services; or, if the individual is not eligible for PIHP or CMHSP services, to community resources that may meet their needs.
   - Inform individuals about all the available mental health and substance abuse services and providers and their due process rights under Medicaid, or MIChild, and the Michigan Mental Health Code.
   - Conduct outreach to under-served and hard-to-reach populations and be accessible to the community-at-large.

3. **Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.**

   On a quarterly basis, the Mission Based Performance Indicator System provides status reports on each CMHSP. These reports provide information on how fast someone is able to access services from the point that they ask for them, how fast follow up services are provided after an inpatient stay and even wait times for emergency hospital screening decisions. Each of these areas have established thresholds that must be met – access and follow up within 7 days and emergency screening completed within three hours.

4. **Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations of MHPAEA?**

   The SMHA/SSA office has a customer service team that is responsible for receiving and reviewing complaints regarding services and supports that are provided in the PIHP/CMHSP system. Depending on the nature of a complaint, this area can work with the individual and the PIHP/CMHSP and/or other provider to resolve a situation or pass the concern on to a higher authority (recipient rights or licensing).

5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Michigan does not need to make changes in the behavioral health system as it relates to the state's EHB package. As it stands, the behavioral health services and supports currently offered in the behavioral health system exceed those that are identified in the state's EHB package.

6. Is the SSA/SMHA involved in various coordinated care initiatives in the state?

The BHDDA is involved in multiple initiatives pursuing improved health for the citizens of Michigan. Integrating behavioral health and physical health care and treating the whole person is in many stages of development throughout Michigan. In addition, through the Integrated Healthcare Learning Community that was referenced earlier, there are other activities in the state focused on coordinated care. Four regions in Michigan are participating in the Dual Eligible (Medicaid and Medicare) project. This project is unique in that the Integrated Care Organizations have contracted with the PIHPs in those regions to provide the behavioral health services to those enrolled in the project.

In Michigan, two regions of the state are participating in a Health Home pilot project that as part of section 2703 of the Affordable Care Act. These projects are focused on providing care coordination and support to individuals with a serious mental illness who also have chronic physical health conditions. This project started in July of 2014. The state is in the process of developing additional health homes within community clinics and Federally Qualified Health Centers. Members of the behavioral health administration are involved in the planning and development of that project to ensure behavioral health needs are being addressed as part of those projects.

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

All of the PIHPs responsible for administering regional SUD services in the state were required to develop a plan for service for a designated three year period. The plan for SUD services was developed in accordance with a guidance document which is provided by BHDDA. This guidance provided the parameters for the provision of SUD services inclusive of state and federal regulations and requirements, priority services as identified by BHDDA and the MDHHS, and special projects to be addressed during the plan of service period.

The current plan of service period is 2014 through 2017. Within the overall plan of service the emphasis has been on the publically funded SUD services system continued transformation to a recovery oriented system of care (ROSC). The ROSC transformation process was announced and initiated at the 2009 Statewide SUD Conference. ROSC transformation is important for many reasons. However, it is of particular importance to the integration of primary and behavioral health care for the infrastructure and culture of care that is established. Successful coordinated care cannot exist without the presence of a recovery oriented system as its foundation.

Additionally, prior to the multi-year plan of action submitted by the PIHPs, the 2012 through 2014 action plan identified two priority projects in which all areas of the state were required to employ. The two project priorities were: 1) a NIATx practices improvement initiatives (intended to improve the capacity and effectiveness of services and their delivery), and 2) a behavioral health and primary health care integrated services project (intended to utilized principles of ROSC, initiate or further enhance critical relationships and key partnership for, and develop and implement an integrated healthcare pilot project). Currently the 10 PIHPs within the State of Michigan are engaged in the planning, development and implementation of their integrated health care projects.

As mentioned above, in 2009 BHDDA announced at the 2009 Statewide SUD Conference that the publically-funded SUD services system would be engaging in a transformation to ROSC. Also explained in response (A.) is the importance and necessity of establishing a ROSC as a foundation to a successful behavioral health and primary health care integration. As a matter of fact, in the regions of Michigan where recovery oriented transformation is strong, the development of collaborations and partnerships naturally lead to coordinated initiatives between the behavioral health and the primary health care systems. As an example, one product of such collaboration lead to an emergency room doctor studying and tracking the utilization of hospital emergency department incidents of care (both emergency and non-emergency) for substance abusing and addicted individuals. This led to the opening of a specialized clinic to assess, plan and provide services to these individuals. The concept of the clinic is to assess the healthcare and SUD status of the individuals via co-located services and providers within the clinic. Once an individual has been stabilized (primary health and SUD) they will be connected to a primary care provider for ongoing health care management. In addition, BHDDA has provided funding to a PIHP to imbed peer recovery coaches in primary care agencies for the purpose of navigating persons in recovery through wellness plans. Moreover, BHDDA has utilized SAMHSA funded Partnership for Success II Grant funding to integrate prevention into primary care settings for the purpose of screening young persons at risk for abusing alcohol and prescription drugs and referring those individuals to evidence-based prevention programs.

Much has been accomplished within the SUD ROSC Transformation, but much has yet to be done. Just as an individual's SUD recovery is not and event but a journey, a systems transformation is much the same. Be it conceptual, practice of contextual strategies at work there is always more to do. Transformation efforts to date have included, but are not limited to: collaboration and partnership development; communication, language and educational tools and initiatives; Infrastructure planning and modifications; policy and regulatory

changes and enhancements; peer recovery services and supports (inclusive of SAMHSA BRSS TACS grant); prevention/wellness efforts, and maintaining cultural competence and best practices within a recovery oriented service environment.

Part of the ROSC work involved in creating a Transformation Steering Committee (TSC) was established to partner with BHDDA in decision making and moving transformation forward. With integrated healthcare as a priority within the state and the work that needs to be done in preparation for 2016, the TSC has primary health care coordination as a standing priority within its agenda and meetings.

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

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

- A representative from the MPCA is a member of the ROSC TSC.
- MPCA is actively involved in the new health home project development.
- On multiple occasions BHDDA and regional SUD agency personnel have been asked, and have presented SUD and ROSC information to the MPCA, and have presented and participated in the MPCA annual conference.
- Information on the effectiveness of recovery oriented systems has been provided by regional SUD providers and stakeholder.
- A representative from MPCA is a member of the Behavioral Health Advisory Committee.
- MPCA was instrumental in facilitating the participation of member FQHCs in the Partnership for Success II Grant Project designed to reduce underage drinking and prescription drug abuse.

8. Are state behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders?

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

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

There are 44 clubhouses in Michigan which are independent non-smoking facilities located in the general community. Approximately 50% have smoking cessation classes.

There are 53 consumer-run drop-in centers in Michigan. All are in non-smoking facilities with smoking tents on the outlying property. About 50% of the drop-in centers have smoking cessation classes.

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

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

9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

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

10. Indicate tools and strategies used that support efforts to address nicotine cessation.

As indicated above, all provider organizations are taking steps to address smoking and nicotine dependence. There are various level of efforts around the state, with some being more advanced. Clubhouses and CPSS are also significant resources for smoking cessation programs and support as noted above.

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

11. The behavioral health providers are screen and refer for: prevention and wellness, heart disease, hypertension, high cholesterol and/or diabetes and recovery supports.

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

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

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

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

Multiple PIHPs are in the process of adding screening and protocols to activities already in place; assuring that each person has a primary care doctor; or working with the FQHC to obtain the services. Some PIHPs and FQHCs have cooperatively developed integrated health models and are at the frustrating stage that requires integrated care encounter coding. Currently, integrated health codes are not available.

In Oakland County, providers are using the health measures for screening and referring for heart disease, hypertension, high cholesterol and/or diabetes.

Saginaw County notes heart disease, hypertension, high cholesterol and/or diabetes, along with other health conditions, including obesity are part of the initial and annual assessment process. Many efforts to heighten the awareness and knowledge of our case managers and

supports coordinators about chronic health conditions, consumer wellness promotion (including BMI charts) and the importance of primary care referrals, coordination and follow up continue. One core case manager mandatory training module is on consumer health and wellness; it includes chronic conditions resources. Agency policy clearly states that the expectation for staff is to become students of the health conditions behavioral health consumers' experience. Nursing staff also assist with more comprehensive health assessments and re-screening of health status at the time of psychiatry appointments. Currently expectations of health care integration knowledge and practices are included in staff evaluations. SCCMHA has also made primary care services available at the key service site in cooperation with the federally qualified health center. Also included in home manager trainings and messages is the critical importance of health care integration and follow up in the management of chronic conditions as well as site emphasis on health and wellness.

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*[52], *Healthy People, 2020*[53], *National Stakeholder Strategy for Achieving Health Equity*[54], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).[55]

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[56]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[57] This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.[58] In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

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

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

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

[52] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[53] http://www.healthypeople.gov/2020/default.aspx

[54] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[55] http://www.ThinkCulturalHealth.hhs.gov

[56] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[57] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[58] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

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.

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP[59] is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[60], The New Freedom Commission on Mental Health[61], the IOM[62], and the NQF.[63] The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[64] SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)[65] are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[66] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding mental health and substance abuse services.

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

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
    a. Leadership support, including investment of human and financial resources.
    b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
    c. Use of financial incentives to drive quality.

d. Provider involvement in planning value-based purchasing.

e. Gained consensus on the use of accurate and reliable measures of quality.

f. Quality measures focus on consumer outcomes rather than care processes.

g. Development of strategies to educate consumers and empower them to select quality services.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

i. The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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[59] Ibid, 47, p. 41

[60] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[61] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[62] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[63] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[64] http://psychiatryonline.org/

[65] http://store.samhsa.gov

[66] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

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.

4. Prevention for Serious Mental Illness

Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.[67] The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.[68] In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.[69] The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.[70] [71] This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

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

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[67] Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

[68] Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

[69] Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

[70] van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

[71] McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

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

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.[72] SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded Recovery After an Initial Schizophrenia Episode (RAISE) initiative[73], a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

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

[72] http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

[73] http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

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

Footnotes:

1. **An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.**

   In Michigan, the Navigate model within RAISE is being implemented in three pilot sites. This particular model was selected because Michigan had three teams that participated in the national study, so Michigan decided to build upon the existing expertise in the state.

2. **An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.**

   No changes have been made to our original plan.

   Network180 (the MDHHS selected subcontractor for the project) contracted with ETCH, LLC for ETCH Clinicians to attend a series of webinars with nationally recognized experts in early identification and intervention of First Episode Psychosis. All members of the ETCH Clinical Team received certification as Trainers/Consultants in the Navigate model of Coordinated Specialty Care. This was accomplished by the end of September 2014.

   In July 2014 a Request for Proposals was released statewide to solicit responses from organizations interested in contracting to implement RAISE. Network180 received responses from five organizations, proposing to implement the program in seven geographic areas. Ultimately, three teams were chosen through an objective scoring process: InterAct of Michigan is implementing in Kent County; ETCH, LLC is implementing in the Lansing/Michigan State University area; and Easter Seals Michigan is implementing in Oakland County. The ETCH Navigate Certified team trainers have trained the implementation teams in the program. Currently, the three teams are up and running and serving clients.

   Agencies continue to do outreach to educate individuals on first episode psychosis and the program. Local inpatient units continue to be the most consistent of referral sources for all three implementation teams. Other referral sources are Michigan State University, self-referrals, interagency referrals, and other agencies providing mental health services. Outreach efforts are primarily focused on maintaining relationships previously built, along with some outreach to the YMCA and the Office of Disabilities at Grand Valley State University.

   InterAct enrolled four (4) individuals this quarter, bringing their year to date (YTD) total to fifteen (15) individuals, all of whom they are currently serving. ETCH enrolled five (5) individuals this quarter, bringing their YTD total to twenty-one (21), twenty (20) of whom they are current serving. Easter Seals enrolled ten (10) individuals this quarter, bringing their YTD total to eighteen (18), seventeen (17) of whom they are currently serving.

3. **The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.**

   The goals set for FY16 and FY17 are to continue to focus on implementation of the Navigate model within RAISE and for each team to maintain capacity of at least 30 individuals served. The population being served continues to be individuals within each team's catchment area, between the ages of 15 and 30, who have experienced first episode psychosis within the previous 18 months.

Network180 will continue to contract with ETCH, LLC to provide oversight, ongoing training and consultation of the Navigate model, including maintaining fidelity of the model. See the attached work plan for additional information.

4. **A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.**

   The entire 5% ($732,000) will be contracted out to Network180 in FY16 (and FY17, if funds continue) who will then subcontract with the three providers to support the three pilot programs. The teams will also focus on maximizing third-party payment (both Medicaid and private insurance) for services whenever possible. See the attached budget for additional information.

5. **The states provision for collecting and reporting data, demonstrating the impact of this initiative.**

   Monthly and quarterly reporting are built into the contracts for services with each implementation team so that success with participant enrollment and implementation can be monitored and reported back to MDHHS. Network180 expects to have data in early FY16 on outcome measures of service utilization, participant perception of functioning and clinician perception on functioning.

ATTACHMENT 1

☒ Subrecipient
☐ Vendor
☐ Research and development project
☒ Not a research and development project

CHILDREN/YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE AGES 0 THROUGH 17 AND THEIR FAMILIES

STATEMENT OF WORK

Goal: Implementation teams will continue to provide services consistent with the RAISE model

Activity(ies)	Responsible Individual(s)	Timeline	Deliverable(s)
Objective			
Implementation teams will maintain program fidelity and continue increasing competency	ETCH, LLC; Implementations teams	Ongoing October 1, 2015 through September 30, 2016	Monthly consultation- ETCH, LLC with the national Navigate consultants, implementation teams with ETCH, LLC

Goal: Enrollment in each implementation team (3 teams) will be maintained at 25-30 participants at any given time, once enrollment of 27 individuals is initially achieved.

Activity(ies)	Responsible Individual(s)	Timeline	Deliverable(s)
Objective			
Guidelines and processes will be identified within each agency to enroll new program participants as existing program participants dis-enroll or “graduate.”	Program Directors within each contracted agency	December 31, 2015	On-going enrollment process
Objective			
The guidelines/enrollment processes will be implemented and utilized	Program Directors within each contracted agency	Ongoing October 1, 2015 through September 30, 2016	25-30 program participants per team at any given time

Goal: An average of 20% of total First Episode Psychosis program expenses will be reimbursed through sources other than grant funds

Activity(ies)	Responsible Individual(s)	Timeline	Deliverable(s)
Objective			
Agencies/providers will complete tasks necessary to apply to be paneled providers for commonly used insurances and payers within their respective geographical regions	Contracted agencies and Program Directors	December 31, 2015	Eligible individual providers (therapists, prescribers) will be paneled in commonly used insurances and payers
Objective			
Agencies/providers will complete tasks necessary to apply to be paneled providers for other insurers and payers as individuals enroll in their respective FEP program	Contracted agencies and Program Directors	Ongoing; within 90 days of enrollment of an individual	Eligible individual providers (therapists, prescribers) will be paneled by less commonly used insurances and payers that are specific to an individual being served
Objective			
100% of services that may be eligible for reimbursement will be submitted to payers	Contracted agencies	Ongoing October 1, 2015 through September 30, 2016	Maximum reimbursement for services will be received
Objective			
Agencies/providers will initiate conversation with primary payers for all program participants regarding development of a bundled or non-traditional payment structure for bundled FEP services	Contracted agencies and Program Directors	September 30, 2016	Documented efforts to develop funding for FEP programs

PROGRAM BUDGET SUMMARY

View at 100% or Larger

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Use WHOLE DOLLARS Only

ATTACHMENT 2

PROGRAM			**DATE PREPARED**		Page	Of
First Episode Psychosis					**1**	**2**
CONTRACTOR NAME			**BUDGET PERIOD**			
Network180			**From: 10/1/2015**		**To: 9/30/2016**	
MAILING ADDRESS (Number and Street)			**BUDGET AGREEMENT**		**AMENDMENT #**	
790 Fuller NE			☑ ORIGINAL ☐ AMENDMENT			
CITY	**STATE**	**ZIP CODE**	**FEDERAL ID NUMBER**			
Grand Rapids	**Michigan**	**49503**	**38-3672594**			

EXPENDITURE CATEGORY				**TOTAL BUDGET** (Use Whole Dollars)
1. SALARY & WAGES				
2. FRINGE BENEFITS				
3. TRAVEL				
4. SUPPLIES & MATERIALS				
5. CONTRACTUAL (Subcontracts/Subrecipients)				$682,224
6. EQUIPMENT				
7. OTHER EXPENSES				49,776
Project Coordination				$49,776
8. **TOTAL DIRECT EXPENDITURES** (Sum of Lines 1-7)				$732,000
9. INDIRECT COSTS: Rate #1 20%				
INDIRECT COSTS: Rate #2 %				
10. TOTAL EXPENDITURES				$732,000

SOURCE OF FUNDS:

11. FEES & COLLECTIONS				
12. STATE AGREEMENT				$732,000
13. LOCAL				
14. FEDERAL				
15. OTHER(S)				
16. TOTAL FUNDING				**$732,000**

AUTHORITY: P.A. 368 of 1978	The Department of Community Health is an equal opportunity
COMPLETION: Is Voluntary, but is required as a condition of funding.	employer, services and programs provider.

DCH-0385(E) (Rev. 04/12) (Excel) Previous Edition Obsolete.

PROGRAM BUDGET - COST DETAIL SCHEDULE

ATTACHMENT 2

View at 100% or Larger MICHIGAN DEPARTMENT OF COMMUNITY HEALTH Page 2 Of 2

Use WHOLE DOLLARS Only

PROGRAM	BUDGET PERIOD		DATE PREPARED
First Episode Psychosis	From: 10/1/2015	To: 9/30/2016	
CONTRACTOR NAME	BUDGET AGREEMENT		AMENDMENT #
Network180	☑ ORIGINAL	☐ AMENDMENT	

1. SALARY & WAGES: POSITION DESCRIPTION	COMMENTS	POSITIONS REQUIRED	TOTAL SALARY
	1. TOTAL SALARY & WAGES:		

2. FRINGE BENEFITS: (Specify) Composite Rate

☐ FICA ☐ LIFE INS ☐ DENTAL INS
☐ UNEMPLOY INS ☐ VISION ☐ WORK COMP
☐ RETIREMENT ☐ HEARING INS
☐ HOSPITAL INS ☐ OTHER:specify-

2. TOTAL FRINGE BENEFITS:

3. TRAVEL: (Specify if category exceeds 10% of Total Expenditures)

3. TOTAL TRAVEL:

4. SUPPLIES & MATERIALS: (Specify if category exceeds 10% of Total Expenditures)

4. TOTAL SUPPLIES & MATERIALS:

5. CONTRACTUAL: (Subcontracts/Subrecipients)

Name	Address	Amount	
InterAct of Michigan	610 S. Burdick St., Kalamazoo, MI 49007	$ 220,177	
ETCH	4572 S. Hagadorn Rd, Ste 1E, East Lansing, MI 48823	$ 235,267	
Easter Seals	2399 E. Walton Blvd, Auburn Hills, MI 48326	$ 226,780	
		5. TOTAL CONTRACTUAL:	$ 682,224

6. EQUIPMENT: (Specify) Amount

6. TOTAL EQUIPMENT:

7. OTHER EXPENSES: (Specify if category exceeds 10% of Total Expenditures) Amount

Communication:
Space Cost:
Others (explain):
Project Coordination $49,776

7. TOTAL OTHER EXPENSES: $ 49,776

8. TOTAL DIRECT EXPENDITURES: (Sum of Totals 1-7) 8. TOTAL DIRECT EXPENDITURES

9. INDIRECT COST CALCULATIONS:

Rate #1 Base $ - x Rate 20.00% =
Rate #2 Base $ - x Rate =

9. TOTAL INDIRECT EXPENDITURES:

10. TOTAL ALL EXPENDITURES: (Sum of lines 8-9) $ 732,000

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding.
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Use Additional Sheets as Needed

PROGRAM BUDGET - COST DETAIL SCHEDULE

ATTACHMENT B.2

View at 100% or Larger MICHIGAN DEPARTMENT OF COMMUNITY HEALTH Page Of

Use WHOLE DOLLARS Only

PROGRAM	BUDGET PERIOD From:	BUDGET PERIOD To:	DATE PREPARED
CONTRACTOR NAME	**BUDGET AGREEMENT** ☐ ORIGINAL ☐ AMENDMENT		**AMENDMENT #**

1. SALARY & WAGES: POSITION DESCRIPTION	COMMENTS	POSITIONS REQUIRED	TOTAL SALARY
	1. TOTAL SALARY & WAGES:	0.000	$ -

2. FRINGE BENEFITS: (Specify) Composite Rate %

☐ FICA ☐ LIFE INS ☐ DENTAL INS
☐ UNEMPLOY INS ☐ VISION INS ☐ WORKS COMP
☐ RETIREMENT ☐ HEARING INS
☐ HOSPITAL INS ☐ OTHER:specify-

2. TOTAL FRINGE BENEFITS: $ -

3. TRAVEL: (Specify if category exceeds 10% of Total Expenditures)

3. TOTAL TRAVEL: $ -

4. SUPPLIES & MATERIALS: (Specify if category exceeds 10% of Total Expenditures)

4. TOTAL SUPPLIES & MATERIALS: $ -

5. CONTRACTUAL: (Subcontracts/Subrecipients)

Name	Address	Amount

5. TOTAL CONTRACTUAL: $ -

6. EQUIPMENT: (Specify)

	Amount

6. TOTAL EQUIPMENT: $ -

7. OTHER EXPENSES: (Specify if category exceeds 10% of Total Expenditures) Amount

Communication:
Space Cost:
Others (explain):

7. TOTAL OTHER EXPENSES: $ -

8. TOTAL DIRECT EXPENDITURES: (Sum of Totals 1-7) 8. TOTAL DIRECT EXPENDITURES $ -

9. INDIRECT COST CALCULATIONS:

Rate #1	Base $		x Rate	0.00%	=	$ -
Rate #2	Base $	-	x Rate	0.00%	=	$ -

9. TOTAL INDIRECT EXPENDITURES: $ -

10. TOTAL ALL EXPENDITURES: (Sum of lines 8-9) $ -

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding.

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Use Additional Sheets as Needed

PROGRAM BUDGET - COST DETAIL SCHEDULE

ATTACHMENT B.2

View at 100% or Larger MICHIGAN DEPARTMENT OF COMMUNITY HEALTH Page Of

Use WHOLE DOLLARS Only

PROGRAM	BUDGET PERIOD From:	BUDGET PERIOD To:	DATE PREPARED
CONTRACTOR NAME	**BUDGET AGREEMENT** ☐ ORIGINAL ☐ AMENDMENT		**AMENDMENT #**

1. SALARY & WAGES: POSITION DESCRIPTION	COMMENTS	POSITIONS REQUIRED	TOTAL SALARY
	1. TOTAL SALARY & WAGES:	0.000	$ -

2. FRINGE BENEFITS: (Specify) Composite Rate %

☐ FICA ☐ LIFE INS ☐ DENTAL INS
☐ UNEMPLOY INS ☐ VISION INS ☐ WORK COMP
☐ RETIREMENT ☐ HEARING INS
☐ HOSPITAL INS ☐ OTHER:specify-

2. TOTAL FRINGE BENEFITS: $ -

3. TRAVEL: (Specify if category exceeds 10% of Total Expenditures)

3. TOTAL TRAVEL: $ -

4. SUPPLIES & MATERIALS: (Specify if category exceeds 10% of Total Expenditures)

4. TOTAL SUPPLIES & MATERIALS: $ -

5. CONTRACTUAL: (Subcontracts/Subrecipients)

Name	Address	Amount

5. TOTAL CONTRACTUAL: $ -

6. EQUIPMENT: (Specify) Amount

6. TOTAL EQUIPMENT: $ -

7. OTHER EXPENSES: (Specify if category exceeds 10% of Total Expenditures) Amount

Communication:
Space Cost:
Others (explain):

7. TOTAL OTHER EXPENSES: $ -

8. TOTAL DIRECT EXPENDITURES: (Sum of Totals 1-7) 8. TOTAL DIRECT EXPENDITURES $ -

9. INDIRECT COST CALCULATIONS:

Rate #1 Base $ x Rate = $ -
Rate #2 Base $ - x Rate 0.00% = $ -

9. TOTAL INDIRECT EXPENDITURES: $ -

10. TOTAL ALL EXPENDITURES: (Sum of lines 8-9) $ -

AUTHORITY: P.A. 368 of 1978
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Use Additional Sheets as Needed

PROGRAM BUDGET - COST DETAIL SCHEDULE

ATTACHMENT B.2

View at 100% or Larger MICHIGAN DEPARTMENT OF COMMUNITY HEALTH Page Of

Use WHOLE DOLLARS Only

PROGRAM	BUDGET PERIOD From:	BUDGET PERIOD To:	DATE PREPARED
CONTRACTOR NAME	**BUDGET AGREEMENT** ☐ ORIGINAL ☐ AMENDMENT		**AMENDMENT #**

1. SALARY & WAGES: POSITION DESCRIPTION	COMMENTS	POSITIONS REQUIRED	TOTAL SALARY
	1. TOTAL SALARY & WAGES:	0.000	$ -

2. FRINGE BENEFITS: (Specify) Composite Rate %

☐ FICA ☐ LIFE INS ☐ DENTAL INS
☐ UNEMPLOY INS ☐ VISION INS ☐ WORK COMP
☐ RETIREMENT ☐ HEARING INS
☐ HOSPITAL INS ☐ OTHER:specify-

2. TOTAL FRINGE BENEFITS: $ -

3. TRAVEL: (Specify if category exceeds 10% of Total Expenditures)

3. TOTAL TRAVEL: $ -

4. SUPPLIES & MATERIALS: (Specify if category exceeds 10% of Total Expenditures)

4. TOTAL SUPPLIES & MATERIALS: $ -

5. CONTRACTUAL: (Subcontracts/Subrecipients)

Name	Address	Amount

5. TOTAL CONTRACTUAL: $ -

6. EQUIPMENT: (Specify) **Amount**

6. TOTAL EQUIPMENT: $ -

7. OTHER EXPENSES: (Specify if category exceeds 10% of Total Expenditures) **Amount**

Communication:
Space Cost:
Others (explain):

7. TOTAL OTHER EXPENSES: $ -

8. TOTAL DIRECT EXPENDITURES: (Sum of Totals 1-7) **8. TOTAL DIRECT EXPENDITURES** $ -

9. INDIRECT COST CALCULATIONS:

Rate #1	Base $		x Rate		=	$ -
Rate #2	Base $	-	x Rate	0.00%	=	$ -

9. TOTAL INDIRECT EXPENDITURES: $ -

10. TOTAL ALL EXPENDITURES: (Sum of lines 8-9) $ -

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding.

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Use Additional Sheets as Needed

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them though the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

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

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x– 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

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

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Client level encounter/use/performance analysis data; and
    f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

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

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[74] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

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

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

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

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[74] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

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

AIHFS: There are twelve federally recognized Tribes in Michigan. Each Tribe provides substance abuse and mental health services to the Tribal citizens residing in their specified Tribal service area. The array of services provided by each Tribe is variable, ranging from limited outpatient services to a more comprehensive array of prevention and treatment services. The Indian Health Services does provide limited resources to Michigan tribes for substance abuse and mental health services through PL 93-638 contracts and compacts. However, many Tribal citizens reside outside the tribal service areas in urban communities. For these citizens, the American Indian Health and Family Services of Southeastern Michigan provides outpatient treatment and prevention services to the Detroit American Indian community and the Grand Rapids community receives limited services from the Grand Rapids office of the Nottawaseppi Huron Band of the Potawatomi.

Citizens of Michigan Tribes experience health disparities unlike any other population in Michigan with higher rates of substance use disorders amongst youth, chronic alcohol and drug use, suicide rates, as well as depression and PTSD. Tribal citizens face unique challenges in their efforts to access effective substance abuse services. These challenges include: limitations on the array of services available from Tribes and Tribal organizations, limitations on the availability of non-tribal culturally competent services, limited access to funding, over-reliance on grant funding, and geographic barriers.

Technical Assistance from SAMHSA is needed in the following area related to this section:
• A new set of policies and procedures established for Tribal Consultation which demonstrates government to government consultation regarding changes to Medicaid and the plans for Michigan Substance Abuse and Mental Health Block Grant priorities and funding allocations.
• This plan will support communication and include collaboration of Michigan's Tribal Nations and the Urban Indian Health Service Center in an informed decision-making process regarding State changes and development of priorities and funding allocations for Substance Abuse and Mental Health services.
• This collaborative process will utilize Tribal Consultation to lead and shape changes affecting the citizens of Michigan Tribes and other Tribal citizens residing in Michigan and improve direct access to block grant resources.

Footnotes:

The response to this section of the block grant application is two-fold. The first part of each response was prepared by the Michigan Department of Health and Human Services (with some input from the Inter-Tribal Council of Michigan) and the second part of each response was prepared by representatives from American Indian Health and Family Services of Southeastern Michigan, Inc. (AIHFS)

1. **Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.**

   MDHHS: Two tribal representatives currently serve on the Behavioral Health Advisory Council, which is Michigan's planning council. A staff person from the Michigan Department of Health and Human Services (MDHHS) attends the Inter-Tribal Council of Tribal Leaders Meetings to share and receive information that will provide our department information on what we can do to assist the tribes in their efforts at administering population health and social service programs. In addition, Behavioral Health and Developmental Disabilities Administration (BHDDA) staff attend the Michigan Intertribal Council's Behavioral Health Communications Network meetings for the purpose of sharing administrative and programmatic information relevant to tribal implementation of substance use and mental health disorder programs. BHDDA staff also receive value added information from tribal members of the network in issues impacting their ability to serve their constituents.

   AIHFS: Currently, the State consults with Tribes on issues pertaining to proposed changes to Medicaid via Tribal Consultation Requirements outlined in OMB No. 0930-0168 State Plan Document section B effective July 1, 2010 and expiring May 31, 2016. The Tribal Consultation outlined in the State plan is limited to written notices of all proposed State plan Medicaid amendment proposals for demonstration projects, waiver request renewals, extensions, or amendments that may have a direct impact on services provided for Native Americans Indian health programs or Urban Indian organizations. Tribal Chairpersons, Tribal Health Directors, Urban Indian Health Directors, and Indian Health Services Representatives are given 60-days to respond to proposed changes in writing and request further actions be taken prior to changes taking effect. This method of Tribal consultation is missing a framework to collect and address Tribal Nation and Urban Indian Health Service concerns that may be addressed in the block grant plan prior to discussions related to or resulting in proposed state plan changes to Medicaid and/or substance use disorder and mental health services. Rather, the information stream is based on data and sources unrelated to Tribal Nations and Urban Indian Health Services with inadequate time to reply regarding proposed changes and lacks Tribal specific priority recommendations in the block grant process.

2. **Describe current activities between the state, tribes and tribal populations.**

   MDHHS: All ten of the Prepaid Inpatient Health Plans (PIHPs) submitted multi-year strategic plans for substance use disorder prevention and treatment and recovery. The plans

included epidemiological summaries of the populations with health disparities to be served in the PIHP regions. The PIHPs will soon provide updates on the status of their strategic plans and we will be reviewing the plans to determine whether the PIHPs are serving populations most in need, including American Indians. If there are updates that do not illustrate meaningful and value added services to American Indians and other populations experiencing health disparities, corrective action will be required.

Moreover, our state has funded 13 communities in Michigan through our Partnership for Success II Grant Project for the purpose of reducing underage drinking and prescription drug abuse. Of the 13 communities, three are tribal entities. The project is in its final year and MDHHS have applied for a new round of funding. MDHHS also received a State and Tribal Youth Suicide Prevention and Early Intervention Grant and the American Indian Health and Family Services, an agency in Detroit serving American Indians is participating in the grant activity.

The MDHHS, Office of Recovery Oriented Systems of Care (OROSC), is in the process of updating our Strategic Plan for Behavioral Health Services, including recovery based services, in the State of Michigan. As we undergo the updating process, we will examine our demographic data illustrative of Michigan populations, including Tribal populations, for accuracy and share the information with our regional and Tribal entities for the purpose of future planning for behavioral health services. As we update our strategic plan we will rely on our State Epidemiological Outcomes Workgroup (SEOW) to collect and review mortality, morbidity, prevalence, incidence, trend and social determinant data related to populations in Michigan with significant health disparities. Based on the SEOW review of the relevant data, recommendations will be issued to the OROSC for the purpose of developing a strategic plan for prevention services. Members of tribal entities in Michigan serve on the SEOW.

MDHHS also provides funding for two contracts with the Inter-Tribal Council of Michigan for behavioral health services. The purpose of the first project is to meet the individualized needs of seven tribes for mental health and aging for elders. The second project provides funding for the delivery of mental health services including treatment, prevention, and awareness activities for Native American members of seven Michigan Indian Tribes and promotes/supports on-site placement of mental health treatment professionals.

AIHFS: Current public activities between the State, Tribal Nations, and Tribal populations include the annual meeting of United Tribes at the State Capital, Michigan Department of Health and Human Service representative attendance at quarterly Tribal Health Directors and the Tribal Behavioral Health Communication Network Meeting and an Urban Indian Health and Tribal Citizen Representative on the Statewide Behavioral Health Advisory Council.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data- driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

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

1. Please indicate if the state has an active SEOW. If so, please describe:
    - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
    - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
    - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
    a. A statewide licensing or certification program for the substance abuse prevention workforce;
    b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
    c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

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:

1. Please indicate if the state has an active SEOW. If so, please describe:

Michigan has an active SEOW, which was implemented as part of the Strategic Prevention Framework/State Incentive Grant (SPF/SIG), and continues to maintain a functioning epidemiological workgroup. In developing and updating Michigan Epidemiological Profile, we collect incidence and consequences of substance use on alcohol, tobacco and prescription drug abuse. Various intervening variables including early initial use and perceived risk of substance are collected. Below table describes areas of focus, available indicators and data sources used in the recent state profile provided by SEOW.

Available Indicators and Data Sources		
Areas of Focus	**Youth Indicators and Data**	**Adult Indicators and Data**
Alcohol Use	• Fatal Traffic Crashes of Alcohol Impaired Underage Drivers (Michigan Office of Highway Safety Planning {MOHSP}) • Current Alcohol Use and Binge Drinking (Michigan Youth Risk Behavior Survey {MiYRBS}) • Early Initial Use (MiYRBS) • Perceived Risk of Binge Drinking (National Survey on Drug Use and Health{NSDUH}) • Drinking and Driving (MiYRBS) • Riding with a Drinking Driver (MiYRBS) • Alcohol Primary Drug of Choice (Treatment Episode Data Set {TEDS})	• Fatal Traffic Crashes of Alcohol Impaired Drivers (MOHSP) • Current Alcohol Use, Binge Drinking, and Heavy Drinking (Michigan Behavioral Risk Factor Surveillance System{MiBRFS}) • Drove After Drinking (MiBRFS) • Alcohol Primary Drug of Choice (TEDS)
Tobacco Use	• Current Tobacco Use and Daily Cigarettes Use (MiYRBS) • Perceived Risk of Smoking (NSDUH) • Early Initial Use (MiYRBS)	• Current Tobacco Use (MiBRFS) • Lung Cancer Mortality and Morbidity (Michigan Vital Statistics)
Prescription Drug Abuse	• Nonmedical Use of Pain Relievers (NSDUH) • Prescription Drug Primary Drug of Choice (TEDS) • Fatal Traffic Crashes of Drug Impaired Underage Drivers (MOHSP)	• Prescription Drug Overdose Death Rate (vital statistics) • Prescription Drug Primary Drug of Choice (TEDS) • Fatal Traffic Crashes of Drug Impaired Drivers (MOHSP)
Mental Health Indicators	• Depressive feelings (MiYRBS) • Suicide Attempts (MiYRBS, national YRBS)	• Major Depressive Episode (National Survey on Drug Use and Health {NSDUH}) • Serious Mental Illness (NSDUH) • Suicidal Thoughts (NSDUH)

- The types of data collected by the SEOW (i.e., incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors); → See the table above
- The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and → See the table above
- The data sources used (i.e., archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey). → See the table above

2. **Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds**.

   Needs assessment data, particularly, severity, prevalence, incidence, and trends, including risk and protective factors, are use in decisions to prioritize priority areas to impact. The recipients of the Substance Abuse Prevention and Treatment Block Grant are regional entities that are required to develop and implement strategic plans based on the priority areas. Regional entities may have the option of selecting and additional priority area, but must provide compelling data substantiating their selection. The allocation of block grant primary prevention funds are based on a formula consisting of rates of poverty and population levels.

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

   Michigan adopted the use of the five-step SPF for all substance abuse prevention planning efforts over ten years ago, and the use of this model is institutionalized across the state. PIHP regional entities are all well-versed on this planning model, including assessment, capacity building, planning, implementation and evaluation.

   MDHHS is responsible for health policy and management of the state's publicly funded health service systems. The Michigan Public Health Code, Public Act 368 of 1978 (as amended), Sections 6201 and 6203, establishes the state's single state authority (SSA) and its duties. The OROSC functions as the SSA within MDHHS. Responsibilities include the administration of federal and state funding for substance abuse prevention, treatment, recovery, and gambling addiction. OROSC allocates Substance Abuse Prevention and Treatment Block Grant funding through ten regional PIHPs, whose responsibilities include planning, administering, funding, and maintaining the provision of substance abuse treatment and prevention services for 83 counties in Michigan. All PIHPs have prevention coordinators (PCs), who receive input from and empower local communities in their response to substance abuse prevention needs. The PIHPs contract with local prevention coalitions and programs to implement the specific activities in their communities.

Since 2002, OROSC has received five major awards specific to substance abuse prevention: 1) State Incentive Grant (SIG); 2) Strategic Prevention Framework State Incentive Grant (SPF/SIG); 3) Center for Substance Abuse Prevention (CSAP) SEOW award; 4) Strategic Prevention Enhancement (SPE); and 5) Strategic Prevention Framework Partnerships for Success II (PFS II). Deliverables from these awards have had a cumulative effect and strengthened our infrastructure systemically to foster the use of a data-driven planning process, expand the use of evidence-based programs, develop epidemiological profiles and logic models, and increase the capacity to address mental, emotional, and behavioral conditions to support and improve the quality of life for citizens of Michigan.

Overall, a sound-functioning and well-organized community prevention infrastructure exists in Michigan. PIHPs are contractually required to submit multiple year Strategic Plans (SPs) to OROSC, which address identified priority problems, and target specific interventions related to the appropriate intervening variables. These prevention strategies illustrate evidence of the five-step SPF/SIG planning process by utilizing local community coalitions, parents, and youth as part of this ongoing planning process. The PIHPs must complete a comprehensive strategic plan, based on this data-driven planning model process, and complete a planning chart using a logic model approach with their submission.

The state also contracts with Prevention Network (PN), another partner involved in the established statewide infrastructure that works to coordinate and allocate funding to high need communities. PN provides support, training, technical assistance and mini-grants to grassroots community groups to offer a full continuum of substance abuse prevention services. As part of PN, the Michigan Coalition to Reduce Underage Drinking (MCRUD) assists local communities across the state, specifically with underage drinking initiatives. As a mechanism to collaborate with Native American Tribes and communities in Michigan, the Michigan Inter-Tribal Council (ITC) has been an integral partner for SPF/SIG, SEOW and PFS II, and OROSC has supported substance abuse training to member tribes of the ITC. This relationship exemplifies an ongoing process and support system that addresses and responds to the substance abuse prevention related needs of tribes and tribal organizations in the state.

4. Please describe if the state has:

a. A statewide licensing or certification program for the substance abuse prevention workforce

Michigan requires PIHPs to only contract with licensed substance abuse prevention providers, with oversight from the Department of Licensing and Regulatory Affairs. In addition, contractually, PIHPs shall have written credentialing policies and procedures for ensuring that all providers rendering services are appropriately credentialed within the state and are qualified to perform their services. The PIHP must ensure that network providers residing and providing services in bordering states meet all applicable licensing

and certification requirements within their state. The PIHP also must have written policies and procedures for monitoring its providers and for sanctioning providers who are out of compliance with the standards. Credentialing in Michigan is primarily conducted through the Michigan Certification Board for Addiction Professionals (MCBAP), a private non-profit not affiliated with state government.

b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce

As part of the SPF/SIG, Michigan developed a training cadre to sustain efforts on the SPF-based components. These individuals have continued to be available over the past six years to provide their expertise via one-on-one technical assistance in addition to formal training. In addition, twelve individuals completed the Substance Abuse Prevention Skills Training (SAPST) Training of Trainers (TOT) two years ago, and a minimum of four SAPST are conducted across the state each fiscal year. Two individuals have either completed or are in the process of completing the TOT for the Native-SAPST. Many components of the 5-step SPF model have also been developed into recorded webinars that are available through the OROSC training contract. Other support is also provided, such as in-service trainings at the local level, numerous webinars in conjunction with the Central Region Center for Application of Prevention Research (CAPT) and an annual statewide substance use disorder conference.

Many resources are available on the OROSC website for technical assistance as well. One such document, the OROSC toolkit *Transforming Cultural and Linguistic Theory into Action*, provides a framework for individuals to examine their own cultural values and evaluate their interpersonal strengths and weaknesses. Self-evaluation is ongoing, recognizing that individuals continually adapt and re-evaluate the way things are done. The ultimate goal is to continually improve the quality of services and health outcomes for all cultural groups and reduce disparities that occur when an individual's culture deviates from the majority or mainstream.

c. A formal mechanism to assess community readiness to implement prevention strategies

Assessing community readiness is part of the SPF 5-step process, and is including as part of the annual Strategic Plan submitted to MDHHS/OROSC. Additionally, training has been provided on how to utilize the Tri-Ethnic Center for Assessing Community Readiness tool. Training has also been provided on conducting focus groups and key informant interviews as part of developing an overall comprehensive plan. Another key element communities utilize in assessing community readiness includes political will.

5. **How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?**

   Michigan uses a public health approach which encompasses improving health through a focus on population-based measures. SEOW provides a baseline data of mental and behavioral health linked to substance use disorders to aid in goal-setting that includes services for children and families. The overall work of the SEOW positions Michigan for effective implementation of a data-driven decision making process in developing prevention prepared communities, which will lead to improved outcomes. Using of a data-driven planning process, Michigan developed public media education campaign *Do Your Part: Be the Solution (www.michigan.gov/doyourpart)*. It was designed to educate Michigan citizens about the dangers and the extent of substance abuse in Michigan, especially the abuse of prescription drugs and alcohol.

6. **Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.**

   Since 2009, Michigan has adopted the recovery oriented systems of care (ROSC) concept as the core philosophy for the design and delivery of substance use disorder (SUD) prevention, treatment, recovery and mental health promotion services. The ROSC is used as a roadmap on how to align substance abuse prevention and fiscal infrastructure with other state and community-level partners. Prevention prepared communities (PPCs) are essential to the successful implementation of a ROSC. As part of the SPE project, environmental scans were conducted in five target regions that helped frame the Capacity Building/Infrastructure Enhancement Plan for prevention prepared communities. One piece of this was the development of a Comprehensive Five-Year Strategic Prevention plan (through 2018) as well as plans for enhancing workforce development and developing state policy to support needed service system improvements.

   This plan identifies the following goals:

   A. Reducing underage and adult problem drinking.
   B. Preventing prescription drug abuse.
   C. Preventing suicide.
   D. Developing a workforce to accomplish goals A, B, and C.
   E. Recommending and implementing policy changes across state-level partners and stakeholders responsible for substance use disorder (SUD) prevention and mental health promotion that will facilitate success in achieving the purpose of this grant.

Specific strategic plans to address underage drinking and prescription drug abuse are being developed, and potential recommendations for environmental change strategies and community based efforts will be likely be part of those plans.

All PIHPs are required to address items A and B in their annual Strategic Plans submitted to OROSC for SABG primary prevention set-aside. Based on local data, if there is a third priority area identified and funds are sufficient, the PIHP may also propose to address that area as well. Strategic plans also must address how PIHPs are working with local collaborators to prevent suicide.

7. **Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.**

   The OROSC advisory group, the Transformation Steering Committee (TSC), has several workgroups established under its umbrella. One of these, the TSC-Prevention Workgroup (PW), is the existing advisory council for all substance abuse related prevention efforts. Membership of this group includes PIHPs, substance abuse coalitions, Department of Education (MDE), MDHHS-Human Services (child welfare), Michigan State Police Office of Highway Safety Planning, Michigan Army National Guard, faith-based agencies, providers, and administrators.

A subgroup underneath the TSC-PW is the Evidence Based Process Workgroup (EBPW). The EBPW developed a *Guidance Document on Selecting, Planning and Implementing Evidence-Based Interventions for the Prevention of Substance Use Disorders*. This document has been used across the state as a first step for communities to begin making decisions regarding evidence based programs, policies and practices, and was developed using language that will easily be understood by the general public and local communities. The document is available at http://www.michigan.gov/documents/mdch/Mich_Guidance_Evidence-Based_Prvn_SUD_376550_7.pdf and is used by regional PIHPs, local coalitions, and community groups to guide their decision making process on which program to implement to best meet their needs and desired outcomes.

Michigan is fortunate to have other SAMHSA Cooperative Agreements. MDHHS was recently awarded a SAMHSA Cooperative Agreement for State-Sponsored Youth Suicide Prevention and Early Intervention, the Transforming Youth Suicide Prevention in Michigan, Phase 2 (TYSP-Mi2). Larry Scott, Michigan's National Prevention Network (NPN) designee and OROSC Section Manager serves on the State Government Interdepartmental Workgroup for the TYSP-Mi2 project. Collaboration and coordination of efforts between these two projects is a priority, primarily in outreach and other engagement strategies to increase participation in and access to services for diverse populations. Part of the TYSP-Mi2 project is to form and participate in a

public/private coalition of youth-serving institutions and agencies that advises, participates in and supports their grant activities. This will also include PFS project activities, including sharing of data, alignment of EBPs when possible, and mutual cross-training for subrecipients and subgrantees.

In addition to TYSP-Mi2, there are two other projects in Michigan occurring with similar overlapping goals related to building health communities and increasing mental health capacity which OROSC coordinates activities at the state and local level: 1) MDHHS (formerly the Department of Human Services - DHS) Pathways to Potential (PP); and 2) MDHHS/MDE Safe Schools/Healthy Students (SS/HS). These projects have identified shared risk and protective factors, as well as causal interconnections, to address overall prevention efforts. Youth and young adults need to be supported by a system including schools, families and community agencies. As youth and families have greater access to and participate more frequently in supportive programs in their communities, there will be reductions in alcohol and other drug use. PP utilizes Strengthening Families EBP, and some districts involved in the SS/HS project utilize Prime for Life, two projects many SABG block grant funded recipients implement. In addition to serving on each other's advisory committees and work groups, cross-training and shared resources for training will be made available.

8. **Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.**

   All six of CSAP's primary prevention strategies are funded as part of Michigan's comprehensive prevention effort, and all three classifications of target population risk (universal, selective and indicated) are allowable, as appropriate given the intervention being implemented. All prevention services identified in region PIHP Strategic Plans must categorized under one of the six federal prevention strategies, and the link to the corresponding intervention for each must be made on the plan's Logic Model.

   The federal prevention strategies that should have priority in each region are Community-Based Process (to bring entire communities together to address an issue through systematic planning, coordinator and collaboration, building coalitions, etc.) and Environmental (addressing working toward actual changes in standards, codes, policies, ordinances, etc.). These two strategies are prioritized due to the understanding that making changes at the local community level will have the greatest impact on and effect changes at the state-level. Education and Problem Identification and Referral are to be the next level of prioritized strategies in a region. The two remaining strategies, information dissemination and alternatives, are allowable as part of an overall comprehensive prevention strategy, however have some qualifiers. Information dissemination can only be used in conjunction with one of the other strategies, and it cannot be a stand-alone strategy. In the same manner, alternative strategies must be evidence-based, are typically used in conjunction with other strategies, and

are for highly targeted populations with the assumption that constructive and health activities offset the attraction to drugs.

1. Information Dissemination: This strategy provides information about the nature and extent of drug use, abuse, and addiction and its effects on individuals, families, and communities. It also provides information on available prevention programs and services. The dissemination of information is characterized by one-way communication from the source to the audience, with limited contact between the two. Examples of methods used for this strategy include the following: media campaigns; brochures; radio and television public service announcements; speaking engagements; and health fairs. As noted above, this strategy cannot be stand-alone in Michigan.
2. Education: This strategy involves two-way communication, and is distinguished from merely disseminating information by the fact that it is based on an interaction between the educator and the participants with the intention of building skills through a structured learning process. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, and critical analysis. Examples of methods used for this strategy include: classroom and small group discussions; parenting and family management classes; peer-leader and peer-helper programs; education programs for youth groups; and groups for children of substance abusers.
3. Alternatives: This strategy provides for the participation of target populations in activities that exclude drug use. The assumption is that because constructive and healthy activities offset the attraction to drugs, or otherwise meet the needs usually filled by drugs, then the population would avoid using drugs and be provided alternative, healthy activities. Examples of methods used for this strategy include: drug-free social and recreational activities; drug-free dances and parties; youth and adult leadership activities; community drop-in centers; and mentoring programs.
4. Problem Identification and Referral: This strategy aims to identify those who have indulged in the illegal or age- inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of drugs, in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if an individual is in need of treatment. Examples of the methods used for this strategy include the following: driving while intoxicated education programs; employee assistance programs; student assistance programs; and screening in primary care or community-based settings to identify those individuals appropriate for selective and indicated population interventions.
5. Community-Based Process: This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for substance use disorders. Activities in this strategy include organizing, planning, enhancing the efficiency and effectiveness of service implementation, building coalitions, and networking. Examples of methods used for this strategy include the following: community and volunteer training (e.g., neighborhood action training, training of key people within the system, etc.); systematic planning; multi-agency coordination and collaboration; accessing service and funding; and community team building.

6. Environmental: This strategy seeks to establish or change written and unwritten community standards, codes, and attitudes, thereby influencing the incidence and prevalence of drug abuse in the general population. Examples of methods used for this strategy include the following: the establishment and review of drug policies in schools; technical assistance to communities to maximize local enforcement procedures governing the availability and distribution of drugs; the review and modification of alcohol and tobacco advertising practices; and product pricing strategies.

Michigan does not limit PIHPs to specific programs to be implemented, nor does OROSC have a list of preferred programs to be funded, as part of SABG efforts. This is a deliberate decision, and is based on the belief local communities are in the best position to make those determinations when the 5-step SPF, data driven process is used. For over ten years there has been a contractual requirement that at least 80% of programs funded in a given region must be evidence-based.

9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?

Regional entities (PIHPs) are required to conduct annual financial audits of providers to determine compliance with SABG terms and conditions. Such audits are made available to MDHHS/BHDDA upon request. In addition, there are single audits conducted by MDHHS Bureau of Audit, Reimbursement and Quality Assurance Staff. The BHDDA Division of Quality Management and Planning staff also conduct site visits to PIHPs to review financial and programmatic information.

10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

All SABG funded community coalitions and providers are required to utilize the Michigan Prevention Data System (MPDS). The MPDS, collaboratively developed by OROSC and regional PIHPs, is a web-based prevention staff activity and program participant reporting system. The MPDS provides an interface for prevention providers to: enter selected prevention staff's direct service activities; enter prevention service and participant information; review status of submitted reports; edit records within established parameters; record units of service for prevention-based activity code sets; and generate standardized reports that are provider-specific. The MPDS provides an interface for PIHPs and OROSC to: review records from each provider; edit (or enter – PIHP only) provider records; perform standardized reporting based on entered data; create user-defined reports via a system download capability; use reporting features of the system (e.g., select from standard state reports); create additional and/or revised existing state-defined reports; and provide an online interface (support page) for posting questions, recommendations, and problems to be

addressed. MDHHS/BHDDA contracts with the Michigan Public Health Institute (MPHI) to operate the MPDS.

OROSC will review this data quarterly to pinpoint areas of concern based on the regional plans submitted. Communicating information back to PIHPs, advisory bodies and stakeholders will be handled through: 1) quarterly calls or emails with each region when areas of concern are identified; 2) progress reports to the TSC and TSC-PW at regular meetings; and 3) written summaries in the form of a dashboard to show comparisons across regions completed on a semi-annual basis.

11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Michigan has prioritized the following outcome indicators to monitor:

- Past 30 day use (alcohol, prescription drugs for non-medical use and marijuana) with focus on those age 12-25
- Age of first use (alcohol, prescription drugs for non-medical use, and marijuana)
- Perception of risk and harm with focus on those age 12-20
- Alcohol related traffic crash deaths (adolescent and adult)
- Family communication around alcohol and other drug (focus on those age 12-18)
- Adult binge drinking

Indicators will be tracked at least two times per year (as possible) and reviewed by the SEOW to monitor trends. If adjustments are needed, the SEOW will make recommendations to OROSC for review.

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

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:

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAMS FOR SPECIALTY PRE-PAID INPATIENT HEALTH PLANS

FY 2016

The State requires that each specialty Prepaid Inpatient Health Plan (PIHP) have a quality assessment and performance improvement program (QAPIP) which meets the standards below. These standards are based upon the Guidelines for Internal Quality Assurance Programs as distributed by then Health Care Financing Administration's (HCFA) Medicaid Bureau in its guide to states in July of 1993; the Balanced Budget Act of 1997 (BBA), Public Law 105-33; and 42 Code of Federal Regulations (CFR) 438.358 of 2002. This document also reflects: concepts and standards more appropriate to the population of persons served under Michigan's current 1915(b) specialty services and supports waiver; Michigan state law; and existing requirements, processes and procedures implemented in Michigan.

Michigan Standards

I. The PIHP must have a written description of its QAPIP which specifies 1) an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP; 2) the components and activities of the QAPIP, including those as required below; 3) the role for recipients of service in the QAPIP; and 4) the mechanisms or procedures to be used for adopting and communicating process and outcome improvement.

II. The QAPIP must be accountable to a Governing Body that is a PIHP Regional Entity. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:

A. Oversight of QAPIP - There is documentation that the Governing Body has approved the overall QAPIP and an annual QI plan.

B. QAPIP progress reports - The Governing Body routinely receives written reports from the QAPIP describing performance improvement projects undertaken, the actions taken and the results of those actions.

C. Annual QAPIP review - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the operation of the QAPIP.

D. The Governing Body submits the written annual report to MDHHS following its review. The report will include a list of the members of the Governing Body.

III. There is a designated senior official responsible for the QAPIP implementation.

IV. There is active participation of providers and consumers in the QAPIP processes.

V. The PIHP measures its performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data.

A. PIHP must utilize performance measures established by the department in the areas of access, efficiency and outcome and report data to the state as established

in contract.

B. The PIHP may establish and monitor other performance indicators specific to its own program for the purpose of identifying process improvement projects.

VI. The PIHP utilizes its QAPIP to assure that it achieves minimum performance levels on performance indicators as established by the department and defined in the contract and analyzes the causes of negative statistical outliers when they occur.

VII. The PIHP's QAPIP includes affiliation-wide performance improvement projects that achieve through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and consumer satisfaction.

A. Performance improvement projects must address clinical and non-clinical aspects of care.

1. Clinical areas would include, but not be limited to, high-volume services, high-risk services, and continuity and coordination of care.

2. Non-clinical areas would include, but not be limited to, appeals, grievances and trends and patterns of substantiated Recipient Rights complaints; and access to, and availability of, services.

B. Project topics should be selected in a manner which takes into account the prevalence of a condition among, or need for a specific service by, the organization's consumers; consumer demographic characteristics and health risks; and the interest of consumers in the aspect of service to be addressed.

C. Performance improvement projects may be directed at state or PIHP-established aspects of care. Future state-directed projects will be selected by MDHHS with consultation from the Quality Improvement Council and will address performance issues identified through the external quality review, the Medicaid site reviews, or the performance indicator system.

D. PIHPs may collaborate with other PIHPs on projects, subject to the approval of the department.

E. The PIHP must engage in at least two projects during the waiver renewal period.

VIII. The QAPIP describes, and the PIHP implements or delegates, the process of the review and follow-up of sentinel events and other critical incidents and events that put people at risk of harm.

A. At a minimum, sentinel events as defined in the department's contract must be reviewed and acted upon as appropriate. The PIHP or its delegate has three business days after a critical incident occurred to determine if it is a sentinel event. If the critical incident is classified as a sentinel event, the PIHP or its delegate has two subsequent business days to commence a root cause analyses of

the event.

B. Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse.

C. All unexpected* deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed and must include:

1. Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
2. Involvement of medical personnel in the mortality reviews
3. Documentation of the mortality review process, findings, and recommendations
4. Use of mortality information to address quality of care
5. Aggregation of mortality data over time to identify possible trends.

* "Unexpected deaths" include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.

D. Following immediate event notification to MDHHS (See Section 6.1 of this contract) the PIHP will submit information on relevant events through the Critical Incident Reporting System described below.

E. Critical Incident Reporting System

The critical incident reporting system collects information on critical incidents that can be linked to specific service recipients. This critical incident reporting system became fully operational and contractually required October 1, 2011 (see Attachment 7.7.1.1).

The Critical Incident Reporting System captures information on five specific reportable events: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrest of consumer. The population on which these events must be reported differs slightly by type of event.

The QAPIP must describe how the PIHP will analyze at least quarterly the critical incidents, sentinel events, and risk events (see below) to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. MDHHS will request documentation of this process when performing site visits.

MDHHS has developed formal procedures for analyzing the event data submitted through this system. This includes criteria and processes for Department follow-up on individual events as well as processes for systemic data aggregation, analysis and follow-up with individual PIHPs.

F. Risk Events Management

The QAPIP has a process for analyzing additional critical events that put individuals (in the same population categories as the critical incidents above) at risk of harm. This analysis should be used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. MDHHS will request documentation of this process when performing site visits.

These events minimally include:

- Actions taken by individuals who receive services that cause harm to themselves
- Actions taken by individuals who receive services that cause harm to others
- Two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period

Following immediate event notification to MDHHS (See Section 6.1 of this contract) the PIHP will submit to MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within one year of the recipient's discharge from a state-operated service.

IX. The QAPIP quarterly reviews analyses of data from the behavior treatment review committee where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management or 911 calls to law enforcement have (see F above) been used in an emergency behavioral crisis. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plans and that have been approved during person-centered planning by the beneficiary or his/her guardian, may be used with beneficiaries. Data shall include numbers of interventions and length of time the interventions were used per person.

X. The QAPIP includes periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with its services. These assessments must be representative of the persons served and the services and supports offered.

A. The assessments must address the issues of the quality, availability, and accessibility of care.

B. As a result of the assessments, the organization:

1. Takes specific action on individual cases as appropriate;
2. Identifies and investigates sources of dissatisfaction;
3. Outlines systemic action steps to follow-up on the findings; and
4. Informs practitioners, providers, recipients of service and the governing body of assessment results.

C. The organization evaluates the effects of the above activities.

D. The organization insures the incorporation of consumers receiving long-term supports or services (e.g., persons receiving case management or supports

coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.

XI. The QAPIP describes the process for the adoption, development, implementation and continuous monitoring and evaluation of practice guidelines when there are nationally accepted, or mutually agreed-upon (by MDHHS and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, best practices and promising practices that are relevant to the persons served.

XII. The QAPIP contains written procedures to determine whether physicians and other health care professionals, who are licensed by the state and who are employees of the PIHP or under contract to the PIHP, are qualified to perform their services. The QAPIP also has written procedures to ensure that non-licensed providers of care or support are qualified to perform their jobs. The PIHP must have written policies and procedures for the credentialing process which are in compliance with MDHHS's Credentialing and Re-credentialing Processes, Attachment P.7.1.1, and includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, recertifying and/or reappointment of practitioners. These procedures must describe how findings of the QAPIP are incorporated into this re-credentialing process.

The PIHP must also insure, regardless of funding mechanism (e.g., voucher):

1. Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following:

    a. Educational background
    b. Relevant work experience
    c. Cultural competence
    d. Certification, registration, and licensure as required by law

2. A program shall train new personnel with regard to their responsibilities, program policy, and operating procedures.

3. A program shall identify staff training needs and provide in-service training, continuing education, and staff development activities.

XIII. The written description of the PIHP's QAPIP must address how it will verify whether services reimbursed by Medicaid were actually furnished to enrollees by affiliates (as applicable***),*** providers and subcontractors.

1.The PIHP must submit to the state for approval its methodology for verification.

2.The PIHP must annually submit its findings from this process and provide any follow up actions that were taken as a result of the findings.

XIV. The organization operates a utilization management program.

A. Written Plan - Written utilization management program description that includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.

B. Scope - The program has mechanisms to identify and correct under-utilization as well as over-utilization.

C. Procedures - Prospective (preauthorization), concurrent and retrospective procedures are established and include:
   1. Review decisions are supervised by qualified medical professionals. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the conditions.
   2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate.
   3. The reasons for decisions are clearly documented and available to the member.
   4. There are well-publicized and readily-available appeals mechanisms for both providers and service recipients. Notification of denial is sent to both the beneficiary and the provider. Notification of a denial includes a description of how to file an appeal.
   5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
   6. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures.
   7. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

XV. The PIHP annually monitors its provider network(s), including any affiliates or sub-contractors to which it has delegated managed care functions, including service and support provision. The PIHP shall review and follow-up on any provider network monitoring of its subcontractors.

XVI. The PIHPs, shall continually evaluate its oversight of “vulnerable” people in order to determine opportunities for improving oversight of their care and their outcomes. MDHHS will continue to work with PIHP to develop uniform methods for targeted monitoring of vulnerable people.

The PIHP shall review and approve plans of correction that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate interval. Reports of the annual monitoring and plans of correction shall be subject to MDHHS review.

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma [75] is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems [76]. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”. [77] This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma [78] paper.

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

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

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

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75 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

76 http://www.samhsa.gov/trauma-violence/types

77 http://store.samhsa.gov/product/SMA14-4884

78 *Ibid*

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

Footnotes:

1. **Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?**

   As part of the Children's Trauma Initiative, participating CMHSPs utilize Trauma Informed Screening and Trauma Informed Assessment (Trauma Symptom Checklist for Young Children and the Northshore UCLA PTSD) as part of the intake process for children and youth with serious emotional disturbance (SED). Each CMHSP that participates in the Children's Trauma Initiative have clinical staff, supervisors and parent support partners trained to implement each component of the initiative. The components are: the Trauma Informed Screening and Trauma Informed Assessment as mentioned above; for those determined to be appropriate after assessment, trauma treatment through the implementation of the evidence-based Trauma Focused Cognitive Behavioral Therapy (TF-CBT) is available; and finally, caregiver education for biological, adoptive, and foster parents is available through the Resource Parent Training curriculum. This curriculum is also used to train community partners. The training is provided by clinical staff and parent partners. The focus of the Children's Trauma Initiative is to provide clinical staff and their supervisors with the skills needed to provide trauma-informed care and trauma treatment to children with SED and their families to ensure appropriate clinical intervention to a population that has a high probability of trauma.

   An extension of the Michigan Fidelity Assistance Support Team (MIFAST) has been developed to begin the process of on-site ascertainment of the degree to which agencies have achieved implementation of Trauma Informed Care. A standardized tool for conducting the on-site ascertainment has been chosen and a cadre of staff who are experts in Trauma Informed Care have been selected to form the team of site reviewers/consultants. The team began meeting in May of 2015 to complete training on the standardized tool and achieve inter-rater reliability prior to use with provider agencies. In 2016 it is expected that the Trauma MIFAST will be a part of the building and support for ongoing effective service quality, and a major part of the outcome tracking and analysis to substantiate progress and cost/benefit value.

2. **Describe the state's policies that promote the provision of trauma-informed care.**

   A draft statewide trauma policy has been created, promoted, and will be implemented throughout the Community Mental Health Services Programs (CMHSPs) and Prepaid Inpatient Health Plans (PIHPs) for all individuals served by the public mental health system. This policy, which is currently in the contract negotiations phase, was developed by the statewide Trauma Subcommittee of the Practice Improvement Steering Committee. This statewide policy outlines the prevalence of trauma, its severe destruction on the lives of individuals, the needs generated by the experience of trauma, and service provisions in the form of trainings, resources for trauma specific models, resources for screening and assessment of individuals tools, organizational self-assessments, and a general outline of the expectations the State has of its provider system. The principles of trauma informed care are detailed in the policy with explanations of these dynamics of trauma resolution. The next facet of implementation is a series of statewide trainings on the trauma policy as well as support, resources, and education.

3. **How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?**

   Please see Question # 1 for information about trauma-specific interventions for children with SED and their families.

   For adults with serious mental illness, the state has made block grant dollars available for trauma-informed system of care development within the PIHP region. These projects involve the review of the provider network to determine its capacity and ability to provide services to individuals and consist of building the organizational structure and framework that will increase the understanding and ability to respond to the effects of trauma.

4. **Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?**

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

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

   This initiative has been supported with block grant funding for several years and has resulted in the participation of 41 out of 46 CMHSPs in Michigan. The initiative continues with the goal of expanding statewide.

   Statewide training for individuals who work with adults with serious mental illness include Seeking Safety, TREM, M-TREM, Cognitive Behavior Therapy, and Beyond Trauma. MDHHS is working with the Michigan Association of Community Mental Health Boards and Community Connections in Washington, D.C. to provide these trainings. Community Connections also provides monthly coaching calls to agencies.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.[79]

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.[80] [81] Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[82]

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

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

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

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

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

[79] http://csgjusticecenter.org/mental-health/

[80] The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman,2000.

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

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

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

Footnotes:

1. **Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?**

   Individuals who are involved in, or at risk of being involved in, the criminal justice system may be enrolled in traditional Medicaid or Medicaid expansion. Those fund sources would be used for the provision of covered behavioral health services. Eligibility for enrollment in Michigan's Medicaid expansion program is not affected by an individual's involvement, or risk of involvement with the criminal justice system.

   This remains a challenge for many communities as consumers who may be eligible for Medicaid may not be enrolled because they are not currently receiving services (where a case manager would be helpful in signing them up), not knowledgeable enough about the system to do it themselves or those that are directly involved with the criminal justice system who fall between the cracks as they move through that system. The Mental Health Diversion Council is funding pilots that are looking at this issue in order to hire jail staff that would be able to recognize and assess these consumers to initiate getting them on Medicaid so the lag time between release and first appointments with treatment remain minimal.

   Youth involved in juvenile justice were not a target population of Michigan Medicaid expansion.

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

   This depends largely on the county and the resources they have available. Some counties have decreased this type of service or dropped it all together based on the availability of general funds. Some jails do offer at least limited mental health services but most do not. There are efforts in some communities to partner jail/prison and CMHSP staff to help coordinate treatment services for both mental health and substance use upon release for consumers but this is hit and miss statewide. The Mental Health Diversion Council has been instrumental in funding pilots around the state to help fill this gap. There is also a national effort moving forward called the Stepping Up Initiative (to which Lynda Zeller is its national co-chair) that is urging local communities to sign resolutions that would bond stakeholders like CMHSPs, sheriffs, prosecutors, judges, local and state representatives, police, etc., in recognizing the need to reduce the number of people with mental illnesses in jails by working closely together to do so.

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

   With regard to reentry from prison for the special needs population, there is a system in place for each of the individual CMHSPs across the state. Professional Consulting Services Re-entry Project does not work at the state level, but rather work with local CMHSPs to get individuals linked in with appropriate services. This process works differently for each

agency. Some will do assessments pre-release and give us a sense of exactly what services they will get once they get released. Others perform face to face assessments and some do video conferences. Some will only do a paper review and give us an idea of eligibility, but cannot firm anything up until the individual is out and they do an assessment in the community. Some will give us an idea of what type of housing would be appropriate based on whatever past experience they may have with an individual AFC vs. Transitional vs. Room and Board. Some of the smaller CMHSPs do not do very much in the area of pre-release and we are working with them to do more. For individuals who do not meet CMHSP eligibility, we have another service provider network that can assist with mental health services for these types of cases. With the implementation of Healthy Michigan, that percentage has gone down, but there are still a number of special needs cases that do not meet CMHSP eligibility.

For jails, all CMHSPs are required to have diversion programs, so there must be some system in each CMHSP area for how services are provided. This method of service provision can be delivered very differently across the state.

The Mental Health Diversion Council continues to fund pilots that offer the goal of stability upon reentry to the community from incarceration. This would include stable housing, medication appointments, employment opportunities, treatment for mental illness and substance use, follow up psychiatric evaluations and case management services.

There is also a Juvenile Justice Diversion Council position funded by state Mental Health and Wellness dollars that is in the process of being hired and will be housed in MDHHS-Division of Mental Health Services to Children and Families who will work with the Council to implement their strategic action plan and focus specifically on issues related to diversion in the juvenile justice system.

4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

This differs from agency to agency. Some CMHSPs offer "mental health" 101 type of training to officers and court staff through their training departments. Many communities do not have the resources to facilitate a comprehensive training regimen that would be deemed a best practice such as Crisis Intervention Training (CIT). CIT would offer a 40-hour training to officers in the field, jail personnel, dispatchers and certain CMHSP staff that would help deescalate situations in the field that translate to less arrests and jail time. The Mental Health Diversion Council is currently sponsoring several pilots in the state to utilize CIT in their communities in an effort to minimize arrests and subsequent incarcerations.

MDHHS also participates in the Juvenile Justice Vision 20/20 Project, which is an ongoing cross-systems collaborative group that began work in 2011 to assess and make recommendation to improve the juvenile justice system in Michigan. The focus of priority projects for this group includes: the unique purpose of the juvenile court; effective outcomes for juveniles, families and communities; juvenile court operational performance; adequate

and sustainable funding and a strong juvenile justice workforce. One of the main activities of the subcommittee working on strengthening the juvenile justice workforce is to plan and host regional and statewide trainings in collaboration with the Michigan Judicial Institute and other stakeholders. This committee has offered bi-annual cross-system trainings for the past two years and plans to do the same in 2016 and 2017.

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.[83]

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.[84]

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

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

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

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

[83] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

[84] Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589-1594

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

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40[85], 43[86], 45[87], and 49[88]. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

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

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

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

[85] http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939

[86] http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

[87] http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131

[88] http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380

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

Footnotes:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?

   - Development of targeted, information specific webinars on medication assisted treatment (MAT) services and the utilization of medications and behavioral health therapies.
   - Presentations and technical assistance provided to foster care, child protective services, prosecuting attorneys, and court systems/judges.
   - Continue the provision of MAT services regulation, infrastructure, addiction education through the state SUD training contract, and the Statewide SUD/Co-occurring conference.
   - Enhance the current "Do Your Part" media campaign website for the purpose of raising awareness within substance abuse treatment programs and the public regarding MAT as a viable option.
   - Implement recommendations from the Governor's Task Force on Prescription Drug and Opioid Abuse.

2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?

   - Review admission data and align outreach efforts.
   - Utilization of social media campaigns to accomplish outreach to pregnant women.
   - Collaboration with the Michigan Primary Care Association (MPCA) and Federally Qualified Health Centers (FQHC), and utilization of peers/recovery coaches in select areas within communities.
   - Explore piloting health homes with MAT services at their core.
   - Collaboration with prisoner re-entry programs to do pre-release assessment and referral initiatives.

3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

   - Continue the MAT Workgroup to identify and promote the use of current, research based MAT services.
   - Continue to work with Medicaid office on MAT policies.
   - Continue SUD contractual requirements for MAT services.
   - Continue roll out and implementation of new Michigan Guidelines for Medication Assisted Treatment of Opioid use disorders that requires availability of all three FDA approved medications for opioid addiction – methadone, buprenorphine, and naltrexone, and provide information regarding program infrastructure and service configurations proven to support opioid treatment/recovery efforts.
   - Continue to monitor service delivery system through data reports and on site reviews.
   - Continue to provide funding for recovery support services.

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[89] ,

> "Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

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

[89]Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

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

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist/Promotoras
- Clubhouses
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Evidenced-based supported
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

employment

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

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

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

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

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:

1. **Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?**

   As part of the state plan, a definition of recovery can be found in the Recovery-Oriented System of Care (ROSC) Glossary of Terms. This twelve page glossary was developed by a behavioral health workgroup comprised of persons from both the substance use disorder and mental health services system. A primary principal in the ROSC transformation process is the importance and value of the voice of lived experience. Additionally, the ROSC implementation plan has goals, objectives and strategies related to recovery, recovery support services, and the integral involvement of individuals in recovery. Individual recovery cannot occur without a system of care that is recovery oriented.

   The state promotes and encourages hiring individuals with disabilities and lived experience in a variety of roles. MDHHS has an established position as the Director of the Office of Consumer Relations. In addition, a person with lived experience in mental health recovery is the state trainer for peer specialist and recovery coach initiatives. Governor Rick Snyder has issued an executive directive for state government to lead by example in hiring people with disabilities. The directive calls for new policies, training across agencies and departments. The MDHHS contract with PIHPs has recovery values woven in multiple places. Person-centered planning has been a mental health code requirement since 1996. In addition, contract requirements in the Managed Care and Specialty Services Waiver includes the opportunity for individuals to participate in self-directed care. Many documents have been developed to provide technical assistance to agencies, individual's, and families. More information can be found at: http://www.michigan.gov/mdch/0,4612,7-132-2941_4868_4900-264686--,00.html

   The mental health system has an array of recovery services and supports. As a national leader in peer services, over 1500 individuals have been trained and certified. As an established profession, the state requires individuals to be working at least 10 hours per week for at least 3 months before acceptance into training. Several Federally Qualified Health Centers employ Certified Peer Support Specialists (CPSS) to run health and wellness groups supporting self-management practices of chronic co-morbid conditions. Peer roles are often blended to perform similar job duties of Community Health Workers and navigators. As an integral component of the state plan, peer roles are clearly outlined in the Medicaid Provider manual for family support partners, peer mentors for person with developmental and intellectual disabilities, CPSS, Certified Recovery Coaches (CRC) and youth peer specialists.

2. How are treatment and recovery support services coordinated for any individual served by block grant funds?

MDHHS, through Medicaid, general fund, and block grant contractual agreements with the CMHSPs and PIHPs, provides for the provision and coordination of services inclusive of treatment and recovery supports. Some examples include, but are not limited to, the following:

- development and utilization of a ROSC implementation plan for Michigan's publicly-funded behavioral health system;
- development of an ongoing planning and reporting tool that encourages planning around key elements of recovery and ROSC;
- development and dissemination of ROSC information via ROSC orientation power points, fact sheets and newsletters;
- training of peer recovery coaches;
- adoption of technical advisories, policies, requirements and regulations related to ROSC initiatives, peer support services, best practices, access to services, etc.;
- provision of educational forums and trainings (i.e., training contract workshops, statewide behavioral health conferences, peer focus groups, ROSC regional symposiums);
- application and receipt of a SAMHSA BRSS TACS grant;
- utilization of Action Plan Guidelines requiring the continued transformation to a ROSC, the use of peer support services, and special projects related to NIATx and Integrated primary health care;
- utilization of behavioral health integration Requests for Application to continue transformation within the common elements shared by mental health and substance use disorder services;
- development of a glossary of ROSC terminology to improve communication;
- development of an essential benefits package for recovery from substance use disorders based on SAMHSA's Good and Modern document and the coalition for whole health document;
- support for the transformation of a recovery workgroup that was part of the ROSC TSC work into Michigan Recovery Voices statewide recovery organization;
- placement of CPSS in Federally Qualified Health Centers;
- inclusion of CPSS roles in a Stanford research study for the Chronic Disease Self-Management Program;
- CPSS as Independent Support Brokers for self-directed care;
- partnership with Michigan Primary Care Association to integrate whole health action planning in primary care settings;
- Veterans Policy Academy initiatives; and
- Development of trainings for the roles of peer providers in the peer-run organizations.

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

   All of the populations mentioned in the question above benefit from recovery-oriented services systems, however, there is only one specialty population receiving targeted peer delivered services at this time and that is women with children and women of childbearing age. Additionally, BHDDA has developed a technical advisory in this regard, Treatment Technical Advisory #8 Enhanced Women's Services. As the ROSC Transformation continues, additional targeted specialty population initiatives are anticipated.

   MDHHS trains veterans for peer support certification side by side with individuals with mental health and co-occurring conditions. This partnership has provided a variety of benefits to individuals served across the state at CMHSPs, the Veterans Administration and regional offices. The Michigan training curriculum developed in partnership with the Appalachian Consulting Group of Georgia and the Depression Bi-Polar Support Alliance is nationally recognized by the federal Veterans administration as an approved curriculum for certification recognized in all states. In addition to the certification process, a variety of continuing education events related to trauma, cultural competency, and Family Psychoeducation are provided across the public system. Several groups are provided in the state specific to the LGBT population. One of Michigan's partners, Michigan Disability Rights Coalition, serves as a peer run organization that provides information and technical assistance to the LGBT community. The peer-run drop-in centers in Michigan also serve many of the same populations listed above.

4. **Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?**

   Since the announcement of the transformation to a ROSC, both the annual statewide substance use conference and the BHDDA substance use disorder training contract and plan have focused primarily on recovery oriented system, principals, and practices. Members of the ROSC TSC are seated on the conference and training contract planning committee, and are diligent in their effort to assure that the state's ROSC transformation priorities are represented within the training plan. Training related to peer recovery support services are part of both training forums, and additional recovery coach training is offered through a separate forum at the regional level. BHDDA is also pursuing ways in which SUD ROSC trainings can be made available through online capabilities. BHDDA recognizes that ongoing transformation initiatives require ongoing training support, and the administration continues to make that a training contract priority.

The PIHPs provide regular and ongoing education on recovery with staff across entire agencies which are included in strategic planning efforts. The area of working with peer providers has been addressed both formally and informally. At the end of the fiscal year a specialized evaluation tool will be piloted that assesses and opens discussion on the strengths of what paid peer providers offer in the continuum of care and the view of supervisors or managers on effective delivery of peer services. This tool is being piloted at Georgia at the same time as Michigan. Many agencies have developed on-line learning and contracted with other organizations in the country to provide information in the areas of recovery and peer providers. Webinars that are offered nationally are attended by MDHHS staff, regional and local providers and peers. MDHHS publishes webinar opportunities broadly in all regions of the state. This area of focus is part of the MDHHS Application for Participation on the expectations of recovery services and supports. The 53 consumer run drop-in centers in Michigan participate in trainings statewide and regionally on recovery oriented and recovery focus principles. Justice in Mental Health Organization (JIMHO), which is peer run, provides peer reviews to assess the quality, appropriateness, and efficacy of consumer run drop-in centers who receive mental health block grant funding. It is the intent of JIMHO to provide oversight, support, and technical assistance to ensure that each consumer run drop-in center operates in an appropriate manner that focuses on improving one's recovery through peer support.

Per the MDHHS Medical Provider Manual, PIHPs must seek approval from MDHHS prior to establishing new consumer run programs. Proposed consumer run organizations will be reviewed against the following criteria:

- Staff and board of directors of the center are 100% primary consumers;
- PIHP actively supports consumers' autonomy and independence in making day-to-day decisions about the program;
- PIHP facilitates consumers' ability to handle the finances of the program;
- The drop-in center is at a non-CMH site;
- The drop-in center has applied for 501(c)(3) non-profit status;
- There is a contract between the drop-in center and the PIHP, or its subcontractor, identifying the roles and responsibilities of each party; and
- There is a liaison appointed by the PIHP to work with the program.

5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?

Several exemplary activities are currently underway, including the training of Certified Peer Support Specialists in prison settings through our SAMHSA BRSS TACS grant. Thirty individuals at Women's Huron Valley prison will be certified as peer specialists, recovery coaches, Whole Health Action Management (WHAM) and Wellness Recovery Action

Planning (WRAP) facilitators. The training provided will be modeled after the community based peer specialists. In addition, recovery coach certification will be provided. Peer specialists and recovery coaches are hired and employed at Federally Qualified Health Centers. Both disciplines served in a broader role of community health workers. A training and credentialing process for youth peers is underway to ensure all populations receive recovery services and supports across the continuum of care.

The department has assembled a group of peer leaders who have lived experience in substance use disorders to develop a statewide curriculum for the certification of recovery coaches. The credentialing process will provide for employment and sustainability.

6. **Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).**

   The planning of behavioral health services is an undertaking of the state's regional PIHPs. The methods that they utilize to gather this information for the planning, delivery, and evaluation of behavioral health services includes the following: client satisfaction score, public hearings, strategic planning initiatives, and family interaction in training sessions. MDHHS has developed a strong relationship with NAMI state and local organizations to ensure efforts at the state level are carried over to the local levels. The Application for Participation has several requirements which include guidance on how to engage persons with lived experience, family members and natural supports in the planning, delivery and evaluation of behavioral health services. Peers at the peer-run organizations have meetings to voice their ideas in the running of their organizations, held directly at their centers.

   Peers are also involved in the Behavioral Health Advisory Council which is involved in the planning and evaluations of services and the review of the state plan for block grant services. Persons with lived experience serve on Transformational Steering Committee supporting the statewide ROSC movement. Peers are also involved in the review and scoring of block grant funding proposals in response to MDHHS' annual requests for applications.

7. **Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?**

   Many of the MDHHS central office staff develop agendas and provide information to the executive management team regarding the voices and input of persons with lived experience. This includes integrated statewide recovery organizations, consumer run drop-in centers and the vast array of recovery oriented service networks. The input provided is utilized in the development of recovery principles and practice documents and strategic planning. The recovery community is involved in the development and review of policies, plans, grant applications and request for proposal development. Statewide central office committees

include a variety of individuals and families with lived experience guiding and steering the process in leadership positions.

Two organizations representing Certified Peer Support Specialists and Certified Recovery Coaches provide leadership in the state. Michigan Recovery Voices, developed and ran by Certified Recovery Coaches, work with recovery community organizations and provide technical assistance on recovery supports and services. Michigan Peer Specialists United are a 501(c)(3) organization representing CPSS. Both organizations are involved in strengthening recovery services and serve as advisors on MDHHS policies and initiatives.

The MDHHS Office of Consumer Relations, which is headed by an individual with lived experience, provides technical assistance and support to the peer-run organizations through consultation, reviews, awards for outstanding peer organizations and support. This position also provides direct support to individuals who attend the peer-run organizations who voice their ideas in support groups, dissemination of resources, and management of the peer-run organizations. The State supports the standard of 100% peer run, empowering the peer leadership, direct ownership and responsibility in the running of the peer organizations.

8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.

MDHHS tracks the activities of peers and peer-run centers by meeting in person monthly with the Justice in Mental Health Organization, which oversees the 53 consumer run drop-in centers in Michigan. This information is also provided through narrative reports and includes problem solving, support, trainings, and management issues. Measuring the impact of peers is done in both personal story accounts directly from peers and also from the peer directors of the centers. The number of peers attending each centers, attending activities put on by the centers, and educational trainings and conferences are noted. Satisfaction surveys are completed intermittently at the centers which are reviewed for the stated needs and ideas for implementation of change based on the voices of consumers.

9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.

Certified Peer Support Specialist continuing education provides a variety of trainings with a health and wellness focus. Wellness Recovery Action Planning (WRAP), an evidence based practice, is provided several times a year. In addition, Whole Health Action Management (WHAM) trainings have been offered to promote wellness with CPSS leading groups using the principles and practices of self-management techniques. The New Jersey CHOICES program for tobacco cessation is consistently offered to the peer workforce as a successful model in reducing and eliminating risks associated with smoking.

A Statewide Integrated Health Learning Community (IHLC) developed by MDHHS in partnership with Michael Association of Community Mental Health Boards and the National Council for Behavioral Health is supported by block grant funds. Any Michigan community mental health agency or partnering primary care health center is encouraged to participate with the overall focus on developing integrated health care efforts and improving the health and well-being of those being served in the behavioral health system. The IHLC focuses on and/or provides guidance in a variety of areas including, but not limited to:

- Discussion forums on a designated website (www.improvingmipractices.org) that allows all partners to provide and discuss concerns and information.
- Additional resources may be shared, provided or gathered in areas such as Financing & Sustainability, Clinical Practices, Administration Health Information Management and the Integrated Healthcare Workforce are readily accessible to those seeking further information on www.improvingmipractices.org
- Webinars on topics pertinent to Integrated Healthcare development such as 'Evolving Models of Integration' and 'Health Information Technology and Quality Improvement.'

Attendees have given positive comments regarding the effectiveness of sharing available materials, perusing through multiple agencies for inspiration, ideas and self-comparisons. This approach has been touted as original, innovative, efficient and constructive.

10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?

MDHHS has developed a Technical Advisory on recovery housing that is being disseminated to the field/public for review and comment.

The Michigan State Housing Development Authority provides the following housing programs that target families and individuals with disabilities with housing needs. Most of the programs focus on homeless households and address chronic homelessness. The programs are integrated into the community, given household choice where they live, and are offered support services to meet their needs.

- HUD 811 Grant
- SAMHSA-CMS Cooperative Agreement to Benefit Homeless Individuals (CABHI) Grant: Michigan Housing and Recovery Initiative
- Low Income Housing Tax Credits with Permanent Supportive Housing
- State Rent Assistance Programs
- Emergency Solutions Grant Rapid Re-Housing
- Housing Choice Voucher Program with the Homeless Preference
- Housing and Urban Development Veterans Affairs Supportive Housing Vouchers

- Project Based Vouchers
- Shelter Plus Care
- Housing Opportunities for Persons with AIDS

The programs above are part of the collaborative work within Michigan's Campaign to End Homelessness which is led by the Michigan Interagency Council on Homelessness (ICH). In January 2015, through the executive order by Governor Snyder, the ICH received official recognition and now includes additional state departments to ensure better efforts in ending homelessness statewide, especially for those with disabilities in need of housing.

The Michigan Mental Health and Wellness Commission organized by Lieutenant Governor Brian Calley, through an executive order by the Governor Snyder, convened in 2013. The commission succeeded at securing funding for five hundred new housing units for people that are homeless and experiencing disabilities. This work is being carried out collaboratively between the Michigan Department of Health and Human Services and the Michigan State Housing Development Authority within a three-year time period.

11. Describe how the state is supporting the employment and educational needs of individuals served.

MDHHS provides fidelity reviews for each approved Evidence-Based Practice Individual Placement and Supports (EBP/IPS) site striving to help each site achieve increasing fidelity scores leading to greater individual employment outcomes. The state also provides a rotation of training events focused on the EBP/IPS model covering job development, retention, benefits planning, basic 101 implementation steps, and supervisory roles and has a growing presence on the www.improvingmipractices.org website to further support and grow this EBP.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

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

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[90] Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[91] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[92]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[93] Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

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

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[94]

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care[95]:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

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

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

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?
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?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
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?
7. What age is considered to be 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.

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

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[90] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[91] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[92] Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

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[95] Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf.

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

Footnotes:

Transition Planning:
A Guidebook for Young Adults and Family

Introduction

- Why Transition?
- How to use this workbook

Health Care Transition

- Health Care Financing
- Adult Providers
- Health Care Skills

Educational Transition

- Transition and Special Education
- Beyond High School
- Employment Assistance

Adult Living

- Independent Living Skills
- Housing
- Managing Money
- Guardianship and alternatives

Bringing it all Together

- Transition Plan of Care

Community Agencies: Navigating the Maze

Introduction

Why Transition?

When you hear the word transition, many things may come to your mind. You will make many transitions in your life. This workbook will look specifically at the transition into adulthood. There are a lot of things to consider for anyone, but for someone with special health care needs there may be some extra steps to take. This includes, finding the right providers for you as an adult, finding new health insurance once you've aged off a family plan, and making the steps to the most independent life possible. This workbook will be the beginning steps in the planning process for this transition and may help you organize this daunting task!

How to Use This Workbook…

This workbook is divided into different sections. Each section describes an area that you might want to start planning for as an adult. Some sections might be more useful to you than others. This is your workbook so move around and use the information and tips that are the most helpful to you. Each section will have background information on the topic. Each section will also offer tips, tools, and strategies to help you in your planning. There will also be room in the back for you to make notes.

While this workbook can be used on your own, it might be helpful for you to discuss certain areas with professionals such as doctors, nurses, and social workers that may help coordinate your care. It is a great tool to begin communication on the topic of transition.

Health Care Transition

Health Care Financing

How you are going to pay for your care as you get older is a very important thing to think about. Sometimes your health insurance changes as you get older. You should know if or when that change happens. You should know what you may do if it does change. Some things to consider:

If you are currently on your Family's Health Plan:

- How long are you eligible to be covered under this plan as you get older?
- Can you stay on the family health plan if you are student? What are the requirements?
- Can you stay on a family plan as a disabled adult?
- What will you do when you are no longer eligible to be covered under a family plan?

If you are currently on a Government-Funded Program:

- How long are you eligible for this program? (Don't assume anything, often times there are different guidelines for people over 18.)
- Will you still be eligible for this program as you get older?
- What will you do when you are no longer eligible for this program?

Adult Providers

As you get older you should have a conversation with your doctors to find out how long they will continue to see you. Some doctors, such as pediatricians, will stop seeing patients when they reach a certain age. You want to be prepared for this change. Ask your current doctors if they will see you as an adult. If they will not see you as an adult they may be able to

Health Care Transition

help you find a new doctor. It is best to have a plan for this transition between providers. Here are a few questions to ask your doctors:

- At what age will you stop seeing me?
- How will you refer me to a new doctor?
- Do you know of any doctors you could refer me to?
- Will you help me put together a portable medical summary?
- Will you communicate with my new doctor during this transition time?

Health Care Skills

As you become more independent as an adult you might need to learn some new skills, especially health care skills, if you have special health care needs. These include things that may have been taken care of for you in the past. These can include getting prescriptions refilled, making doctor's appointments, or setting an alarm to remind you to take medications. Use the health care skills checklist to find out what you may need to learn or what you already know.

Parent Tips

- Let your child meet privately with providers at appointments.
- Start planning health care transition early.
- Research the options available on your family health plan.

Youth Tips

- Meet privately with your provider at appointments.
- Take more control of you health care activities.

Health Care Skills Checklist
(Check items you can do)

- ☐ I can describe my chronic illness or disability
- ☐ I am responsible for taking my own medications
- ☐ I know how to call the doctor's office to make an appointment
- ☐ I know about my medical insurance coverage
- ☐ I prepare questions to ask my doctors, nurses, and therapists

Educational Transition

Transition and Special Education

If you receive special education services in school you will also start transition planning at school. You will probably even have a special transition IEP. IEP stands for Individualized Education Program. You will only have one of these if you receive special education. If you do not receive special education, but still need some assistance when you are done with high school skip to "Beyond High School".

What will a transition IEP include?
The Transition IEP should focus on any supports you may have to help you carry out a course of study. It should also include any needs for post-school activities such as work experiences, college or trade schools, daily living skills, and many other things for post high school living. Emphasis should be on life planning. The IEP should be an ongoing planning process. In order for transition planning to be successful it should be meaningful to your vision and goals.

Beyond High School

You should think about your future after high school. If you have special health care needs there may be some extra steps you need to take. The most important thing to your future is staying healthy. You can't work or go to school if you are not healthy. That is why it is important to remember your health care as you think about your future plans. If you are attending school away from home you should consider how you will continue to receive the care that you need. Some family health insurance plans will let you stay on the plan as long as you are a full time student. You should know these rules ahead of time. Sit down with your family to talk about these issues.

Educational Transition

If you are heading off to college

- ☐ Identify local providers in the area where you will be living
- ☐ Contact the schools disability office for needed accommodations
- ☐ Prepare a portable medical summary in case of an emergency.
- ☐ Understand how your health insurance works and what doctors you are allowed to see.

Employment Assistance

Finding a job is not always easy. That is why it is important to plan for employment and get training through school. In high school you may have opportunities like job shadowing or volunteering. In college you might have an internship to help you get ready for work. All of these activities can help you prepare for finding employment as you get older. For those with special health needs you might need some extra support to get ready for work. If you receive special education and have a transition IEP, make sure you let them know what special supports you need.

In Michigan you may also be eligible for employment assistance through agencies such as Michigan Rehab Services or Michigan Works!. You can find contact information for these agencies in the last section of this workbook titled "Community Agencies".

Parent Tips

- Let your child lead any meetings you might have about education and employment
- Encourage your child to pursue volunteer opportunities

Youth Tips

- Don't be afraid to ask for the supports you need in school and at work
- Take advantage of volunteer opportunities and part-time employment

Adult Living

Independent Living Skills

Whether you plan to live by yourself, with your family, or with roommates when you get older you will need to learn some things that will make you more independent. Some of these things include:

Daily Living Skills: These skills include cooking, cleaning, self care, and household safety. Most likely you already know some or most of these skills through chores or helping out around the house.

Decision Making: Many decisions must be made by adults on a daily basis. Some decisions are more serious than others. Begin to plan for what decisions you will make on your own or what decisions you might want to rely on a trusted person to help you make.

Transportation: Getting from one place to another is an important part of daily life. Whether you are living by yourself or with family you should begin to plan for your transportation needs. That may include learning to drive and getting a drivers license. It may also include learning how to ride the bus or calling a friend for a ride. It's also important to plan ahead if you have a wheelchair or other assistive devices.

Housing

As you begin to plan for your transition to adult life one of the most important things, and sometimes exciting, is the prospect of where you will live. Some people may remain at home with their family. Other people may want to live on their own or with roommates in an apartment or even someday own their own home. This is a decision you will have to make. Here are some things to think about:

Adult Living

- Identify interests and options for future living arrangements, including supports if needed.
- Investigate assistive technology tools that can increase independent living and community involvement
- Pursue and use local transportation options available outside of your family

Managing Money

Paying bills and managing money are important skills that adults need to learn. You should learn money management skills such as balancing a checkbook, or paying utility bills. While you are learning these skills you also want to consider how you plan to earn an income. For many people income will come from employment. For others income may come from Social Security benefits. Consider the following:

- Determine your need for financial support
- Investigate money management and identify necessary skills
- Apply for any financial support programs that may be needed

Guardianship and Alternatives:

At age 18, you become your own guardian. Some people are unable to do this because of their disability. If so, you and your family may face some choices. Questions for you and your family to ask are:

- What are my main concerns for my future? Are they financial, medical, or emotional concerns?
- What decisions will I be able to make on my own?
- What decisions will I need assistance making?

Adult Living

Think about what you would like to secure for your future. Below is a list of choices you and your family may consider if you need this kind of help. The list does not include all options. Other choices may be best for your family.

- **Full Guardianship** provides full decision making rights to an appointed guardian.
- **Partial Guardianship** provides rights in certain areas of decision making to an appointed guardian.
- **Durable Power of Attorney** allows health care decisions by an appointed guardian. Power of Attorney can cover other decisions too.
- **A Patient Advocate** acts for the individual receiving care. Most hospitals and providers have information on this choice. The appointed individual might be a family member or friend.
- In a **Conservatorship** an appointed individual manages a person's finances.
- A **Representative Payee** manages the finances of a person with SSI or SSDI benefits. Applications and help are available at local Social Security Administration offices.

Many of these actions must be done through the court system. Start exploring them when you turn 17. There may be legal and court fees for each. Seek qualified legal counsel if needed.

Bringing it all Together

Transition Plan of Care

Once you have thought about all or some of the areas discussed in the previous sections it is a good idea to start putting a plan in place. A Transition Plan of Care will help to keep things organized. It might also help you remember different things you need to do to get ready for the transition to adulthood. A Transition Plan of Care can be on paper or it can be done on a computer. However you want to keep it is fine. If someone is helping you put a plan together be sure to tell them how you would like to keep it.

What should a Transition Plan of Care include?

A Transition Plan of Care may look different for everyone. It will typically include goals that you have for yourself as you get older. For each goal you might find activities listed that need to be completed in order to reach your goals. For each activity you can create a list of who will be responsible to do these things. The person responsible can be you, your parent, family member, nurse or care manager you're working with. Whoever is helping you put the plan together might have different ways of doing it. Be sure you are comfortable with everything that is included in your plan.

Youth Tips

- Now is the time to speak up! Make sure you are heard and your personal goals are included.

Who can help me put a Transition Plan of Care together?

A transition plan of care can be put together with your help by someone at your doctor's office, or any other person/program that is helping you get ready for the transition to adult life.

Community Agencies: Navigating the Maze

This workbook has looked at health care, education, and independent living. Putting all these different topics together in a plan of care can help keep you organized. When you need assistance to reach some of your future goals you might find yourself working with different organizations and agencies, even programs at the state and federal level. So who do you go to? And what do you ask for? This section should give you some guidance on navigating your way to find help. It is also a place to keep notes and find contact information for some helpful resources.

Making the Call…

Don't know what to ask when you call? Consider this first. What information/support do you really want from this agency? Be sure you are specific and only ask about services they provide. Once you clear that up use this very simple script:

> Sample Script for calling community agencies:
>
> "Hello my name is _____. I have questions about_____. Can you please connect me with someone who can help?"

If you will be contacting many community agencies here is a tip. Keep a notebook with dates, names of who you spoke with, the action to be taken and expected date of completion.

Use the notes section to keep contact information handy.

Community Agencies: Navigating the Maze

Notes:_____

Community Agencies: Navigating the Maze

Notes:

Community Agencies: Navigating the Maze

Who to Call…

AIDS 24-Hour Hotline	800-342-2437	ARC Michigan	800-292-7851
American Cancer Society	800-ACS-2345	Autism Society of Michigan	800-223-6722
Center for Self-Determination	734-722-7092	CAUSE (Citizens Alliance to Uphold Special Education)	800-221-9105
Cystic Fibrosis Foundation	800-968-7169	Children's Special Health Care Services	800-359-3722
Department of Human Services (DHS)	517-373-2035	Diabetes Foundation	800-223-1138
DHS Adult Abuse Hotline	800-996-6228	Epilepsy Center of Michigan	800-377-6226
DHS Child Abuse Hotline	800-942-4357	Family Support Network of Michigan	800-359-3722
DHS Emergency Shelter Hotline	800-ASHELTER	Family Voices	888-835-5669
DHS Home Heating Hotline (Energy Assistance)	800-292-5650	Learning Disability Association of Michigan	888-597-7809
DHS Homeless Hotline	800-274-3583	Make-A-Wish Foundation of Michigan	800-622-WISH
DHS Medicaid Help Line	800-642-3195	March of Dimes	888-663-4637
DHS Parent Help Line	800-942-4357	Michigan Assistive Technology Resource (MATR)	800-274-7426
DHS Runaway Assistance Hotline	800-292-4517	Michigan Dental Association	800-255-7543
DHS Tuition Incentive Program …….	800-243-2847	Michigan Developmental Disabilities Council	517-334-6123
Easter Seals – Michigan	800-75-SEALS	Michigan Respite Programs	989-466-4164
Michigan Association For Deaf, Hearing and Speech Services.	800-YOUR-EAR	Michigan Self-Help Clearinghouse	800-777-5556
Michigan Association of Centers for Independent Living…….	517-339-0539	Michigan Tel-Help (United Way Community Services)	800-552-1182

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Community Agencies: Navigating the Maze

Michigan Protection and Advocacy	800-292-5896	National Mental Health Association	800-969-6642
Michigan Rehabilitation Services	800-605-6722	National Organization for Rare Disorders	800-999-6673
Michigan Works! Association	517-371-1100	Parents of the Visually Impaired	313-272-3900
Muscular Dystrophy Association	734-416-7076	Spina Bifida Association	800-621-3141
Partnership for Prescription Assistance	888-477-2669	The Family Center	800-359-3722
Poison Control	800-764-7661		
Social Security Administration	800-772-1213		
Special Olympics Michigan	800-644-6404		
United Cerebral Palsy Association of Michigan	800-828-2714		

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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 Kazee 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 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 Facts[1]

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

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

A*dults ages 45–59 have the highest suicide rates.*

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

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

F*irearms are the most frequent method used.*

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:

Did You Know

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.

Survivors[6]

- *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 65Americans 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, 2000–2010[6]
(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 study[12] and multiple school evaluations have demonstrated positive results at the community level. Other major studies are currently underway to evaluate and replicate programs with potential. One-time and isolated prevention efforts may have some value, but have not demonstrated sustainable positive impact on suicide behaviors. Recent evidence suggests that effective suicide prevention programs also reduce other violent behaviors. Some interventions have shown promise for the treatment of depressed, despondent or suicidal individuals;

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

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

- **MEANS OF DEATH**

In the U.S., the method used in more than 50% of suicide deaths is firearms. The 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, 2010[6]

Suicide Method	***No.***	***Rate***	***% of total***
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 2012[13]

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

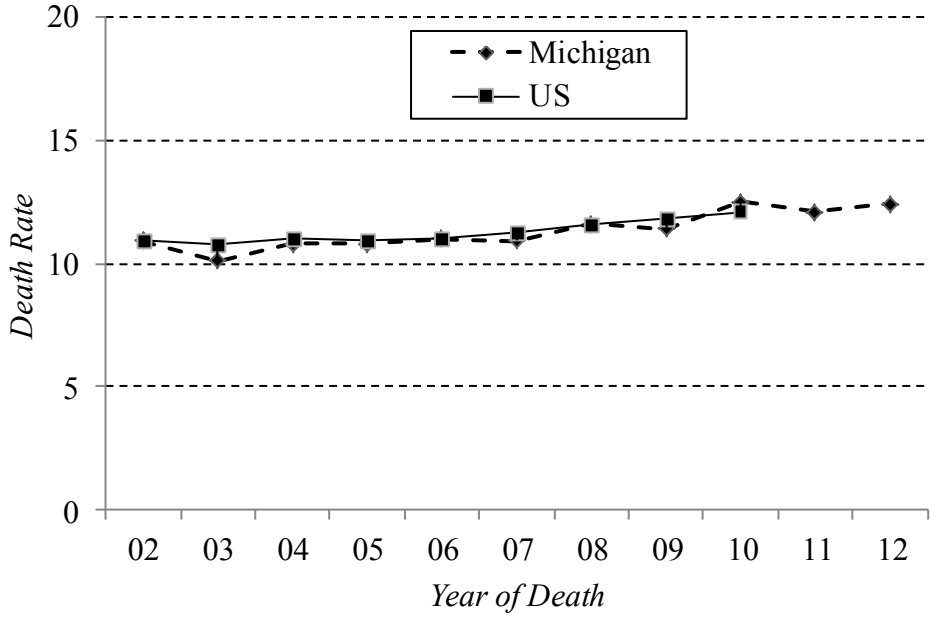

FIGURE 1. Suicide rates (age-adjusted), Michigan and U.S. Residents, 2002-2012[17]

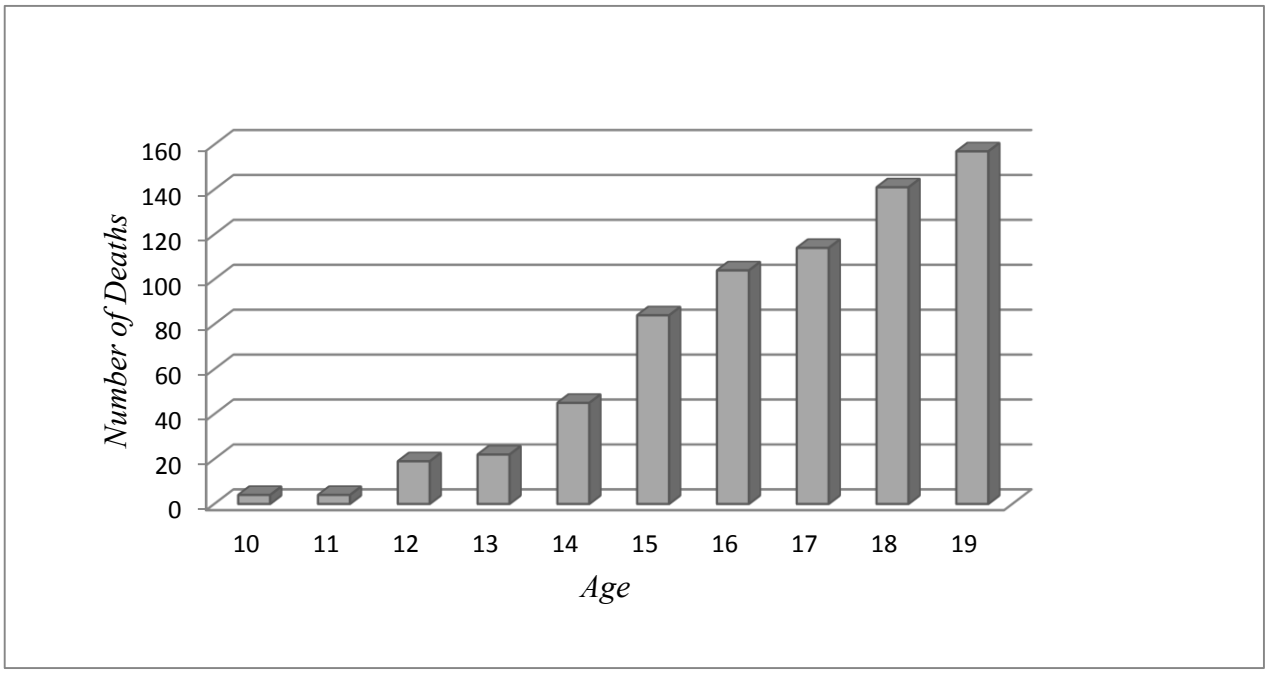

Figure 2. Adolescent suicide deaths, Michigan, 2003–2012[18]

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GOALS AND OBJECTIVES

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

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

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

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]

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[97] http://beta.samhsa.gov/grants/block-grants/resources

[98] There 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.

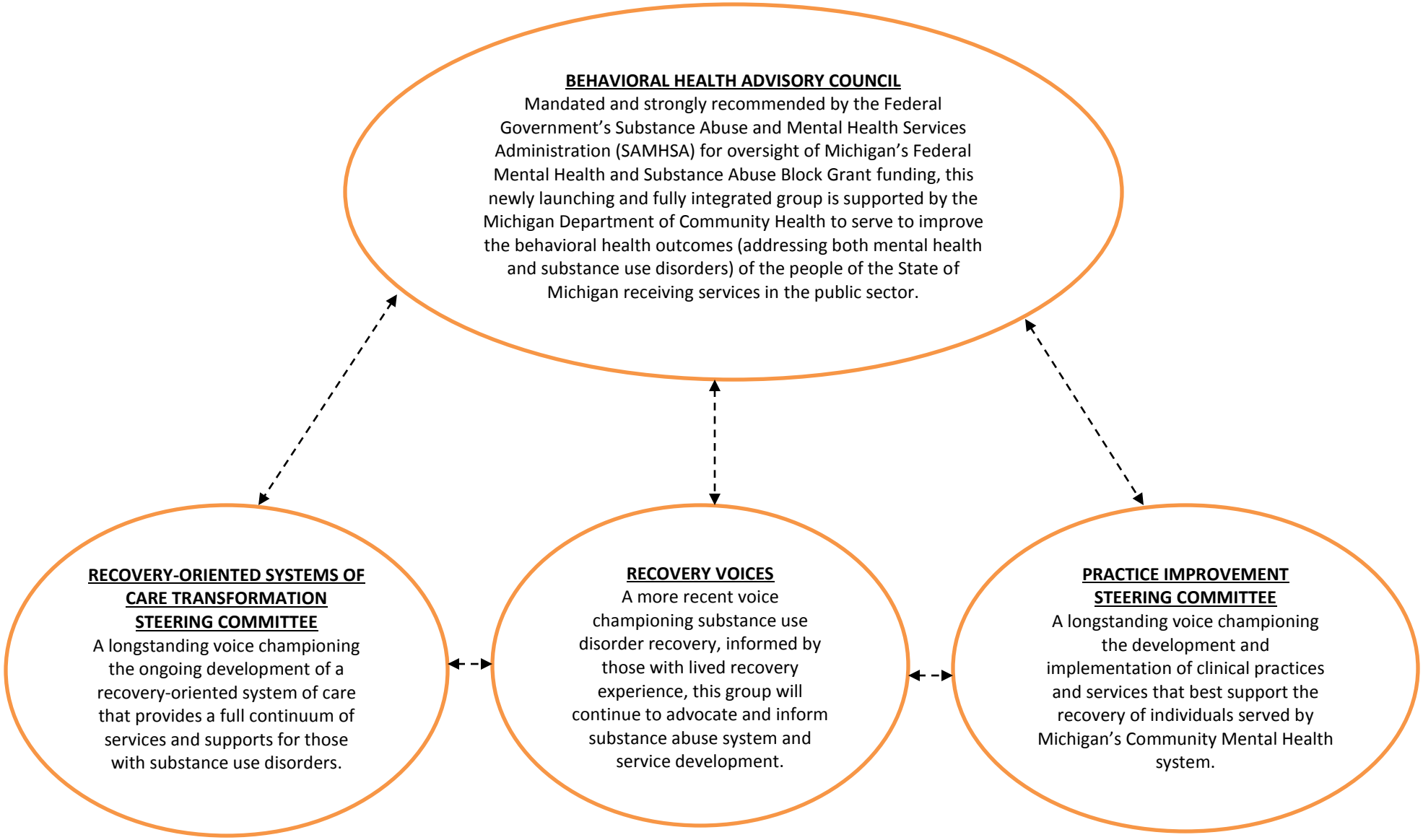
Meetings will take place quarterly with the potential for additional sessions depending on the work and will of the group. All meetings will be centrally located with the option for in-person participation and/or "attendance" through electronic means, such as teleconferencing and/or webinar options.

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 (Lonnetta Albright), Erin Emerson (Amy Allen), Julie Barron, Joelene 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 lburghardt@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 replace 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 Lonnetta Albright), Amy Allen, Julie Barron, Joelene 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-aging 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 in 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 is 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 Schmiege
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 **H**ealth **A**dvisory **C**ouncil
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.

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.

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 ½ of the number of members serving on the Council at the time of the vote.

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

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

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: 2016

End Year: 2017

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
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
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
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
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
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
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
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
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
Michael Davis	State Employees	Department of Corrections	9036 East M-36 Whitmore Lake, MI 48189 PH: 734-449-3897	davism24@michigan.gov
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
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
Arlene Kashata	Federally Recognized Tribe Representatives		2815 Hilltop Court #204 Traverse City, MI 49686	a_kashata@hotmail.com
Lauren Kazee	State Employees	Department of Education	608 W. Allegan Street, 2nd Floor Hannah Building Lansing, MI 48933 PH: 517-241-1500	kazeel@michigan.gov
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
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
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
Paula Nelson	Providers	Sacred Heart Rehabilitation Center, Inc.	400 Stoddard Road Memphis, MI 48041 PH: 810-392-2167	pnelson@sacredheartcenter.com
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
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
Jamie Pennell	Family Members of Individuals in Recovery (to include family members of adults with SMI)		211 Butler Street Leslie, MI 49251 PH: 517-589-9074	jpennell00@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
Mark Reinstein	Others (Not State employees or providers)		27655 Middlebelt, Suite 170 Farmington Hills, MI 48334 PH: 248-473-3143	msrmha@aol.com
Ben Robinson	Others (Not State employees or providers)		5130 Rose Hill Boulevard Holly, MI 48442 PH: 248-634-5530	brobinson@rosehillcenter.org
Lori Ryland	Providers	Southwest Michigan Behavioral Health	5250 Lovers Lane, Suite 200 Portage, MI 49002 PH: 269-979-9132	lori.ryland@swmbh.org
			1333 Brewery Park	

Kristie Schmiege	Providers	Gateway Community Health	Boulevard Detroit, MI 48207 PH: 810-965-2675	kschmiege@gchi.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
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
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
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

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2017

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)	3	
Parents of children with SED*	0	
Vacancies (Individuals and Family Members)	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	0	
Total State Employees & Providers	15	41.67%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	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	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:

Substance Abuse and Mental Health Services Administration
SAMHSA
1 Choke Cherry Road • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

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.

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,

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,

Rick Snyder
Governor

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

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

August 21, 2015

Ms. Virginia Simmons
Grants Management Specialist
Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20857

Dear Ms. Simmons:

As the federal and state governments are working together to implement federal mental health and substance abuse block grants, this letter documents my designation of Thomas Renwick, Director of the Bureau of Community Based Services, as administrator of the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant, respectively, on behalf of the state of Michigan.

Additionally, Mr. Renwick is designated the authority to present the combined mental health and substance abuse application to the Substance Abuse and Mental Health Services Administration and to modify the plan if necessary.

Sincerely,

Nick Lyon

NL:tb

c: Lynda Zeller
Thomas Renwick
Deborah Hollis
Karen Cashen

201 TOWNSEND STREET • LANSING, MICHIGAN 48913
www.michigan.gov/mdhhs • 517-373-3740