

I: State Information

State Information

Plan Year

Start Year:

2014

End Year:

2015

State SAPT DUNS Number

Number

113704139

Expiration Date

9/30/2015

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

Agency Name

Michigan Department of Community Health

Organizational Unit

Behavioral Health & Developmental Disabilities Administration

Mailing Address

320 S. Walnut, 5th Floor

City

Lansing, MI

Zip Code

48913

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

First Name

Deborah

Last Name

Hollis

Agency Name

Michigan Department of Community Health

Mailing Address

320 S. Walnut, 5th Floor

City

Lansing, MI

Zip Code

48913

Telephone

517-241-2600

Fax

517-241-2199

Email Address

hollisd@michigan.gov

State CMHS DUNS Number

Number

113704139

Expiration Date

9/30/2014

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

Agency Name

Michigan Department of Community Health

Organizational Unit

Behavioral Health & Developmental Disabilities Administration

Mailing Address

320 S. Walnut, 5th Floor

City

Lansing, MI

Zip Code

48913

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

First Name

Elizabeth

Last Name

Knisely

Agency Name

Michigan Department of Community Health

Mailing Address

320 S. Walnut, 5th Floor

City

Lansing, MI

Zip Code

48913

Telephone

517-335-8401

Fax

517-335-4798

Email Address

kniselye@michigan.gov

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

From

To

IV. Date Submitted

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

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name

Karen

Last Name

Cashen

Telephone

517-335-5934

Fax

517-335-5376

Email Address

cashenk@michigan.gov

Footnotes:



STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

JAMES K. HAVEMAN
DIRECTOR

March 25, 2013

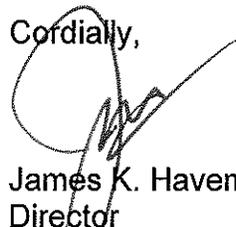
Ms. Virginia Simmons
Grants Management Specialist
Division of Grants Management, OPS, SAMHSA
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20857

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 Ms. Lynda Zeller, Deputy Director of the Behavioral Health and Developmental Disabilities Administration, 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.

Additionally, Ms. Zeller is designated as having 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.

Cordially,



James K. Haveman
Director

cc: Lynda Zeller
Elizabeth Knisely
Deborah Hollis
Karen Cashen



STATE OF MICHIGAN
EXECUTIVE OFFICE
LANSING

RICK SNYDER
GOVERNOR

BRIAN CALLEY
LT. GOVERNOR

March 18, 2013

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

Dear Secretary Sebelius:

As the federal and state governments are working together to implement federal mental health and substance abuse block grants, this letter designates James K. Haveman, Director of the Michigan Department of Community Health, 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. Haveman 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, SAMHSA
James K. Haveman, Director, MDCH

I: State Information

Assurance - Non-Construction Programs

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

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

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

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

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

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

Name	<input type="text" value="James K. Haveman"/>
Title	<input type="text" value="Director"/>
Organization	<input type="text" value="Michigan Department of Community Health"/>

Signature: _____ Date: _____

Footnotes:

I: State Information

Assurance - Non-Construction Programs

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

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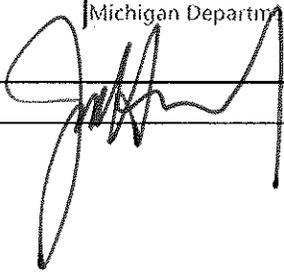
Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

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.
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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.
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name:
Title:
Organization:

Signature:  Date: March 6, 2013

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

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

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

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

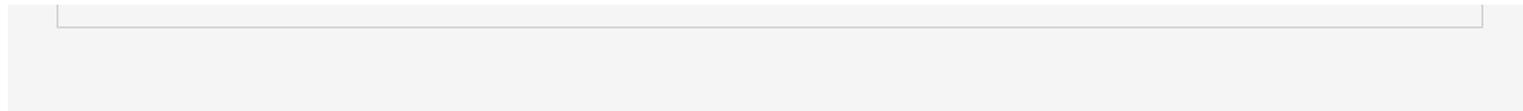
The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

Name	James K. Haveman
Title	Director
Organization	Michigan Department of Community Health

Signature: _____ Date: _____

Footnotes:



I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

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

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

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

Name: James K. Haveman
Title: Director
Organization: Michigan Department of Community Health

Signature: _____

Date: March 6, 2013

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [SA]

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
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Title 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 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32

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

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.

Name of Chief Executive Officer (CEO) or Designee

Title

Signature of CEO or Designee¹: _____ Date: _____

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

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [SA]

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Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
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Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
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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

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

Signature of CEO or Designee¹:  Date: 7/31/13

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

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [MH]

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
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 as required by
 Community Mental Health Services Block Grant Program
 as authorized by
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Title XIX, Part B, Subpart I 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
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Name of Chief Executive Officer (CEO) or Designee

Rick Snyder

Title

Governor

Signature of CEO or Designee¹: _____ Date: _____

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Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [MH]

U.S. Department of Health and Human Services
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Title XIX, Part B, Subpart I of the Public Health Service Act

Section	Title	Chapter
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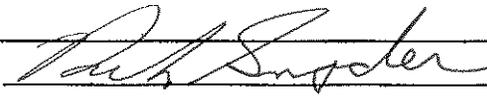
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Name of Chief Executive Officer (CEO) or Designee	<input type="text" value="Rick Snyder"/>
Title	<input type="text" value="Governor"/>

Signature of CEO or Designee¹:  Date: 7/31/13

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

Footnotes:

I: 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	<input type="text" value="James K. Haveman"/>
Title	<input type="text" value="Director"/>
Organization	<input type="text" value="Department of Community Health"/>

Signature: _____ Date: _____

Footnotes:

No lobbying has taken place, therefore, this form has not been signed.

II: Planning Steps

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

Narrative Question:

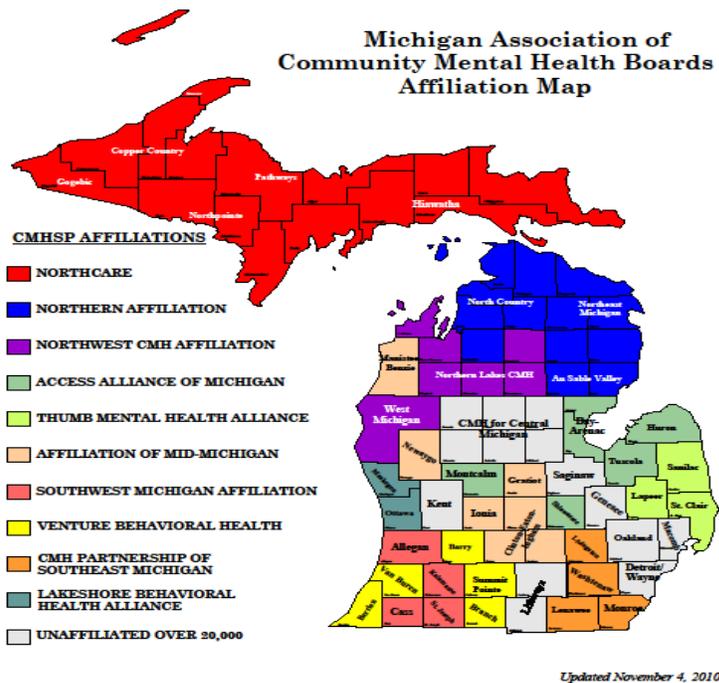
Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should 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.

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 abuse services authorities, collectively known as the Behavioral Health and Developmental Disabilities Administration (BHDDA), and located within the Michigan Department of Community Health (MDCH). MDCH, one of the largest of the 18 departments in Michigan's State government, is responsible for health policy and management of the State's publicly-funded health service systems. At least 2 million Michigan residents will likely receive services in 2014 that are provided with total or partial support from MDCH. The department was created in 1996 by consolidating the Department of Public Health (now the Public Health Administration), the Department of Mental Health (now BHDDA), and the Medical Services Administration (MSA-the state's Medicaid agency). The Office of Drug Control Policy and the Office of Services to the Aging were later consolidated within MDCH.

At the time of this writing, MDCH has contracts with 18 Prepaid Inpatient Health Plans (PIHPs), which are comprised of single or multiple Community Mental Health Services Programs (CMHSPs), for Medicaid services to children with serious emotional disturbance (SED), adults with serious mental illness (SMI), and children and adults with developmental disabilities. Each region 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. Individual plans of service are developed using a person-centered planning process for adults and a person-centered/family-centered process for children.

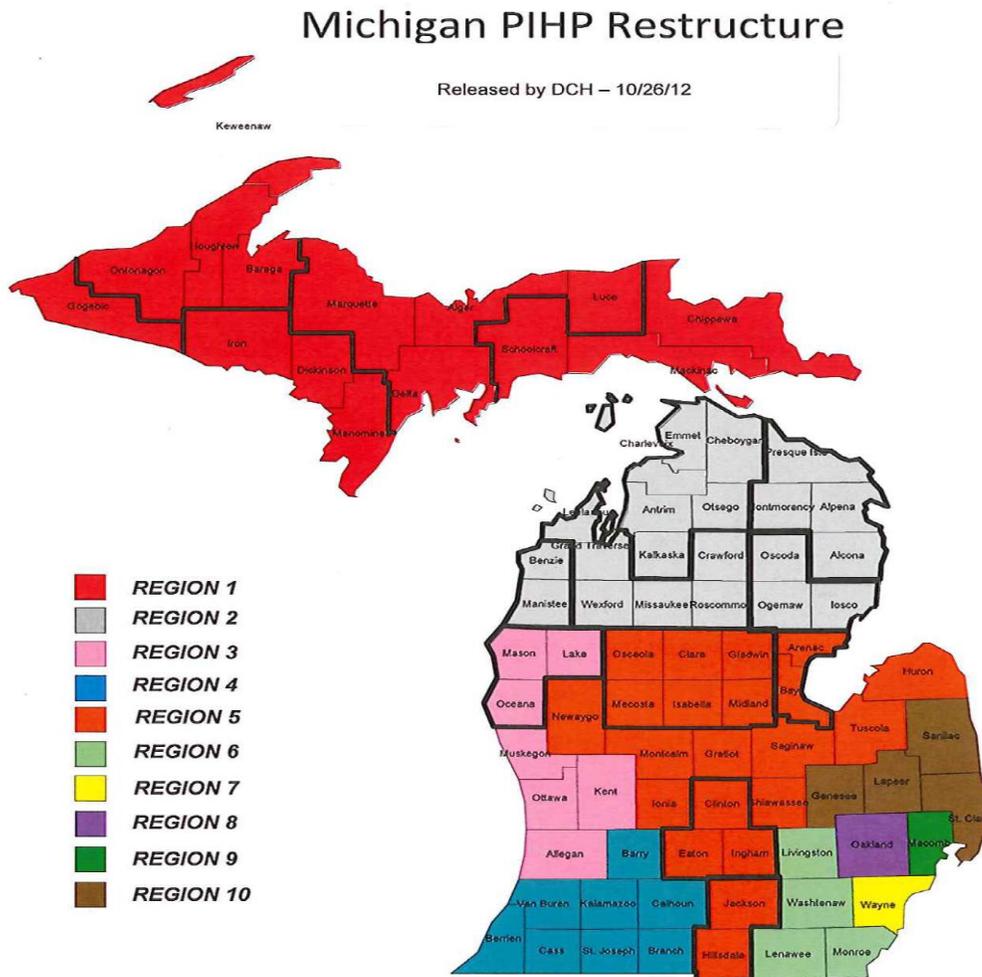


The State of Michigan is in the process of undergoing a structural reorganization in its public behavioral health service sector, to accomplish both greater administrative efficiencies and more complete integration in the delivery of mental health and substance use disorder services. The passage of 2012 legislation, Public Act 500 and 501 requires full integration of Michigan's Mental Health and Substance Abuse Coordinating Agencies (CAs) into the statewide provider network of regional PIHPs. The statewide provider network will move from the current 18 regional PIHPs to 10 such regional entities. Each of which will also serve as both the mental health and substance abuse authority for their respective region. MDCH will continue to contract with 46 CMHSPs for delivery of non-Medicaid funded services (including federal mental health block grant).

Ongoing health reform efforts (including Medicaid expansion decisions) will likely change the landscape as we move into 2014-15. The public mental health service delivery system currently contains a small outpatient mental health benefit (20 visits) within the Medicaid Health Plans, which are presently contracted with MDCH through the Medical Services Administration to provide health and dental care to Medicaid beneficiaries. There is also a small fee-for-service mental health benefit for Medicaid beneficiaries (up to 10 visits) with a physician or psychiatrist. The array of Medicaid mental health specialty services and supports provided through PIHPs under Michigan's 1915b/c capitated managed care waiver includes: Applied Behavioral Services, Assertive Community Treatment, Assessments, Case Management, Child Therapy, Clubhouse Rehabilitation Programs, Crisis Interventions, Crisis Residential Services, Family Therapy, Health Services, Home-Based Services, Individual/Group Therapy, Intensive Crisis Stabilization Services, Medication Administration, Medication Review, Nursing Facility Mental Health Monitoring, Occupational Therapy, Personal Care in Specialized Settings, Physical Therapy, Speech, Hearing and Language, Substance Abuse, Treatment Planning, Transportation, Partial Hospitalization, and Inpatient Psychiatric Hospitalization. The specialty services and supports known as (b)(3) services which are included in the MDCH contract include: Community Inclusion and Integration Services, Family Support and Training (including Parent-to-Parent Support), Respite Care, Housing Assistance, Peer-Delivered or Operated Support Services, Prevention and Consultation Services (e.g., School Success Program, Childcare Expulsion Prevention Program, Infant Mental Health, Family Skills Training) and Wraparound Services. Additionally, in July of 2011, some of the services included as (b)(3) for individuals over the age of 21 are now included in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program covered by Medicaid for individuals under 21 only. These include: Community Living Supports, Family Training (e.g., Parent Education, Programs for children of parents with mental illness) Peer-Directed and Operated Support Services, Prevention-Services Direct Model, Skill Building Assistance, Supported Employment, Supports Coordination, and Wraparound Services.

MDCH has a number of mechanisms in place to provide leadership in the coordination of mental health services within the broader system. The PIHP contracts currently describe the PIHPs' responsibilities and deliverables, and will continue to do so under the reorganized system. These contracts place a heavy emphasis on customer service, uniform data collection and encounter data reporting, fiscal management, quality assessment, and utilization. Each PIHP is currently required to have agreements in place with Medicaid Health Plans, CAs, and other human services agencies that serve people in the mental health system. In Michigan's upcoming reorganized system, even fuller assurances of integrated and coordinated care will be required.

will be integrated, geographically and administratively, within 10 PIHP entities, serving as their respective region’s integrated mental health and substance abuse authorities (see “Michigan PIHP Restructure” map below).



Prospective 2014-15 Restructure/Integration of Michigan’s Behavioral Health System

The Public Health Administration (PHA) within MDCH is responsible for behavioral health promotion and early intervention activities and other activities which complement the behavioral health services offered by BHDDA. The PHA is also responsible for statewide suicide prevention planning and activities, maternal, infant and early childhood programs that include

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

The Michigan Department of Community Health (MDCH) is one of 16 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.

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

In Fiscal Year (FY) 2009, 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.

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

Prevention programming is intended to reduce the consequences of SUDs in communities by preventing or delaying the onset of use, and reducing the progression of SUDs in individuals. Prevention is an ordered set of steps along a continuum that promotes individual, family and community health; prevents mental and behavioral disorders; supports resilience and recovery;

and reinforces treatment principles to prevent relapse. The Michigan ROSC Implementation Plan goal four: *To enhance our collective ability to support the health, wellness, and resilience of all individuals by developing prevention prepared communities*, comprises the umbrella under which prevention services are conducted. This goal underscores the value of prevention prepared communities (PPCs) as the cornerstones of a ROSC. CAs are expected to sustain a strategic planning framework (SPF) process and a service delivery system that will show evidence of working toward community-level change. A role for prevention services directed toward individual behavior change remains for specific high-risk selective and indicated populations.

CAs are expected to employ the six SAMHSA Center for Substance Abuse Prevention (CSAP) strategies to 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 2013.

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

Annually CAs 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 to prevent substance use and SUDs; promote mental health; and reduce obesity and infant mortality.

Early Identification

Treatment is intended to assist those individuals identified as having a substance abuse or dependence diagnosis. Each regional CA utilizes an Access Management System (AMS) that acts as a gatekeeper of sorts 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 CAs, the CAs 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 CA and provider level based on the demographics of the regional population, practices that are in place to ensure appropriate cultural training for staff and culturally appropriate resources for the individuals accessing services. 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 CA. Michigan has developed a Recovery Coach Technical Advisory for the SUD field and identified the Connecticut Connection for Addiction Recovery curriculum for those interested in becoming recovery coaches. Regional CA representatives and representatives from the recovery community were important contributors to this process. Training opportunities were offered regionally in FY 2011 and 2012.

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 sometimes lengthy wait times, depending on what is available in their region, how far they can travel, and their financial situation. Those placed on the waiting list for MAT are offered interim services, as well as services at a lower level of care to keep them engaged while 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. 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 (parents and children) in SUD treatment. Several other residential programs are able to accommodate women and their children, and at the outpatient level, ancillary services such as child care are offered both to mothers and fathers who are primary caregivers. If parents are at risk of losing their children and involved with the child welfare system, they are a priority population in Michigan and are able to access SUD treatment services immediately.

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

Persons with or at risk for HIV/AIDS and who are in treatment for substance abuse: Each CA must assure staff knowledge and skills in the provider network are adequate and appropriate for addressing communicable disease related issues in the client population. To assist in meeting this requirement, BSAAS, in conjunction with other partners in MDCH, has developed a web-based Level I training curriculum. In addition, CAs are required to assure that all SUD clients entering treatment have been appropriately screened for risk of HIV/AIDS, STD/Is, TB and hepatitis, and that they are provided basic information about risk. For those clients with high risk behaviors, additional information about the resources available and referral to testing and treatment must be made available.

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 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

CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (SED)

The organization of 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. For example, the Michigan Department of Community Health (MDCH) is responsible for health and mental health services, some housing services, substance abuse services, medical and dental services, and Medicaid and Children’s Special Health Care Services (Title V). The Michigan Department of Human Services (MDHS) is responsible for foster care, children’s protective services, delinquency services and some housing assistance services. The Family Division of County Circuit Courts is responsible for juvenile justice services. The Michigan Department of Education (MDE) is responsible for educational services and the implementation of Parts B and C of the Individuals with Disabilities Education Act. Employment services and housing services are provided by the Department of Labor and Economic Growth (DLEG) and the Michigan State Housing Development Authority (MSHDA).

As indicated earlier in this document, recent legislation passed in Michigan is requiring that each CA be incorporated into an existing PIHP to formally integrate mental health and substance use disorder services statewide by October 1, 2014. Many CAs have already merged into the PIHP system, however some have not. This transition is currently underway and will impact the way service providers are structured into FY14-15 and provide for the development of a formally integrated behavioral health service network statewide. Some PIHPs have placed a specific focus on training on COD for children and these include Oakland and Central Michigan. Oakland County PIHP has held training in Motivational Interviewing in order to increase engagement of families in PMTO, as well as addressing the mental health and substance use issues of adolescents and family members. CMH for Central Michigan also includes a specific COD focus on children/adolescents to assist with meeting goals around their substance use. Several other PIHPs use Multi-Systemic Therapy (MST) as a strategy for addressing co-occurring disorders. There continues to be a need for additional cross-agency cooperation

between mental health and substance abuse services with regard to serving youth with co-occurring disorders. The integration of the CAs into the public mental health system statewide may contribute to additional solutions in this area as well.

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 FY14-15. 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 FY14-15. 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. MDCH 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 MDCH that requires providers to utilize a family-driven youth-guided approach to services provided in the public mental health system.

MDCH has been a leader in increasing collaboration with other state agencies, local communities, and families. MDCH participates in many interagency groups and emphasizes collaboration for children's services. Through these groups, the SOC has improved through the elimination of duplicative efforts and new projects being planned with joint efforts in development, implementation, and evaluation of services. More work is being planned to further improve the SOC, increase parent leadership development, and increase and maintain youth involvement on interagency committees. FY14-15 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.

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

and with the CMHSPs. Standardized, validated and reliable outcome measures, the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 1989)¹ for youth ages 7-17 and its counterpart for children ages 3-7 the Preschool Early Childhood Functional Assessment (PECFAS) (Hodges, 1994a)² are used to assess treatment effectiveness for all children served in the public mental health system. MDCH is supporting with block grant funds the statewide implementation of two evidence-based practices Parent Management Training-Oregon Model (PMTO) (Bank, Rains, & Forgatch, 2004; Forgatch, 1994)³ and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (Cohen, Mannarino, Deblinger, 2006)⁴. And in fiscal year 2009, the SOC planning process was formally incorporated into the public mental health system through the Program Policy Guidelines (PPGs) through which MDCH requires CMHSPs to provide an assessment of their local SOC and how they plan to move forward to improve outcomes for children with SED and their families and children with developmental disabilities and their families. MDCH is working individually with PIHPs to provide technical assistance regarding progressing to more comprehensive SOCs. CMHSPs were also required to utilize a SOC planning process to prepare their applications for funding through the children's portion of the mental health block grant and/or in implementing the 1915(c) Waiver for children with SED (SEDW). MDCH has been particularly interested in increasing access to specialty mental health services and supports for Medicaid eligible children/youth with SED in child welfare (i.e., abuse/neglect, foster care and/or adopted children/youth) and juvenile justice. 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, an official MDCH 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 MDCH, and training began in 2010 and will continue in FY14-15. The child welfare and judicial systems have also begun including family-driven and youth-guided concepts in their routine operations.

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

² Hodges K. *The Preschool and Early Childhood Functional Assessment Scale*. Ypsilanti, MI: Eastern Michigan University, Department of Psychology; 1994a.

³ 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.

⁴ Cohen, J., Mannarino, A., Deblinger, E. (2006) *Treating Trauma and Traumatic Grief in Children and Adolescents*. London and New York: The Guilford Press.

Another key component of SOC that has been addressed recently is cross-system funding. MDCH and MDHS have 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 MDHS foster care. This initiative provided the impetus for further collaboration between MDCH and MDHS 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. MDHS provides the state match to Medicaid for both these projects in order to increase access to mental health services through CMHSPs/PIHPs for children in MDHS foster care and child protective services levels 1 and 2. Also, an MDCH block grant funded SEDW Access position, located at the local MDHS office, was offered to participating SEDW sites to provide mental health screening, assessment and liaison functions to facilitate children being identified and enrolled in appropriate mental health services. This partnership has been integral in assisting MDHS in responding to the consent decree that was the result of the Dwayne B. v. Granholm (2006) lawsuit (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.

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

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 trials 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.”⁵

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.”⁶*

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 evidence-based practices (EBPs) and cross-cutting initiatives across our CMH provider system, including block grant-supported projects targeting the following adult service practice areas. As many of these practices are only partially implemented and/or are encountering sustainability challenges, they also continue to represent ongoing needs for the coming FY14-15 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.

⁵ 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.

⁶ 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.

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 IDDT and FPE. 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 MDCH 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.

Basic research was completed with Medicaid data from 10/1/09 to 9/30/11. Consumers participating in multi-family problem solving groups were evaluated to determine whether

participation in FPE decreases the use of higher intensity mental health services [Crisis Intervention (CI), Crisis Residential (CR), and Inpatient (IP)] measured nine months before FPE and measured nine months after FPE. Those receiving less than ten units of multi-family groups nine months before FPE and nine months after FPE were measured. The findings are as follows: less than 10 units of multi-family groups showed small decreases in CR -7.0%, IP -22.9% and a significant decrease in CI -46.4%. Also measured were those receiving ten or more units of multi-family groups nine months before FPE and nine months after FPE. Consumers participating in more than ten units of multi-family groups showed significant decreases in CI -58.6%, CR -62.9%, IP -78.4%. It is important to note that many FPE participants had no CI, CR, IP before, during, or after FPE. This is an area rich for research but, meanwhile, it looks like FPE can greatly reduce the use of expensive services.

Data is from the “Point-in-Time Survey” Family Psychoeducation, November 2012, Initial Report, University of Michigan, Mary Ruffolo. 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)

MDCH 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.
- Co-occurring Change Agent Leadership (CoCAL);
 - Monthly meetings of this subcommittee of Michigan’s statewide Practice Improvement Steering Committee.

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. In 2012, eleven agencies requested DDCMHT site-reviews of their outpatient treatment programs. Each site was provided with a scoring report and a work plan with suggested activities for enhancing supports and services in each area reviewed.

The 2013 plan for MIFAST IDDT is to ascertain the number of IDDT teams practicing across the State of Michigan; determine the number of IDDT teams who have had four or more IDDT 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 CoCAL has goals and objectives for the continuance of implementation, sustainability and improvement of the standards of practice for integrated treatment. The CoCAL currently has four defined work groups organized around its goals: 1) COD Workforce Development; 2) COD Outcomes Work Group; 3) MIFAST Activities; and 4) Systems Integration & Funding. The COD Workforce Development activities include planning the annual statewide Co-occurring Conference, and additional staff training and development.

The annual Co-occurring Conference is 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 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 2014-15 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.
- Final development and placement of web-based Motivational Interviewing training modules on the Improving MI Practices (www.improvingmipractices.org) website, to be made available to the frontline workforce of Michigan's public behavioral health system.
- Placement of the Video Assessment of Simulated Encounters (VASE-R) on the Improving MI Practices (www.improvingmipractices.org) website so that Michigan's behavioral health workforce members can have access to an assessment tool that is easy

to use and that can give them a reliable assessment of the degree to which training has enhanced their understanding and application of the Motivational Interviewing philosophy and skills.

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, leading to ongoing redesign for FY14-15 to increase cost-effectiveness and sustainability. An extensive practice knowledge exam has been developed and is currently being beta-tested, for eventual roll-out to all DBT practitioners in Michigan's public sector behavioral health service system, to better gauge the level of core knowledge and skills, and to inform future training and support for performance quality. This DBT practice knowledge exam will be made available in an online format via the Improving MI Practices (www.improvingmipractices.org) website, with test results immediately available to MDCH 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 newly convened DBT Subcommittee, led by experienced practitioners from within Michigan's behavioral health service network, which advances the products of its work to the MDCH-advising Practices Improvement Steering Committee.
- One pilot FY12-13 project involves tracking consumer-level outcomes utilizing the BSL-23 (23-item Borderline Symptom Checklist) to collect changes in symptoms over time, with practitioners inputting this outcome data into a secure, web-based application for subsequent aggregation and analysis.
- Needs moving forward include supporting ongoing effective service quality, with better outcome tracking and analysis to substantiate progress and cost/benefit value.

Supported Employment (SE)

The focus has been and needs to continue to be the increased access to employment enhancing services for those who may not otherwise utilize these programs. SE program numbers have increased by 18%--much of that is due to the fact that adults with mental illness are able to access services in locations where there were not services previously offered. Five new SE programs were started in the last fiscal year—offering access to services primarily in rural areas of the state. SE should be seen as a means to re-enter the community for many instead of the

few—education for case managers and other referrers was started and needs to continue by way of initial training on the subject as well as on-going refresher courses.

Partnerships with Vocational Rehabilitation (VR) (including Michigan Rehabilitation Services and the Bureau of Services for Blind Persons) continue to be enhanced. Work has been done on a joint document that describes the role of mental health and of VR in the development of work opportunities for individuals with disabilities across the state. Stronger partnerships continue to develop in regions across the state to promote joint funding for individuals who are co-recipients of service. There is a more focused effort to train staff from VR and from mental health on working jointly toward employment for people with mental illness and/or co-occurring disorders.

Effective service quality is enhanced by the fidelity efforts across the state. 15 projects received comprehensive reviews, resulting in quality improvement plans that will enable programs to work toward more effective and efficient programs. Quality improvement has focused primarily on preference development, individualized job development and executive buy-in—all leading to sustainability for SE. To determine cost/benefit, MDCH is piloting a data collection and analysis project with five of the largest PIHPs—the outcomes of which will lead us to the development of a data collection process for the state that will be able to give us information which is the most important in the development of sustainable and effective programs.

Much work has gone into “cleaning up” the data that MDCH receives and aggregates from locals. During the past fiscal year, definitions of different levels of employment were streamlined. Analysis has been done to determine reporting methodology that would give the department data that is easier to report, aggregate, and analyze in a timely fashion so the department can guide the field. This new method of reporting is being piloted this fiscal year with five large PIHPs. The intent will be to learn and adjust during this pilot and roll out the new tracking method to the field by October 2013.

MI Benefits Information Network Training is key to developing a state-wide multi-agency/partner training and support network using braided funding to best assure a long-term, sustainable benefits planning information structure across Michigan. With loss of Social Security grant funding to employ a network of well-trained benefits planners, a new and better Michigan specific training model is very needed to assist individuals with mental illness in making well-informed choices about employment. Approximately 90 individuals will attend this training in FY 2013. Joint planning meetings have started to determine possible certification of attendees, quality assurance of analyses completed, monthly support topics, and on-line training events.

MDCH continues to offer SE 101 training and will be developing the web-based training equivalent. Skills training to practitioners, new practitioners and case managers continue to be provided. Several areas of Michigan remain where SE is not available as well as communities where the services are only open to few consumers of service. Efforts will continue to influence access to services via direct attention to non-participating locals, increased technical assistance to small programs and maximizing partnerships with VR.

Legislation (Senate Bill 564) to amend Freedom to Work should provide opportunities to persons with mental illness because they are commonly the individuals with larger SSDI checks and face Medicaid with a Deductible (spend-down). Now individuals may make an informed choice

about working or increasing their work, paying a premium if earnings exceed a given amount, and retain needed Medicaid coverage. It is projected that about 3,300 additional individuals will attain Medicaid eligibility through this legislation. Growing efforts to advance Employment First in Michigan through an executive order or legislation will focus on changing “expectations” of individuals, families, agencies, organizations and employers to expect that all individuals can and should be employed. This commonly grows out of services for persons with developmental disabilities but efforts in MI clearly intend to include people with mental illness.

Older Adults

Older adults are eligible for the same service array as younger adults within the public behavioral health system. Dementia, as a primary diagnosis MAY be covered under the current Public Mental Health Code but usually is not. In FY 12 about 8,500 older adults received public behavioral health services which are less than 5% of the total number of adults served. 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. Approximately another 800 people had both a Developmental Disability and a mental illness and some 3,256 received behavioral health services in a nursing facility. One population specific grant, “The Mental Health and Aging Project” has multiple activities among the Inter-Tribal Council, but all focus block grant funding on Native Elders.

MDCH has partnered 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. Department staff wrote “Concepts and Elements of Dementia in Person-Centered Training” for the Michigan Alliance of Person-Centered Communities, which is a coalition of organizations working in long-term care. An online general education course has been developed for both the geriatric workforce as well as the general workforce.

Recently, MDCH began working with the Geriatric Education Center of Michigan (GECM) and the Center for Rural Health. Providing behavioral health information through the monthly teleconference “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. MDCH staff re-wrote two educational modules on “Caring for Caregivers: Basics” and “Caring for Caregivers of Persons with Dementia” for primary care continuing education. 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 MDCH’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.

MDCH directs the “Nursing Home Training on Dementia Care” which is in its third year of a grant from CMS’ Civil Monetary Penalty funding. Dementia Educators develop staff skills in dementia care in 20 selected nursing homes in Michigan, and act as consultants and mentors to co-train facility staff for sustainability. They teach non-pharmacological approaches and interventions to reduce and prevent distressed and challenging behaviors by residents with diagnosed dementia, with an anticipated outcome of reduced discharges to hospitalization because of behaviors. This work now coincides with a 2012 national CMS initiative to reduce use of psychotropic drugs for nursing home residents with dementia.

Involvement in the Michigan Dementia Coalition, a grassroots collaboration of representatives of universities, community agencies, and state government units continues. Department staff led the Respite Care Award Program in 2012, with written press releases and connection with professional organizations for inclusion in professional conferences to promote awareness of respite care for persons with dementia and to share innovative and exemplary practices. The article, “Best Practices in Respite Care” was written and disseminated.

As adjunct members of NASMHPD Older Persons Division, Department staff share state programming information. In 2012 staff participated in a presentation on Depression in Older Adults SAMHSA toolkit at its annual conference in Mississippi. Staff also presented a session on Wraparound for Persons with Dementia project.

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.

Jail Diversion

Diverting justice involved persons from incarceration is a top strategic priority in Michigan. Jail Diversion programs operate in each Community Mental Health Services Program (CMHSP) and Prepaid Inpatient Health Plan (PIHP). While diversion programs and services vary by size and location, they all have the same goal in common. Diverting individuals who have a serious mental illness, including those with co-occurring substance use disorder, or who have a developmental disability and have contact with the criminal justice system around misdemeanor or non-violent felony offences is the goal. Screening and assessment for mental health intervention are provided to determine whether appropriate services can be offered in the community as an alternative to serving jail time. Law enforcement and the judiciary make the

final determinations. In prior fiscal years', the Mental Health Block Grant supported post-booking diversion activities in Genesee and Kalamazoo counties through mental health court programs. Both programs funded peer support specialists and reported the effectiveness of integrating such supports into all aspects of mental health programming. In Kalamazoo, peer support specialists provided assistance to new participants and also facilitate wellness recovery groups to current participants and graduates. In Genesee, peer support specialists assisted new participants with post-booking services including transportation as well as providing expertise in joint training efforts with local law enforcement and CMH staff.

FY12 data reported by the CMHSPs and PIHPs indicates that the number of pre-booking diversion incidents with adults having mental illness totaled 2,721 (up from 2,608 in FY11). The number of pre-booking diversion incidents with those having developmental disabilities totaled 36, and the number of pre-booking incidents with those having a co-occurring SUD (a newly tracked category beginning in FY11) totaled 602. The number of post-booking incidents of adults with mental illness totaled 872, the number of post-booking diversion incidents with those with developmental disabilities totaled 141, and the number of post-booking diversion incidents with those with co-occurring SUD totaled 1,722. MDCH is available to provide technical assistance and consultation via national, regional and local resources, identifying training opportunities and to keep CMHSPs/PIHPs in touch with each other to offer individual and specific assistance when requested or as needed. A new jail diversion workgroup was started in February 2012 with the goal of further reducing incarceration rates of those with a mental illness.

Mental Health Courts

Beginning in FY09, appropriations for both the State Court Administrator's Office (SCAO) and MDCH included funding for implementation of a pilot mental health court program. MDCH funds supported treatment costs and Judiciary funds supported court operations. Boilerplate for each agency (FY09 section 459 of the MDCH appropriations) requires collaboration and joint development of guidelines for the operation and evaluation of these pilot courts. Correspondingly, in collaboration with the SCAO, a joint application was issued, applicant proposals reviewed and nine pilot mental health court programs project sites were approved and funded for FY09 implementation. This collaboration continues.

When state general fund appropriations for these pilot projects were reduced in FY09 and eliminated in FY10, funding to continue these projects was made available through Byrne/JAG American Recovery and Reinvestment Act of 2009 federal grant funds which supported the pilot projects through FY 2012. Funded mental health courts are operational in Wayne, Oakland, Berrien, Livingston, Jackson, St. Clair, Grand Traverse and Genesee counties. In FY 13 approximately 2 million was appropriated to the State Court Administrative Office to continue the funded pilot projects as well as to fund a new mental health court in Saginaw County.

MDCH contracted with Dr. Sheryl Kubiak and her team from Michigan State University (MSU) to conduct an outcome evaluation of the eight pilot programs located in Wayne, Oakland, Berrien, Livingston, Jackson, St. Clair, Grand Traverse and Genesee counties spanning 2009-2011. The evaluation examined multiple data sources to analyze both mental health court processes and outcomes. The following is an overview of the results contained in the report.

- Participant characteristics at admission: 678 individuals admitted into the mental health courts prior to 12/31/2011. Average age of admission was 35 years of age; two-thirds were male and 67% Caucasian. Majority were unemployed at admission (91%) and 20% were homeless. 40% admitted with a primary diagnosis of bipolar disorder, 29% schizophrenic/psychotic or delusional disorders (21%) 12% other such as developmental or personality disorders.
- Average length of stay was 276 days of those admitted; of 450 discharged 43% successfully completed. Successful completions were typically older (avg. 39 years) and had misdemeanor/civil offenses. Younger participants combined with a felony offense were predictive of a lower chance of successfully completing.
- 406 (60%) of the 678 admitted into mental health court screened positive for a current substance abuse problem. Of the 406, 185 (46%) did not receive any formal substance treatment in the year prior to mental health court.
- 70% of participants received substance abuse treatment within CMH at some point in time (pre, during, post mental health court) SUD service utilization generally increased during mental health court participation but declined post mental health court with 28% of those discharged receiving a SUD treatment service after mental health court.
- Prior to mental health court, 81% spent an average of 39 days in jail. During mental health court, 54% spent an average of 24 days in jail. Of the 450 discharged 149 participants were jailed post mental health court averaging 23 days in jail.
- Recidivism data: During Mental Health Court (MHC): 55 (8%) were charged with a new offense and 46 convicted. Of the 46, 10 were convicted of a felony offense.
- Post-MHC: 44 (6.5%) participants were charged with a new offense. Examining both during and post mental health court periods: as of 12/31/2011, 14% of participants had been charged and convicted of a new offense since admission into mental health court. Of 93 convicted, 30 were convicted of a felony offense.

Drug Treatment Courts

Drug treatment courts represent an enhancement of community supervision by closely supervising drug offenders in the community, placing and retaining drug offenders in treatment programs, providing treatment and related services to offenders who have not received such services in the past. The benefits of drug treatment courts include generating cost savings when offenders' reliance on the service delivery system is ultimately or eventually reduced and especially when drug courts reduce jail and prison utilization. They have been found to substantially reduce drug use and recidivism while offenders are in the program. Drug courts have evolved over time and now include several models to serve specific subsets of the offender population. These models include adult drug treatment courts, driving while intoxicated courts, family dependency treatment courts, juvenile drug courts, tribal courts and more recently Veterans courts. Although they share the same therapeutic jurisprudence model, each drug court model has program-specific components designed to meet the needs of its target population.

These programs have offered a solution to the problem of jail overcrowding, as well as to the problem of drug and alcohol-related crime.

Michigan has led the way in drug treatment court implementation. In June 1992, the first woman's drug treatment court in the nation was established in Kalamazoo County targeting felony offenders. The program was very successful and other courts sought to establish drug court programs as well. Due to continued success and increasing levels of dedicated federal and state funds, drug courts grew rapidly over the next ten years. Currently, 105 drug courts are operating, not including 11 veterans courts of which 4 are in the planning stages.

Prisoner Re-entry

Based on a model developed by the National Institute of Corrections, Michigan's Re-entry program was implemented in 2005 over eight pilot sites; the state sought to reduce recidivism rates among those returning to state correctional facilities. Initially a two-phased program that addressed "Going Home and "Staying Home", the program expanded in 2009 to include the "Getting Ready" phase and in preparation, trained over 3,500 employees. The first phase begins two months prior to release on parole where they are transferred to a facility in close proximity to the community of where they will be residing. Prisoners meet with community transition teams where needs such as housing, substance use, mental health issues are assessed and addressed. The second phase continues the work from the first phase but prioritizes employment and provides linkages and support with the local Michigan Works program. The third phase continues support services in attaining housing, employment, behavioral health services and any other tools necessary for parolees to succeed as they transition into their community.

A three-year follow-up study through 2011 of those released in 2008 (most recent cohort to complete 3 year follow up period) found that those in the re-entry program were thirty-eight percent less likely to return to prison. Additionally, the overall revocation rate for 2011-174 per 1,000 is the lowest rate since 1987. (Michigan Prisoner Reentry, A Success Story MDOC 2012)

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 1,200 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. Michigan was the second state in the country to receive approval from CMS for Medicaid reimbursement of peer services. A strong relationship with the Veterans Administration has led to over 65 Veterans receiving certification working at community mental health programs, provider agencies and VA centers.

Currently a Transformation Transfer Initiative (TTI) grant is being implemented that employs CPSS at FQHCs in two locations of the state. The grant has demonstrated successful outcomes in improving peer led whole health and wellness initiatives. Ongoing continuing education trainings for peer specialists are provided including Wellness Recovery Action Planning (WRAP), emotional CPR, Chronic Disease Self-Management Program, smoking cessation,

motivational interviewing, Whole Health Action Management (WHAM), trauma informed care, housing outreach, and development and implementation of support groups. Training is focused on a train the trainer model and developing recovery cultures and practices statewide.

The Michigan Recovery Council established in 2005 continues to provide leadership in strengthening a recovery based system of care. The Council developed and implemented a recovery train-the-trainer curriculum called Making Recovery Real to educate local communities, families, agencies and interested others in recovery. The Council provides information to local and regional areas of a diverse membership with the majority of individuals being persons with lived experience in public mental health services and supports.

Integrated Physical & Behavioral Health initiatives

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 traditional primary care clinics, and in CMH and other traditional mental health care settings.

A statewide Integrated Health Learning Community has been established, in partnership with the Michigan Association of Community Mental Health Boards and with ramp-up assistance from National Council consultants. Technical assistance and training will be made available through this Learning Community, as well as enhanced communication between Michigan communities as they strive to advance integration initiatives in their respective regions.

Needs moving forward include continuing to learn and apply lessons from pilot projects and initiative implementation to inform ongoing efforts to be optimally positioned to develop and utilize various health home models and 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 newly established 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.

Needs include building and supporting ongoing effective service quality, with 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. As of the time of this writing, Michigan had yet to decide about our state's Medicaid expansion as part of national health reform efforts. Estimates project that if/as Medicaid expands, up to 500,000 new service recipients may become eligible for Medicaid-covered services, with a significant percentage of those needing behavioral health intervention. Although additionally available Medicaid funding would be a welcome resource, issues of capacity, available workforce level and competency, and service population shifting from Block Grant and General Fund to Medicaid fund sources will all pose transitional challenges as Michigan moves into the 2014-15 grant cycle.

II: Planning Steps

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

Narrative Question:

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

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

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

Footnotes:

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 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 BSAAS for ultimate decisions. The project director for the SEOW is a BSAAS staff member, as are the SEOW epidemiologist and the SEOW liaison.

The 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 SUD and mental health service provisions; and implement a ROSC. The combined SUD and mental health indicator tracking system to support MDCH'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 2014-2015 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 Prevention Coordinator of the Clinton Eaton Ingham-Community Mental Health Authority/Coordinating Agency. Membership on the SEOW includes representatives of various state-level departments including Michigan Department of Education, Michigan State Police, and various divisions and administrations within MDCH including epidemiology, local health services, mental health, and SUD treatment. In addition, CAs, community coalitions, and the Michigan Primary Care Association are represented on the SEOW. As of January 31, 2013, the following are SEOW members:

MEMBER NAME	ORGANIZATION	WORKGROUP AFFILIATION
Elizabeth Agius	Wayne State University	Member/Evaluator
Dr. Lorri Cameron	MDCH, Division of Environmental Health	Member
Rebecca Cienki	Michigan Primary Care Association	Member
Lisa Coleman	Genesee County Community Mental Health	Member
Katy Gonzales	MDCH, Lifecourse Epidemiology & Genomics Division	Member
Jon Gonzalez	MDCH, Office of Local Health Services	Member
Denise Herbert	Network 180	Member
Joel Hoepfner	Michigan Association of Substance Abuse Coordinating Agencies (MASACA) Representative	Member/Chairperson
Charlotte Kilvington	Michigan State Police	Member
Kim Kovalchick	Michigan Department of Education	Member
Mary Ludtke	MDCH, Mental Health	Member
Dr. Corinne Miller	MDCH, Bureau of Epidemiology	Member
Dr. Su Min Oh	MDCH/BHDDA (Prevention)	Member/SEOW Epidemiologist/Staff Liaison
Larry Scott	MDCH/BHDDA (Prevention)	Member/SEOW Project Director
Angela Smith-Butterwick	MDCH/BHDDA (Treatment)	Member
Felix Sharpe	MDCH/BHDDA	Member
Brenda Stoneburner	MDCH/BHDDA (Prevention)	Member
Jeff Wieferich	MDCH/BHDDA (Treatment)	Member
Brittany Beard	Michigan Primary Care Association	Alternate 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)

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 2010, alcohol-related traffic crashes involved at least one driver, aged 16-20, who had been drinking, caused an annual average of 173 deaths and serious injuries.
- In 2010, underage alcohol use cost Michigan taxpayers \$2.1 billion dollars.
- In 2010, 3,993 youth, 12-20 years-of-age, were admitted for alcohol involved treatment in Michigan, accounting for 10.8% of all alcohol involved treatment admissions in the state.
- In 2011, 40 percent of Michigan 9 through 12th grade students had tried smoking and 14% of students smoked cigarettes on one or more of the past 30 days.
 - In 2011, 16% of Michigan youth reported having seriously considered suicide and 8% students reported having attempted suicide one or more times.

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

- Of all 2010 traffic crash fatalities, 30.4% involved at least one alcohol-impaired operator, bicyclist, or pedestrian.
- Between 2004 and 2010, alcohol-related traffic crashes involving at least one driver, 16-25 years-of-age, who had been drinking, caused an average of 470 deaths and incapacitating injuries.
- During 2008-2010, an estimated 5.4% of individuals over the age of 18 years old are heavy drinkers and 16.6% of them were binge drinkers.
- In 2011, prescription drugs totaled 5,581 treatment episodes with the highest rates in adults 21-54 years-of-age.
- Between 2003 and 2010, the biggest increase in the number of legitimate prescriptions was noted as Opioid antagonists (Suboxone).
- In 2010, Michigan's age-adjusted suicide rate was 12.5 per 100,000 population, with the rate of death for males, four times higher than for females.
- Between 2008-2009, young adults 18-25 years-of-age in Michigan, had higher rates of a major depressive episode and psychological distress, compared to adults 26 years-of-age.

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

As a result of this work, unmet service needs and critical gaps have been identified as follows:

- Reducing childhood and underage drinking
- Reducing prescription drug and over-the-counter (RxOTC) misuse and 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.

CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

According to 2012 US Census figures, Michigan is the 8th most populous state in the United States with an estimated population of 9,883,360, with approximately 2,295,812 of those residents being children, ages 0-17 (per most recently available 2011 Census figures). Prevalence data supplied by the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2011 National Outcome Measures Prevalence Report suggests 7-13% of the 1,214,930 children from ages 9 to 17 in Michigan could be identified as having a serious emotional disturbance (SED). That means anywhere from 85,045 to 157,941 children ages 9 to 17 might have been eligible for services in the public mental health system in 2011 alone. However, data compiled by MDCH indicates 39,748 children (ages 0 through 17) with SED were served in the public mental health system. Improvement in identifying and engaging children who may be in need of mental health services in Michigan is needed. According to the Michigan Department of Human Services (MDHS) 13,098 children were residing in out-of-home foster care and juvenile justice placements which cost \$164,123,227.31. According to the Michigan Department of Education (MDE) the statewide high school drop out rate was 11% despite a concerted effort by education to reduce youth leaving school before graduation. According to Human Rights Watch, as of 2012, Michigan remains second in the nation for the number of juveniles (358) serving a life sentence without parole. 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 two 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 8.9% in December 2012 which was better than December 2011 but remained 1.1% above the national average of 7.8% for that same time. Also, the number of children living in poverty in Michigan has risen from 23% in 2010 to 25% in 2011. According to information provided by SAMHSA in the 2011 National Outcome Measures Prevalence Report, Michigan dropped to 37th in the national poverty ranking which

remains in the high poverty tier. Data reported in the MDHS' Green Book Report of Key Statistics, November 2012 edition, indicates that 1,920,155 Michigan residents were eligible for Medicaid in that month and of those eligible residents, 744,467 were families and 82,335 were other children. Also, according to the Annie E. Casey Foundation Kids Count Data Center, the 25% of the children (ages 0-18) in Michigan living below the federal poverty level in 2011, remained above the national average of 23% for that same time period. In addition, Medicaid births in Michigan are now approximately 50% of all births. Additional data from the National Center for Children in Poverty website indicates that 21% of low-income children and youth, ages 6 through 17, have mental health problems. It is prime time in Michigan for partnerships to be forged to attempt to meet the needs of Michigan's children and families collaboratively on a larger scale and a statewide SOC is an effective way to achieve this.

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

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

- lack of a comprehensive assessment of disparities in mental health outcomes for children of color and the impact of poverty on health and mental health;
- inconsistent access to comprehensive and meaningful mental health evaluations and risk assessments for children and youth involved in all systems;
- differing levels of awareness and education regarding identifying and treating trauma 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. MDCH believes that there are many reasons that these needs have not been fully addressed at this point after so many years of SOC work in the state, but two main reasons appear to be that the SOC has historically been viewed as a mental health initiative that can either be imposed upon or opted out of by other systems instead of a statewide initiative to better serve the children with SED in every system. There is a need to unify the approach and

encourage all partners to recognize their vital role in the statewide SOC and understand the benefits to them for their involvement because the mental health system cannot do this alone. Secondly, Michigan has never developed an 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.

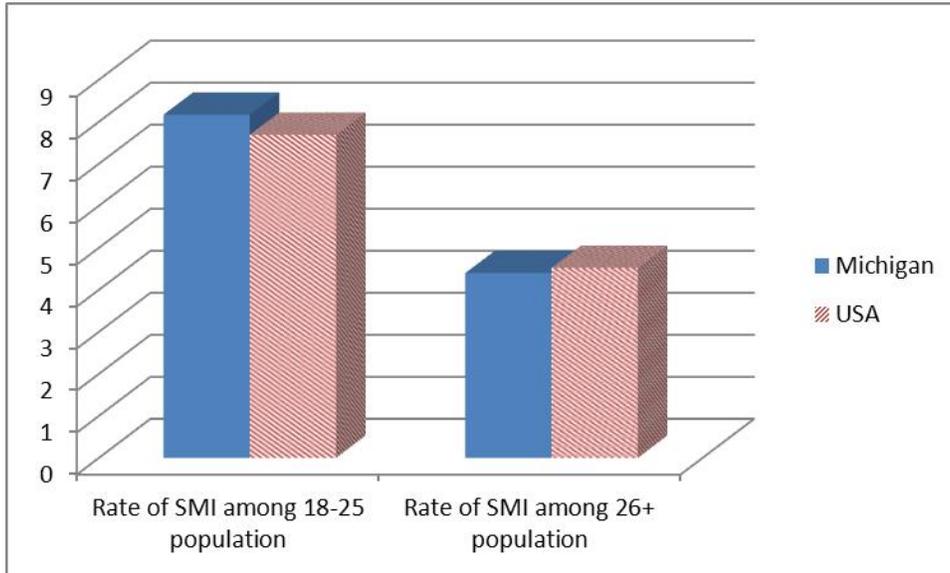
ADULTS WITH SERIOUS MENTAL ILLNESS (SMI)

Of Michigan's estimated population of 9,883,360 reported in the 2012 US Census, 76% are over the age of 18, an adult population estimate of 7,576,157. Per the 2011 data set provided by the National Survey on Drug Use and Health (NSDUH) and revised in March of 2012, 4.99% of American adults (approximately 15.6 million) were estimated to have SMI. Michigan's total number of civilian adults with SMI as calculated in 2011 by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute's State Data Infrastructure Coordinating Center (NRI/SDICC) was estimated at 409,112 for a prevalence rate of 5.4%. Applying the NRI/SDICC low/high prevalence rate range of 3.7-7.1% to the 2012 state adult population total would predict Michigan's adult SMI population to be between 280,318 and 537,907. Another source of prevalence data is the National Survey on Drug Use and Health, which estimates that 4.95% of Michigan's adult population have serious mental illness, with the confidence interval range between 4.28% and 5.72%, and predictive of a Michigan's adult SMI population between 324,260 and 433,356.

Per data reported by Michigan's public mental health care system, only 144,668 adults were provided with Community Mental Health services, suggesting a significant gap between the prevalence of serious mental illness in Michigan's adult population and the penetration of public sector mental health services, as it is unlikely that the differential can be fully accounted for by the cohort of SMI adults served in the private-sector, or via other systems. Clearly, improvement in identifying, 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 SMI population, needs that block grant resources can assist in meeting.

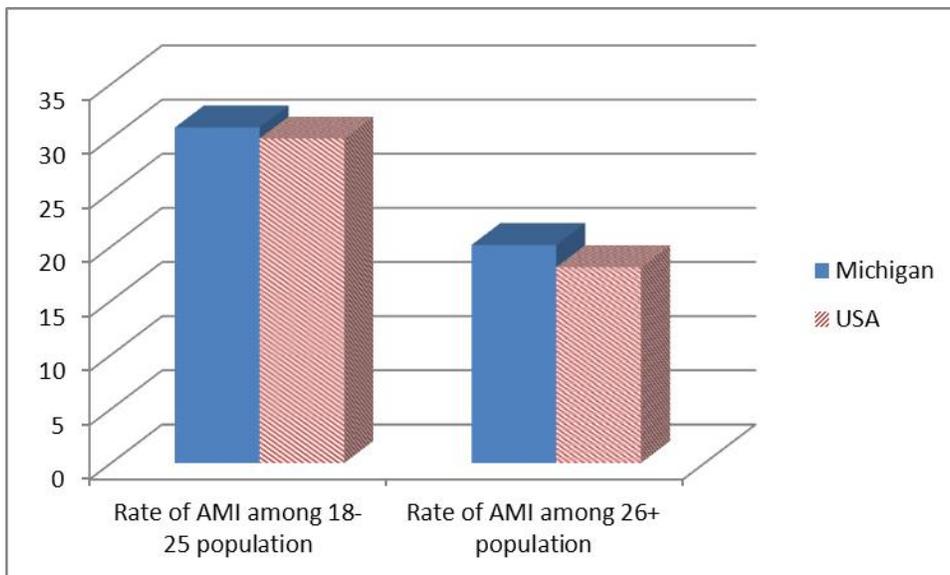
Additional indicators of the need for mental health services include Michigan's data on the incidence rates of suicide, Serious Mental Illness, and Any Mental Illness. According to data provided by the SEOW, Michigan's 2010 age-adjusted suicide rate was 12.5 per 100,000 individuals, up from the 2009 rate of 11.3 per 100,000. The rate of suicidal deaths for Michigan males was found to be four times higher than for Michigan females. According to 2010-11 NSDUH findings of the prevalence of a Serious Mental Illness (SMI) within the prior year, Michigan's young adults in the 18-25 age range showed higher rates (8.17%) than the national average (7.69%) in 2010-11. Michigan's adults aged 26 and older were found to have lower

incidence rates of Serious Mental Illness within the prior year (4.4%) when compared to the national average (4.52%).



Michigan’s Rates of Serious Mental Illness among Adults, 2010-11

According to 2010-11 NSDUH findings of the prevalence of Any Mental Illness (AMI) within the prior year, Michigan’s young adults in the 18-25 age range showed higher rates (30.98%) than the national average (29.95%) in 2010-11. Michigan’s adults aged 26 and older were also found to have higher incidence rates of Any Mental Illness within the prior year (20.14%) when compared to the national average (18.08%).



Michigan’s Rates of Any Mental Illness among Adults, 2010-11

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. Although there currently exists the means to accurately capture the delivery of the IDDT-level of intensive Dual Diagnosis Treatment services, Michigan still has room to grow in working out improved identification, delivery, and capture of Dual Diagnosis Treatment services at lower levels of intensity. To this end, the use of the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) has been piloted in Michigan as a framework for capturing and supporting the continued development and implementation of Dual Diagnosis Treatment services across the entire continuum of service type and intensity of need.

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

HEALTHCARE HOMES/INTEGRATED BEHAVIORAL AND PHYSICAL HEALTH

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

OUTPATIENT SERVICES

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

RECOVERY SUPPORT SERVICES

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

SYSTEMS IMPROVEMENT

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

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

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

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

**BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES ADMINISTRATION
STRATEGIC PLAN GOALS**

1. Individuals served by the Behavioral Health and Developmental Disability (BH&DD) Service System receive appropriate general health care services that effectively identify, treat and reduce co-morbidities (1 and 2; 1a and 2d)

- a. Integrate Behavioral Health and General Health services to assure easy, effective and timely access.

Objectives:

1. Develop plan for integration of health care services
2. Include primary prevention of health problems; such as obesity, diabetes, cardiovascular disease, chronic obstructive pulmonary disease (COPD), hypertension, substance use disorders, and promotion of health as explicit activities
3. Develop plan for viable Health Home models for persons with chronic and co-morbid conditions (or tendencies toward same)
4. Promote evidence-based protocols for assessment of adverse health effects of psychotropic medications as routine part of psychiatric visits.

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

Objectives:

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

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

Objectives:

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

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

- a. Treatment outcomes for each population improve

Objectives:

1. Establish measures for key outcomes

2. Promote and support the expansion and continuation of evidence-based and promising practices

b. Quality of Life for each population is improved

Objectives:

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

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

Objectives:

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

d. BHDDA helps ensure system accountability regarding performance improvement

Objectives:

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

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

Objectives:

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

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

Objectives:

- a. PIHPs consolidate administrative functions within affiliations to reduce costs and/or improve the consistency of policies and services
- b. PIHPs and CMHSPs reduce redundancies in reporting, training and oversight requirements in their contracting with providers

- c. Disparities in access, type and intensity of services across the system are minimized
 - d. BHDDA reduces redundancies in reporting and oversight requirements of CMHSPs, PIHPs, and CAs
 - e. BHDDA provides the leadership to local BH&DD Service Systems, as well as BHDDA Central Office, in achieving positive results regarding administrative efficiency and effectiveness
- 6. The provision of care (services/supports) throughout the BH&DD Service System is one that supports the culture of gentleness, resiliency, recovery, and full integration into community life (2)**
- Objectives:**
- a. Services and supports for individuals with mental illness are based on a foundation of recovery
 - b. SUD services and supports are offered within a recovery-oriented system of care
 - c. A system of care is in place for children with serious emotional disturbances and children with developmental disabilities
 - d. All persons served are supported to integrate into the mainstream of community life
 - e. Services and supports for individuals with developmental disabilities, adults with serious mental illness and children with serious emotional disturbance are provided within in a culture of gentleness
 - f. The workforce understands and can implement the mission and goals of the BH&DD Service System
 - g. The workforce is able to provide culturally competent services

Table 1 Step 3,4: -Priority Area 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 continue to improve through participation in a statewide SOC.
Strategies to attain the goal:	
	<ul style="list-style-type: none"> - Develop a structure to expand the availability and access to a statewide comprehensive SOC for children/youth and their families that includes improved treatment outcomes, using block grant funding in addition to other resources. - Engage system partners and stakeholders in the process of developing as statewide SOC. - 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. - 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. - Utilize data to inform policy and program decision making and improvements.
Annual Performance Indicators to measure goal success	
Indicator #:	1
Indicator:	Statewide total CAFAS scores from intake to discharge for children/youth with SED served in the public mental health system will go down in FY14 and again in FY15 from a baseline

average obtained from FY10 data.

Baseline Measurement: FY10 baseline: 56.5% of children assessed with the CAFAS statewide demonstrated at least a 20 point (statistically significant) reduction in their overall CAFAS score from intake to discharge.

First-year target/outcome measurement: FY14 target: 58.0%

Second-year target/outcome measurement: FY15 target: 58.25%

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::

Data must be sent to Dr. Carlson from Multi-Health Systems, Inc. who collects and stores data from the online CAFAS system. There have been delays in obtaining data from Multi-Health Systems, Inc. which are being addressed.

Indicator #: 2

Indicator: The number of children/youth with SED served in the public mental health system that receive wraparound services will increase in FY14 and again in FY15 from a baseline of number served in FY10.

Baseline Measurement: FY10 baseline: 1,332 children served by Wraparound

First-year target/outcome measurement: FY14 target: 1,350 children

Second-year target/outcome measurement: FY15 target: 1,400 children

Data Source:

MDCH Division of Quality Management and Planning

Description of Data:

State encounter data

Data issues/caveats that affect outcome measures::

Data reporting is not complete at time of application, estimates are used.

Indicator #:

3

Indicator:

The number of children/youth with SED served in the public mental health system that receive PMTO will increase in FY14 and again in FY15 from a baseline of number served in FY10.

Baseline Measurement:

FY10 baseline: 263 children served by PMTO

First-year target/outcome measurement:

FY14 target: 320 children

Second-year target/outcome measurement:

FY15 target: 330 children

Data Source:

MDCH Division of Quality Management and Planning

Description of Data:

State encounter data

Data issues/caveats that affect outcome measures::

Data reporting is not complete at time of application, estimates are used.

Indicator #:

4

Indicator:

The number of children/youth with SED served in the public mental health system that receive Trauma-Focused Cognitive Behavior Therapy will increase in FY14 and again in FY15 from a baseline of number served in FY10.

Baseline Measurement:

FY10 baseline: 283 children served by PMTO

First-year target/outcome

FY14 target: 467 children

Priority #: 2

Priority Area: Enhanced Partnerships for Children/Youth with Serious Emotional Disturbance (SED) and Their Families

Priority Type: MHS

Population SED

(s):

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.

Strategies to attain the goal:

- Expand the SEDW
- Continue to support DHS access positions in SEDW sites.
- Continue to support juvenile justice projects and foster the relationship between MDCH and MDHS and the State Court Administrative Office to encourage more collaborative work.
- Continue to pursue and support integrated physical health and behavioral health initiatives for children and youth with SED and their families.
- Begin training and support initiative for youth with SED and co-occurring substance use disorders (SUD).

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	The number of children enrolled in the SED Waiver (SEDW) will increase in FY14 and again in FY15 from FY11baseline.
Baseline Measurement:	FY11 baseline: 265 children served by the SED Waiver
First-year target/outcome measurement:	FY14 target: 400 children
Second-year target/outcome measurement:	FY15 target: 450 children
Data Source:	

SEDW online data management system

Description of Data:

Count of kids on the SEDW

Data issues/caveats that affect outcome measures::

None

Indicator #:

2

Indicator:

The number of youth involved in the juvenile justice system who received necessary public mental health services will increase in FY14 and again in FY15 from FY11 baseline.

Baseline Measurement:

FY11 baseline: 1,572 youth served

First-year target/outcome measurement:

FY14 target: 1,650 youth

Second-year target/outcome measurement:

FY15 target: 1,700 youth

Data Source:

MDCH Division of Quality Management and Planning

Description of Data:

State encounter data

Data issues/caveats that affect outcome measures::

Data reporting is not complete at time of application, estimates are used.

Indicator #:

3

Indicator:

The number of children served in integrated physical and mental health projects will increase in FY14 and again in FY15 from FY12 baseline.

Baseline Measurement:

FY12 baseline: 662 children served by integrated physical and mental health projects

First-year target/outcome measurement: FY14 target: 700 children

Second-year target/outcome measurement: FY15 target: 750 children

Data Source:

Project LAUNCH, SKIPP Project and any additional integrated project data

Description of Data:

Count of children served

Data issues/caveats that affect outcome measures::

None

Indicator #: 4

Indicator: A baseline of youth receiving co-occurring services will be obtained in FY14 and the number served will increase in FY15.

Baseline Measurement: FY14 baseline: To be determined

First-year target/outcome measurement: FY14 target: To be determined

Second-year target/outcome measurement: FY15 target: To be determined

Data Source:

MDCH Division of Quality Management and Planning

Description of Data:

State encounter data

Data issues/caveats that affect outcome measures::

Data reporting is not complete at time of application, estimates are used.

Priority #: 3

Priority Area: Integration of Behavioral Health and Primary Care Service Delivery to Mental Health Service Recipients

Priority Type: MHS

Population SMI

(s):

Goal of the priority area:

To link a greater number of individuals with SMI to coordinated and/or integrated primary care services to improve duration and quality of life.

Strategies to attain the goal:

- Continue to support regional PIHP health home projects with Block Grant resources, to increase the number of SMI individuals receiving primary care services.
- Continue to support statewide Integrated Health Learning Community as a venue for sharing information, resources, training, and trial-and-error learning gains.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of adults receiving services from integrated/coordinated physical and mental health projects will increase in FY14 and again in FY15 from FY12 baseline.

Baseline Measurement: FY12 baseline: 821 adults receiving services from integrated/coordinated physical and mental health projects

First-year target/outcome measurement: FY14 target: 900 adults

Second-year target/outcome measurement: FY15 target: 975 adults

Data Source:

PIHP Integrated Health Block Grant project reports, and any additional integrated project data, up to and including Learning Community survey data.

Description of Data:

Count of adults served through the PIHP block grant projects.

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: The number of CMHSP and/or Primary Care provider staff receiving training in integrated behavioral and primary health care delivery will increase in FY14, and again in FY15 from FY12 baseline.

Baseline Measurement: FY12 baseline: 0 staff receiving training

First-year target/outcome measurement: FY14 target: 90 staff

Second-year target/outcome measurement: FY15 target: 110 staff

Data Source:

PIHP Integrated Health Block Grant project reports, and any additional integrated project data, up to and including Learning Community survey data.

Description of Data:

Staff registrations from Learning Community sessions; quarterly narrative report data from the PIHPs.

Data issues/caveats that affect outcome measures::

None

Priority #: 4

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

Priority Type: MHS

Population: SMI

(s):

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.

Strategies to attain the goal:

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

- 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 IDDT, DDCMHT, and/or DDCAT program site reviews will increase in FY14 and again in FY15 from FY12 baseline.

Baseline Measurement: FY12 baseline: 18 program site reviews

First-year target/outcome measurement: FY14 target: 20

Second-year target/outcome measurement: FY15 target: 22

Data Source:

MIFAST data from MDCH Specialist on number of IDDT, DDCMHT, and/or DDCAT program site reviews conducted.

Description of Data:

Number of IDDT, DDCMHT, and/or DDCAT reviews conducted.

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: The number of adult CMH service recipients receiving treatment services for co-occurring mental health and substance use disorders will increase in FY14 and again in FY15 from FY12 baseline.

Baseline Measurement: FY12 baseline: 15,711 adults receiving services

First-year target/outcome measurement: FY14 target: 16,497 adults

Second-year target/outcome measurement: FY15 target: 17,322 adults

Data Source:

MDCH Data warehouse encounter data for services modified with HH or HH&TG modifiers.

Description of Data:

Count of adults receiving co-occurring services.

Data issues/caveats that affect outcome measures::

Data reporting is not complete at time of application, estimates are used.

Priority #: 5

Priority Area: Indicated behavioral health service delivery to justice-involved consumers.

Priority Type: MHS

Population SMI

(s):

Goal of the priority area:

Reduce the number of SMI adults in jail/prison who could benefit from full engagement in outpatient behavioral health services.

Strategies to attain the goal:

- Leverage Governor Snyder's proposed increase in state funding for specialty courts including mental health courts of \$2.1 million (FY13) levels and an additional \$2 million in FY14/15 to increase pre-booking and post-booking diversion, including expansion of Mental Health Court Programs, in partnership with the State Court Administrative Office.

- Provide support to projects to implement a process to improve screening and assessment for behavioral health issues and assist projects to provide greater access to such services.

- Provide training to workforce members involved with mental health court programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of mental health court programs will increase in FY14 and again in FY15 from FY12 baseline.

Baseline Measurement: FY12 baseline: 8 State-subsidized mental health court programs + 4 locally funded

First-year target/outcome measurement: FY14 baseline: 9 State-supported + 5 locally funded

Second-year target/outcome measurement: FY15 baseline: 11 State-supported + 6 locally funded

Data Source:

Data from MDCH Specialist and mandated project reporting.

Description of Data:

Count of mental health court programs from project reporting.

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: The number of Adults with mental illness receiving behavioral health services through a mental health court program will increase in FY14 and again in FY15 from FY12 baseline.

Baseline Measurement: FY12 baseline: 530 adults receiving services through a mental health court program

First-year target/outcome measurement: FY14 target: 610 adults

Second-year target/outcome measurement: FY15 target: 700 adults

Data Source:

Data from MDCH Specialist and mandated project reporting/Michigan State University Statewide Mental Health Court Evaluation.

Description of Data:

The number of adults receiving behavioral health services through a mental health court program.

Data issues/caveats that affect outcome measures::

None

Indicator #:

3

Indicator:

Increase knowledge base of mental health diagnosis, developmental disabilities, and/or co-occurring disorders of specialty court/mental health court teams. Collaborate with other state agencies (SCAO) to provide targeted training to courts/teams.

Baseline Measurement:

FY12 baseline: 0 workforce members representing courts/teams will receive training

First-year target/outcome measurement:

FY14 target: 60 workforce members

Second-year target/outcome measurement:

FY15 target: 80 workforce members

Data Source:

SCAO conference attendance record; MSU Statewide Mental Health Court Evaluation.

Description of Data:

Count of training specialty court/mental health court team participants.

Data issues/caveats that affect outcome measures::

None

Priority #: 6

Priority Area: Promote Healthy Births

Priority Type: SAT

Population PWWDC

(s):

Goal of the priority area:

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

Strategies to attain the goal:

- Increase outreach to pregnant women to increase the population's access to treatment.
- Provide extended case management to pregnant women to provide support after the treatment episode in order to promote a healthy birth.
- Promote recovery support services to extend engagement and support retention.
- 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: FY14 Target: 205 drug free births

Second-year target/outcome measurement: FY15 Target: 210 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. MDCH 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 IVDUs

(s):

Goal of the priority area:

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

Strategies to attain the goal:

- 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.
- Work with regional coordinating agencies to manage wait lists and expand services as needed to limit wait times for methadone treatment.
- 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:

FY14 Target: 10.8% of individuals

Second-year target/outcome measurement:

FY15 Target: 9.7% 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 PWWDC

(s):

Goal of the priority area:

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

Strategies to attain the goal:

- Outreach to collaborative partners to ensure that parents are identified as priority populations.
- 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.
- Encourage the use of recovery support services to extend engagement and support retention.
- 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
OMB No. 0930-0168 Approved: 05/21/2013 Expires: 05/31/2016

residential treatment

First-year target/outcome measurement:

FY14 Target: 37.3% of parents with dependent children

Second-year target/outcome measurement:

FY15 Target: 38.2% 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:

Increase the percentage of integrated treatment expenditures by 10%.

Strategies to attain the goal:

- 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.
- Encourage regions to provide technical assistance to those agencies working to become co-occurring capable and enhanced.
- Encourage the use of recovery support services to extend engagement and support retention.

- Build capacity to provide trauma-informed care.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of Substance Abuse Coordinating Agency (CA) expenditures on integrated services for individuals with co-occurring disorders.

Baseline Measurement: FY12 Baseline: 13.1% of expenditures

First-year target/outcome measurement: FY14 Target: 13.8%

Second-year target/outcome measurement: FY15 Target: 14.4%

Data Source:

Section 408 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: Underage Drinking

Priority Type: SAP

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

(s):

Goal of the priority area:

Reduce childhood and underage drinking.

Strategies to attain the goal:

- Increase multi-system collaboration.
- Reduce adult abuse by engaging all segments of the community in establishing ROSC and increase the use of brief intervention.
- Engage parents in helping reduce underage drinking.
- Over the next five years all existing community coalitions will become Prevention Prepared Communities and implement at least one environmental strategy.
- Provide training on Communities that Care and Community Trials.

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: FY14 Target: 29.0%

Second-year target/outcome measurement: FY15 Target: 26.0%

Data Source:

Michigan Profile for Healthy Youth (MiPHY); 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 Other (Adolescents w/SA and/or MH)

(s):

Goal of the priority area:

Reduce youth access to tobacco

Strategies to attain the goal:

- Synar and Non Synar compliance checks to discourage sells to minors.
- Increased youth engagement.
- "Read the Red" vertical driver's license education.
- Encouragement through positive community recognition.
- Vendor education.
- Increased community awareness of health issues and access through coalitions and health departments.
- "Kick Butts" annual smoking cessation day.
- Improved English language proficiency, multi-lingual signage availability.
- Use of research-based curriculum.
- Increased law enforcement involvement.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator: Effect a 10% retail merchant sells rate to minors
Baseline Measurement: FY12 Baseline: 14.9% Michigan Retailer Violation Rate
First-year target/outcome measurement: FY14 Target: 10%
Second-year target/outcome measurement: FY15 Target: 10%
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::

None

Footnotes:

Table 2 State Agency Planned Expenditures [SA]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	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*	\$81,465,114		\$88,770,000	\$400,000	\$54,000,000	\$	\$
a. Pregnant Women and Women with Dependent Children*	\$11,244,880		\$	\$	\$	\$	\$
b. All Other	\$70,220,234		\$88,770,000	\$400,000	\$54,000,000	\$	\$
2. Substance Abuse Primary Prevention	\$21,808,763		\$	\$200,000	\$	\$	\$
3. Tuberculosis Services	\$106,480		\$	\$	\$	\$	\$
4. HIV Early Intervention Services	\$		\$	\$	\$	\$	\$
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	\$5,441,071		\$	\$200,000	\$1,600,000	\$	\$
11. Total	\$108,821,428	\$	\$88,770,000	\$800,000	\$55,600,000	\$	\$

* Prevention other than primary prevention

Footnotes:

Table 2 State Agency Planned Expenditures [MH]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	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			\$ 44,594,000	\$ 25,927,680	\$ 387,759,200	\$ 29,643,200	\$ 6,481,920
6. Other 24 Hour Care		\$	\$	\$	\$	\$	\$
7. Ambulatory/Community Non -24 Hour Care		\$	\$	\$	\$ 891,200	\$	\$
8. Mental Health Primary Prevention		\$	\$	\$	\$	\$	\$
9. Mental Health Evidenced- based Prevention and Treatment (5% of total award)		\$ 1,987,200	\$	\$	\$	\$	\$
10. Administration (Excluding Program and Provider Level)		\$ 1,145,530	\$	\$	\$	\$	\$
11. Total	\$	\$ 3,132,730	\$ 44,594,000	\$ 25,927,680	\$ 388,650,400	\$ 29,643,200	\$ 6,481,920

* Prevention other than primary prevention

Footnotes:

Based on spending used to calculate our Maintenance of Effort for Mental Health Block Grant, gross state agency planned expenditures for Mental Health services in Michigan for FY2014 and FY2015 are approximately \$5.2 billion. We do not track services per the majority of the categories listed in Table 2.

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From 07/01/2013 to SFY 06/30/2015

Service	Unduplicated Individuals	Units	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health			\$	\$
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 Dissemination			\$	\$
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			\$	\$
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			\$	\$
Children's Mental Health 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			\$	\$
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 (please list)			\$	\$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SABG Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$ 40,732,557	
2 . Substance Abuse Primary Prevention	\$ 10,904,382	
3 . Tuberculosis Services	\$ 53,240	
4 . HIV Early Intervention Services**	\$ 0	
5 . Administration (SSA Level Only)	\$ 2,720,535	
6. Total	\$54,410,714	

* Prevention other than primary prevention

** HIV Early Intervention Services

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Strategy	IOM Target	FY 2014		FY 2015	
			SA Block Grant Award		SA Block Grant Award
Information Dissemination	Universal		\$ 320,510		
	Selective		\$ 100,120		
	Indicated		\$ 132,330		
	Unspecified		\$ 2,000		
	Total		\$554,960		
Education	Universal		\$ 2,045,102		
	Selective		\$ 2,327,840		
	Indicated		\$ 1,144,410		
	Unspecified		\$ 48,000		
	Total		\$5,565,352		
Alternatives	Universal		\$ 426,400		
	Selective		\$ 429,930		
	Indicated		\$ 98,600		
	Unspecified		\$ 0		
	Total		\$954,930		
Problem Identification and Referral	Universal		\$ 291,010		
	Selective		\$ 328,350		
	Indicated		\$ 315,040		
	Unspecified		\$ 0		
	Total				

	Total	\$934,400	
Community-Based Process	Universal	\$ 1,331,150	
	Selective	\$ 235,350	
	Indicated	\$ 98,100	
	Unspecified	\$ 0	
	Total	\$1,664,600	
Environmental	Universal	\$ 695,720	
	Selective	\$ 106,960	
	Indicated	\$ 31,200	
	Unspecified	\$ 0	
	Total	\$833,880	
Section 1926 Tobacco	Universal	\$ 162,860	
	Selective	\$ 14,200	
	Indicated	\$ 12,060	
	Unspecified	\$ 0	
	Total	\$189,120	
Other	Universal	\$ 107,300	
	Selective	\$ 99,840	
	Indicated	\$ 0	
	Unspecified	\$ 0	
	Total	\$207,140	
Total Prevention Expenditures		\$10,904,382	
Total SABG Award*		\$54,410,714	
Planned Primary Prevention Percentage		20.04 %	

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

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	\$ 3,198,711	
Universal Indirect	\$ 2,231,341	
Selective	\$ 3,642,590	
Indicated	\$ 1,831,740	
Column Total	\$10,904,382	
Total SABG Award*	\$54,410,714	
Planned Primary Prevention Percentage	20.04 %	

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

Footnotes:

Table 5c SABG Planned Primary Prevention Targeted Priorities

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

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$				
2. Quality Assurance	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$				
3. Training (Post-Employment)	\$ 56,428	\$ 112,772	\$ 169,200	\$338,400				
4. Education (Pre-Employment)	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$				
5. Program Development	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$				
6. Research and Evaluation	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$				
7. Information Systems	\$ 60,000	\$ <input type="text"/>	\$ 60,000	\$120,000				
8. Enrollment and Provider Business Practices (3 percent of BG award)	\$ <input type="text"/>	\$ 1,632,321	\$ 1,632,321	\$3,264,642				
9. Total	\$116,428	\$1,745,093	\$1,861,521	\$3,723,042				

Footnotes:

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	\$ 3,368,881
MHA Planning Council Activities	\$ 9,000
MHA Administration	\$ 590,448
MHA Data Collection/Reporting	\$ 491,031
Enrollment and Provider Business Practices (3 percent of total award)	\$ 470,000
MHA Activities Other Than Those Above	\$
Total Non-Direct Services	\$4929360
Comments on Data:	

Footnotes:

IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their 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?

Footnotes:

IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?
5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.
6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.
7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.
8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

IV: Narrative Plan

E. Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (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 utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

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. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. 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. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Encounter/utilization/performance analysis; and
 - f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Footnotes:

IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

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. SAMHSA is requesting that states respond to the following questions:

- 1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?
- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
 - a) What information did you use?
 - b) What information was most useful?
- 3) How have you used information regarding evidence-based practices?
 - a) Educating State Medicaid agencies and other purchasers regarding this information?
 - b) Making decisions about what you buy with funds that are under your control?

Footnotes:

IV: Narrative Plan

G. Quality

Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

- 1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
- 2) Please provide information on any additional measures identified outside of the core measures and state barometer.
- 3) What are your states specific priority areas to address the issues identified by the data?
- 4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

IV: Narrative Plan

H. Trauma

Narrative Question:

In order to better 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 care approach consistent with SAMHSA's trauma-informed care definition and principles. 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 more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

H. Trauma

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?

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).

For adults with serious mental illness, there are no policies for screening for personal history of trauma. There are Trauma Informed and Trauma Specific subcommittees, which are beginning to communicate with each other.

There are no policies for substance use. However, many providers do screen clients as part of the bio-psychosocial assessment.

2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?

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 (Trauma Symptom Checklist for Young Children and the Northshore UCLA PTSD) 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. MDCH is currently investigating a group trauma treatment model to pilot with children and youth as well.

3. Does your state have any policies that promote the provision of trauma-informed care?

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.

4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?

Please see Question # 2 for information about trauma-specific interventions for children with SED and their families.

There are multiple interventions for adults with serious mental illness that are offered at the provider level. They include Seeking Safety, Beyond Trauma, Helping Women Recover, TREM (Trauma, Recovery and Empowerment Model) and M-TREM (male-specific version).

5. What types of trainings do you provide to increase the capacity of providers to deliver trauma-specific interventions?

The Children's Trauma Initiative collaborative participants attend 3-4 day training with topics focused on Complex Trauma and Trauma Informed Assessment measures, including assessment to determine child/parent readiness for TFEBT and/or other potential treatment strategies, as well as TFEBT 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, TFEBT 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 TFEBT 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 36 out of 46 CMHSPs in Michigan. The initiative continues with the goal of expanding statewide.

For adults with serious mental illness, statewide and regional trainings are being held for TREM and M-TREM.

Multiple trainings on trauma have been supported by BHDDA as well. Five have addressed the basics of trauma-informed care and how to establish an environment that does not re-traumatize individuals. Three of these were presented in collaboration with a CSAT Technical Assistance request. The same information was offered in three locations around the state to afford those in outlying regions the opportunity to participate. Four of the basic trainings were specific to women's programming. We have also held a training that specifically addresses the Seeking Safety model. Other opportunities are in the planning process.

IV: Narrative Plan

I. Justice

Narrative Question:

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 abuse 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.^{42,43} 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 utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.⁴⁴

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. 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 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 answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating 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. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide 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?

42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman, 2000.

43 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.

44 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.

Footnotes:

I. Justice

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?

Medicaid expansion in Michigan remains undecided.

2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

MDCH administers both the public mental health service delivery system and the state's substance use disorder prevention and treatment system thus also enabling screening and other appropriate services to be provided to those with behavioral health issues including those with co-occurring disorders.

The Michigan Mental Health Code requires that local CMHSPs provide services to divert persons with serious mental illness, serious emotional disturbances, or developmental disabilities from jail incarceration when appropriate. Although jail diversion requirements have had some impact diverting mentally ill persons into treatment, a large number remain incarcerated due to a number of factors such as State law that does not permit the CMHSP to pay for mental health services provided to inmates of local jails unless the jail and the CMHSP have a contractual arrangement to administer/pay for jail-based mental health treatment services.

The state requires that an alcohol screening/assessment be completed on individuals convicted of any alcohol related offence prior to sentencing. Most Michigan district courts are licensed to conduct substance abuse screenings/assessments which are completed by the probation department and include recommendations to the sentencing judge on referral to appropriate rehabilitative treatment services.

3. Are your SMHA and SSA coordinating 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?

Diverting justice involved persons with behavioral health issues from incarceration is a top strategic priority of Michigan's Governor Snyder. In March 2013, Executive Order 2013-7 was issued which created a 14-member Mental Health Diversion Council within DCH to provide an ongoing examination of mental health issues in Michigan. The Council is tasked with assessing, implementing practices to improve diversion activities. MDCH has also recently been invited to participate on a cross-system committee coordinated by the Michigan Department of Human Services that is re-evaluating re-entry procedures for youth with disabilities.

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

For justice involved individuals that meet the SPMI criteria, the full array of CMHSP services are made available and are subject to the needs of the participant and their Person Centered Plan. Person Centered Planning is also required under the Mental Health Code and ensures that individuals are to be directly involved in the process of planning for their mental health supports and services. For youth who are transitioning out of juvenile justice residential facilities, special

provisions in the location of service language in the Michigan Medicaid Provider Manual added in FY12 allows for public mental health system case management and/or wraparound services to begin prior to discharge from the facility to assure youth and their families are linked up with appropriate mental health and other supportive services upon discharge.

5. What cross-trainings do you provide 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?

MDCH provides training that addresses clinical needs of MDCH, PIHP, and CMHSP staff. Training workshops also include promising or best practices of locally developed programs conducted by both clinical and justice staff directly involved with such programs. Jail diversion teams and mental health court teams are examples of workshops recently presented. MDCH 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 sub-committee 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.

As discussed earlier in the application, Michigan has a long history of implementing successful problem solving courts that address the unique needs of justice involved persons. Cross training is also provided through collaborative state level efforts through MDCH, State Court Administrator's Office, Department of Human Services and Department of Corrections, as well as associations such as the Michigan Association of Drug Court Professionals.

IV: Narrative Plan

J. Parity Education

Narrative Question:

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. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?)
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

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 rewarded to coordinate 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 answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
3. 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 publicly funded behavioral health providers?
4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
6. Describe how your behavioral health providers are screening and referring for:
 - a. heart disease,
 - b. hypertension,
 - c. high cholesterol, and/or
 - d. diabetes.

Footnotes:

K. Primary and Behavioral Health Care Integration Activities

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

‘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 agency/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 Community Health (MDCH) Behavioral Health and Developmental Disabilities Administration (BHDDA) have provided targeted support to provider infrastructure development of IH for mental 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, MDCH has developed a cooperative alliance with the Michigan Association of Community Mental Health Boards (MACMHB), and contracted with The National Council for Behavioral Healthcare. PIHP and Drop-In Center grants and technical assistance has been developed and is provided. Some of the efforts achieved through mental health block grant funding and technical assistance provided through this process include:

- I. A Statewide Integrated Health Learning Community (IHLC) - MDCH has partnered with MACMHB and the National Council to deliver a yearlong Integrated Primary and Behavioral Healthcare Learning Community. Any Michigan community mental health center 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 through 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 [improvingmipractices.org](http://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.

Seventeen of Michigan's Prepaid Inpatient Health Plans (PIHP) have developed a work plan through noncompetitive block grant funding to support and further the development of regional IH. Attention was focused on meeting with and assisting each PIHP at the current IH development level. Each PIHP assessed their level of implementation and began to build upon IH from that point. Participants completed a self-assessment tool for readiness. Logic models were required in addition to goals, objectives, activities, data collection, and timeframes for assessing progress and the specific staff responsible to achieve the success measures. Significant technical assistance was provided at a statewide meeting where grant specialists worked closely with grantees. Some projects included having IT Health Home functionality in their work plan; workforce competency in moving from case management to care management; providing wellness programs; and establishing a train-the-trainer model for staff and peers to assist others in improving behavioral changes and health outcomes. Further assistance is provided as needed with the new requirements that indicate success. Technical/coaching phone calls are conducted that include PIHP staff, MDCH staff and National Council consultants.

To further support this steep learning curve, participants shared information on a dedicated website called "www.improvingmipractices.org". This information includes:

- a. A work plan, contact information and brief grant summary.
- b. Quarterly progress reports.
- c. Opportunities to learn from each other.

Each PIHP has access both for posting and gathering multiple resources related to IH. 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 and innovative, efficient and constructive.

Drop-In Center Wellness projects are another mental health block grant funded initiative to provide additional State supported resources to the advancement of wellness programming and physical activity in for Drop-In Center participants. 56 individual centers currently have work plans demonstrating a wide variety of initiatives centering on themes of healthy behaviors (exercises like walking, biking, Wii games, coaching support, shopping, cooking and eating).

The examples below give a flavor of the range of the commitment and innovations being used:

- Walking, healthy eating and interactions (Washtenaw);
- Improve fitness level and manage chronic pain (Lifeways);
- Healthy Behaviors such as increased activity using the Wii is popular, PATH and Smoking Cessation (Ventures);
- Resources and Support for relaxation, increased physical activity, knowledge of disorders, and weight management opportunities (Southwest);
- Exercise equipment and pedometers (NW Affiliation);
- Increasing activity by promoting activities that members can incorporate into their daily life (Pathways);
- 33% of members will use exercise bike 5 minutes, then minimum of 5 minutes, then 10 minutes to improve health (Copper Country);

- A therapeutic healing garden that has been carefully planned and is being implemented with ownership and pride (network180).

Results of quarterly progress are available for sharing and problem solving on www.improvingmipractices.org.

2. Are there other coordinated care initiatives being developed or initiated in addition to the opportunities afforded under the Affordable Care Act?

The Behavioral Health and Developmental Disabilities Administration are involved in multiple initiatives pursuing improved health for the citizens of Michigan. A healthy population is priority #1. Integrating mental health and substance abuse agencies and treating the whole person is in many stages of development throughout Michigan. There are four regions in Michigan that will begin Dual Eligible (Medicaid and Medicare) projects in July of 2014.

Culturally-sensitive access to all services for persons with disabilities is needed. Inclusion of often excluded populations, such as the deaf and hard of hearing community is important as is implementation of the Medicaid ABA benefit through waiver and state plan amendment.

In Michigan, three regions of the state are participating in ‘Exploring 2703 of the AFA’ which is a pilot program will develop Medicaid Behavioral Homes. January of 2014 is the begin date.

In December 2012, Governor Snyder commissioned a Mental Health and Wellness Commission, tasked with looking at the system specifically to identify gaps. Within the year, five workgroups are expected to provide results by addressing the following areas:

1. Workgroup on education, employment and veteran items will be headed by Senator Rebekah Warren (D-Ann Arbor).
2. Workgroup on housing, independent living support and long term care, will be headed by Department of Community Health (DCH) Director James K. Haveman.
3. Workgroup on mental and physical health integration and services delivery will be led by Rep. Phil Cavanagh (R-Redford Twp.).
4. Workgroup on public safety, beneficiary rights and protection items, will be headed by Rep. Matt Lori (R-Constantine).
5. Workgroup on societal impacts, data and stigma reduction and awareness, will be led by Sen. Bruce Caswell (R-Hillsdale).

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 older adult behavioral health/dementia specialists from BHDDA has been developed

and continues to grow. Specialists have edited and assisted in Dementia and Alzheimer's curriculums and assisted in identifying a FQHC to dual train physical and behavioral health staff.

SOAR training are increasing to expedite disability determination for those who are homeless and at risk of homelessness.

Timely implementation of a Veteran's Action Plan will improve access to federal benefits and local services. Michigan ranks in the lowest quartile of veteran's taking advantages of benefits they have earned.

Michigan's publically-funded substance use disorder (SUD) system engages in an action plan process. Through this effort all of the coordinated regions for SUD services in the state are required to develop a plan for service for a designated three year period. The plan for SUD services is developed in accordance with a guidance document which is provided by BHDDA. This guidance provides the parameters for the provision of SUD services inclusive of state and federal regulations and requirements, priority services as identified by BHDDA and the MDCH, and special projects to be addressed during the action plan period.

The current action plan period is 2012 through 2014. Within the overall action plan 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, the 2012 through 2014 action plan identified two priority projects in which all areas of the state must plan and engage. The two project priorities are: 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). The 16 regional coordinating agencies within the State of Michigan all submitted and are engaged in the planning, development and implementation of their integrated health care projects. The regions are halfway into the Action Plan period and their 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.

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 an 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 2014, the TSC has primary health care coordination as a standing priority within its agenda and meetings.

In 2012 the BHDDA issued an RFP for Screening and Brief Intervention and Referral to Treatment (SBIRT) pilot projects. Four regions to the state were awarded grants of \$500,000.00 each to implement their proposed MI-SBIRT Projects. All of the projects include: the co-location of behavioral health personnel within medical settings; training of medical staff at all levels about the MI-SBIRT purpose and process; inclusion of prevention and education services; and partnering of medical, SUD and mental health providers for persons needing primary care and behavioral health services beyond the initial MI-SBIRT interaction. One of the strengths of the MI-SBIRT initiative is the variety of primary care institutes as partners in the MI-SBIRT projects – include: hospital residency programs, hospital emergency departments, community-based health care clinics, and Federally Qualified Health Centers entities.

Although these pilot projects will not be complete until September, 2013 – with follow-up to extend an additional 6 months – BHDDA is already seeing positive outcomes. These outcomes include but are not limited to: the openness by which individuals/patients have accepted the MI-SBIRT process; the ancillary outcome from the training of medical personnel (the training focused on the MI-SBIRT process and engaging individuals as part of that process, but also identifying and bridging the gap on how unfamiliar and unknown the issues of SUD were to medical practitioners); and the relational benefit of co-located service provision within the medical settings. At the conclusion of the pilot projects BHDDA anticipates the continuation of the MI-SBIRT initiatives, as the elements and practices of MI-SBIRT will have become imbedded within the welcoming and orientation process, as well as referral and treatment mechanisms within the medical facility.

3. 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
- 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

4. Describe how your 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 at agency specified time periods reassess. 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% (22 in number) have smoking cessation classes. There are 56 consumer-run drop-in centers in Michigan. All are in non-smoking facilities with smoking tents on the outlying property.

Drop-in Centers in Michigan are smoke-free facilities. 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. MDCHs smoking cessation work with CPSS has received a smoking cessation award by the Michigan Cancer Coalition.

Resources range from the MDCH 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 MDCH 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.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that supports your efforts to address smoking.

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.

An effort by one provider involves smoking status and quantity 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. Clubhouses and CPSS are also significant resources for smoking cessation programs and support as noted above.

6. Describe how your behavioral health providers are screening and referring for: heart disease, hypertension, high cholesterol and/or diabetes.

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 and Axis III diagnosis 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.

IV: Narrative Plan

L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). 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, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, 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, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

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. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to 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).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, 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.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?
2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?
3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?
4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).
5. 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?
6. 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?
7. Does the state have an accreditation program, certification program, or standards for peer-run services?
8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must 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 actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?
2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?
4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

M. Recovery

Indicators/Measures

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

Yes, a state policy and practice guideline is under revision and will be finalized by the end of the fiscal year. The policy defines recovery, includes values and principles with the addition of measurements expected from the PIHPs. The document was developed with individuals with mental health, substance use, and co-occurring needs and was a direct result of a recovery dialog training that was part of the Michigan Bringing Recovery Services and Supports to Scale action plan. In addition to the policy, 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.

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state office of Community Affairs) within the state behavioral health system?

Within MDCH, an individual in recovery leads the Office of Consumer Affairs. Also within the state behavioral health system, there are a number of persons in recovery. However, the state has not documented these individuals in any way due to the anonymity of the circumstances and the stigma still surrounding the disease. The Michigan ROSC Implementation Plan has as an objective “To increase the number of people in recovery who are visible in leadership positions, within the system and throughout Michigan’s communities.”

3. Does the state’s plan include strategies that involve the use of person centered planning and self-direction and participant directed care?

Michigan has a strong history and background in both person-centered planning and self-determination. Since 1996, person-centered planning has been a Mental Health Code requirement in how an Individual Plan of Services is developed. A variety of documents are on the state website that include information on the Choice Voucher System, agency with choice, how to develop an arrangement to support self-determination and a variety of user friendly documents for person’s in recovery developed in a brochure format. One of the MDCH staff is part of the national advisory committee for the environmental scan of self-direction for persons with mental illness part of the Robert Woods Johnson and Boston College initiative. For substance use disorder services, since 2006 BHDDA has required individualized treatment planning within the Action Plan Guidance and the contract with the CAs. Additionally, BHDDA has a Policy, *Treatment Policy #6 Individualized Treatment and Recovery Planning*, which was most recently updated on April 22, 2012.

4. Does the state’s plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible?

Recovery supports and services include a mix of services outlined in the Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery support services (e.g., warm lines, recovery housing, consumer/family education, supported employment, peer-based crisis services, and respite care).

The BRSS policy academy and the Application for Participation (AFP) were grounded in the values and principles of the Good and Modern Continuum of Care publication. In the AFP one of the five policy sections was devoted to Recovery with many of the requirements cohesive to this area of focus. The CPSS workforce enhance services and supports in the areas listed above which are a covered service in the Managed Care and Specialty Services 1915 (b)(c) Waiver. In addition, the Action Plan Guidance and the ROSC implementation plan outline a variety of recovery services and supports. There are some that are considered as primary to effective recovery, and others that are considered as ancillary to specific types of services.

Additionally, the ROSC TSC developed a benefits package with support documentation inclusive of the services and supports believed to be necessary to achieve and maintain recovery from drug and alcohol dependence and addiction. The basis for the benefits package and support paper is the SAMHSA Good and Modern document and the Coalition for Whole Health document.

5. Does the state’s plan include peer-delivered services designed to meet the needs of specific populations, such as veteran and military families, people with a history of trauma, members of racial/ethnic, LGBT populations, and families/significant others?

All of the populations mentioned 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. MDCH trains veterans for peer support certification side by side with individuals in mental health and co-occurring conditions. This partnership has provided a variety of benefits to individuals served across the state at Community Mental Health Services Programs, the Veterans Administration and regional offices. The Michigan training curriculum developed in partnership with the Appalachian Group of Georgia (ACG) and the Depression Bi-Polar Support Alliance (DBSA) 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.

6. Does the state provide 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?

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 states 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 separate forum at the regional level. BHDDA is also pursuing ways in which SUD ROSC trainings can be made available through online capabilities.

The PIHP regional authorities 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 this 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/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 MDCH staff, regional and local providers and peers. MDCH publishes webinar opportunities broadly in all regions of the state. This area of focus is part of the MDCH Application for Participation on the expectations of recovery services and supports.

7. Does the state have an accreditation program, certification program, or standards for peer run services?

Currently, individuals who complete training to be a recovery coach are certified as peer recovery coaches. Beginning in June 2011 the first Connecticut Community Alliance for Recovery (CCAR) training of recovery coaches took place. Of the 45 individuals trained, all 45 were certified as peer recovery coaches and 15 were also trained to be trainers of peer recovery coaches. Since that initial training approximately eight trainings have been conducted at regional levels throughout the state.

BHDDA has also developed and adopted a Technical Advisory (TA), *Technical Advisory #7 Peer Recovery Support Services*. This TA was originally issued March 17, 2008 and has since been revised and made effective September 1, 2012. Within the TA the roles of peer recovery coaches and peer recovery associates are defined, as well as providing the minimal elements to be included in the training of peer recovery coaches, should an alternative to the CCAR training be utilized. There has been a concerted effort to keep the cost of the recovery coach to a minimum. The desire is that cost does not prohibit an individual in recovery from becoming a peer recovery coach, or to engage in other aspect of giving back and assisting others in their recovery journey.

For persons with a serious mental illness and/or co-occurring needs a curriculum for certification has been developed and enhanced since 2005. Currently 1140 individuals have been certified in the state and are required to be employed at least 10 hours per week in a position with job responsibilities outlined in the Medicaid Provider Manual. Michigan was one of the first states to received approval from the Center for Medicare and Medicaid Services to cover CPSS services through the Managed Care and Specialty Services 1915 (b) (c) waiver authority. The

statewide job description is outlined in the provider manual. Several Michigan CPSS have been involved and instrumental in the work and efforts of developing national standards for peers.

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advances the state-of-the-art in recovery oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery support services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

MDCH has engaged in a number of activities to promote utilization of peer support services, disseminate information related to ROSC innovation/best practices, and other innovative services. These activities and initiatives include, but are not limited to:

- development and utilization of a ROSC implementation plan for Michigan's publically funded SUD system;
- 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 SUD conferences, peer focus groups (one on accessing medical care and one on the development of peer support services), 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;
- development of a glossary of ROSC terminology to improve communication regarding ROSC;
- 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 roles of CPSS in a Stanford research study for the Chronic Disease Self-Management Program;
- partnership with Michigan Primary Care Association to integrate whole health action planning in primary care settings; and
- Veterans Policy Academy initiatives.

Involvement of Individuals and Families

1. How are individuals in recovery and family members utilized in planning, delivery, and evaluation of behavioral health services?

The planning of substance use disorder services is an undertaking of the state's regional substance use coordinating agencies. 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. This same process is integrated with mental health services and supports. In addition evidence-based practices, including Family Psychoeducation, is implemented statewide. MDCH 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.

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health services system and develop a process for addressing these concerns?

The state sponsored a peer symposium for the purpose of engaging individuals in recovery in the ROSC transformation process. During this event there was significant discussion on what is needed to support successful substance use disorder recovery, what recovery really looks like, and the issue of stigmatization of persons struggling with a substance use disorder. The event was successful and there has been a request to continue these types of forums in the future.

Individuals in recovery are members of the ROSC TSC, they are also represented in work groups convened for the purposes of planning services, and of those developing policy regarding the needs and nature of recovery oriented services.

In January 2013, the state convened a Behavioral Health Advisory Council (BHAC), which is the state's Planning Council, for the purpose of advising the 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. Approximately 55% of the BHAC membership is comprised of persons in recovery. This council forum will provide the opportunity for persons in recovery to make recommendations, and express ideas and concerns on a regular basis.

In addition to the TSC and the BHAC the Michigan Recovery Council provides information and guidance to the PIHPs with representation of individuals with lived experience across the entire state. Information that is presented at the meetings is conveyed to MDCH with actions taken to address the input of the Council. The Council Co-Chairs include an individual with lived experience and the Director of the Bureau of Community Based Services.

The vast representation of the three groups provide unique opportunities to collectively identify stakeholders of each represented area leading to an integrated process for MDCH to incorporate in state level communications to the PIHP regions in the state.

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system, participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

Methods include the requirements in the Mental Health Code for person-centered planning, self-determination and person-centered planning contract attachment with PIHPs, individualized treatment and recovery planning for which the state has a policy (*Treatment Policy #6 Individualized treatment and recovery planning*), representation on the State BHAC, communicating with the regional substance abuse coordinating agencies and/or a representative of the ROSC TSC and PIHPs, through participation on the SUD coordinating council board, PIHP/CMHSP and Provider agency boards and consumer advisory councils, and through participation in public hearings regarding legislation, appropriations, and changes, recommendations in the integrated service delivery system.

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery oriented services?

Many of the 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 the AFP including stakeholder input into the PIHP contracts each fiscal year. Statewide central office committees include a variety of individuals and families with lived experience guiding and steering the process in leadership positions.

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

The State has included as part of the Action Plan Guidance the required consideration of how housing supports can be provided to persons seeking recovery. Due to this portion of the Action Plan Guidance, several regions of the state have established recovery housing, or are considering how this may be achieved within their region. The state has also recommended that key partnerships be pursued with HUD and other housing authorities at the state and regional level.

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

The State has implemented multiple collaborative projects to ensure housing needs and community engagement for persons served. In 2006 the State and key community partners implemented Michigan's Campaign to End Homelessness. The vision of the Campaign is to end homelessness by providing the most vulnerable members of our society with access to housing, services and income supports they need in a timeframe they deserve.

Within this campaign ongoing strategies include ending chronic homelessness given this has a huge financial impact on the funds made available from the state and federal government.

Interdepartmental collaboration between the Michigan State Housing Development Authority, Department of Human Services, and Department of Community Health ensures that housing and health resources are integrated. The current key tasks within the Campaign are:

- Steering Campaign partner resources to support central points of housing assistance that align and coordinate systems of care, continually improve services and systems, and thoughtfully prioritize services to the most vulnerable.
- Increase Safe and affordable housing opportunities with necessary services to allow the most vulnerable to attain success.
- Collect and report quality data for accountability and decision making.

The State provides the following housing programs which also include support services for households with a disability: Low Income Housing Tax Credits with Permanent Supportive Housing; Tenant Based Rental Assistance; Emergency Solutions Grant Rapid Re-Housing; Housing Choice Voucher Program; VASH Vouchers; Project Based Vouchers; Prisoners Using Supportive Housing; SSI Outreach, Access and Recovery, and Shelter Plus Care.

IV: Narrative Plan

N.1. Evidence Based Prevention and Treatment Approaches for the SABG

Narrative Question:

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did 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)?
2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. What outcome data 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?
5. How is the state's budget supportive of implementing the Strategic Prevention Framework?
6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)
7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Footnotes:

N.1. – Prevention – SA

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the type of primary prevention services that are needed?

As identified in Table 1: Step 2, the mission of Michigan's 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 the quality of life for citizens of Michigan. Through the use of various data sources, the State Epidemiological Profile is updated on an annual basis. This process includes review of residents' consumption patterns, intervening variables, and substance abuse consequences as well as mental health well-being. The SEOW makes recommendations on priorities to be addressed, which in turn will lead to the ultimate decision resting with BHDDA. Once priorities are identified, CAs are contractually required to submit multiple-year Action Plans to BHDDA which address the priority problems identified and target specific interventions related to the appropriate intervening variables in their communities.

Priorities that have been identified in the Action Plan are to reduce childhood and underage drinking; reduce prescription and over-the-counter drug misuse and abuse; and reduce youth access to tobacco. If needed, CAs are also able to identify a fourth priority area given their local needs and based on epidemiological evidence. The CAs must complete a comprehensive strategic plan based on a data-driven planning process, and complete a planning chart using a logic model approach with their submission. CAs are expected to employ any of the six SAMHSA Center for Substance Abuse Prevention (CSAP) strategies (information dissemination; education; alternative programs; problem identification and referral; community-based process; and environmental) to engage individuals and the community to effect population-based change. It is critical to note that, especially in the case of information dissemination and alternative programs, multi-component community-based strategies are more effective than single-component strategies. These two strategies should only be implemented as part of a multi-faceted effort.

A multi-component and strategic approach in each CA region should cover age groups including support for children, senior citizens, socio-economic classes, diverse cultures, minority and under-served populations, service men and women, gender-specific and targeted high-risk groups, as has been identified in each of the CA regions as part of a comprehensive needs assessment process.

The ultimate goal of implementing the six strategies is to enhance the development of PPCs with community norms that reduce alcohol and other drug consumption, or modify the conditions under which they are consumed. This will, in turn, reduce SUDs.

2. What specific primary prevention program, practices and strategies does the state intend to fund with SABG prevention set aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

As part of the CA Action Plan process, a planning chart logic model is submitted by each CA. For each priority area identified by the state, the CA logic model first identifies the consequence to be addressed in their region, with supporting data for that consequence identified. Associated intervening variables are then noted, with the primary federal strategy and appropriate evidence-based service or intervention to address that intervening variable. CAs further identify the population type, as well as immediate and long-term outcomes (which are linked to National Outcome Measures). Finally, training and technical assistance needs (if any) are identified as the final step of this logic model. In order for CAs to be able to address their local needs in the least restrictive way possible within the parameters given, the state has not developed a specific list of primary prevention program, practices and strategies eligible for funding. CAs are directed to the National Registry of Evidence-Based Programs and Practices (NREPP) for guidance and programs, practices and strategies appropriate to address the consequence and variables identified. In addition, Michigan developed a *Guidance Document on Selecting, Planning and Implementing Evidence-Based Interventions for the Prevention of Substance Use Disorders* in January 2012 for CAs to use with their local community coalitions and providers to determine appropriate “fit” and selection. CAs are required to assure that at least 90% of prevention services funded with SABG prevention set aside dollars are evidence-based.

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

The primary purpose of the SPE project was to strengthen and expand our state prevention framework, thereby increasing state capacity to support effective substance abuse prevention and mental health promotion services across systems. Five CA communities were identified to be targeted as part of the SPE, with lessons learned and goals achieved used as a template by BHDDA for statewide expansion of PPCs. During this project, an environmental scan and workforce development survey was administered to identify gaps in training and technical assistance and develop a plan to fill those gaps. Sixty-three completed responses were collected from provider networks in the five SPE target communities. Compiled results were then shared with the other eleven CA regions seeking input on concurrence or non-concurrence with the issues identified in the five regions. Based on these responses and other CAs input, a plan was developed to fill specific gaps identified.

Assessment of training and technical assistance needs is also conducted by BHDDA based on requests provided by CAs in their Action Plans. Another assessment is conducted by the advisory committee of the Michigan Prevention, Treatment and Education (MI PTE) project. All of these assessments are reviewed and prioritized by BHDDA staff and are incorporated into a yearly training plan.

Through this yearly training plan, BHDDA provides training and technical assistance to prevention (as well as treatment) practitioners in the state via a contract with the MI PTE. Funding for the training and technical assistance is supported by SAPT Block Grant and State General Fund dollars. Historically, about one-third of the training budget has been dedicated to prevention. Content experts in the state are identified and secured for training and technical assistance. BHDDA also has a Training Cadre for prevention that has been well-trained in the SPF five-step model, and many of these Training Cadre members recently completed the Substance Abuse Prevention Skills Training (SAPST) and SAPST Training of Trainers (TOT). CSAP and the Center for Applied Prevention Technology (CAPT) have also been used as resources for training; providing training and technical assistance both face-to-face and via webinar.

In an effort to encourage workforce development, the cost of training and technical assistance has been minimal and all workshops offer credit toward certification to encourage attendance by as many practitioners as possible. BHDDA also holds an annual substance abuse conference including workshops on evidence-based practices, and include plenary sessions performed by national experts representing behavioral health administration and service delivery.

In addition to the above formal training opportunities, SEOW members are available to provide technical assistance on the use of data, trends, and the use of a data-driven process to local communities.

It is planned all of the above efforts will continue through 2015.

4. What outcome data 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?

Performance management, evaluation process and methodology are accomplished through various mechanisms. Michigan has established a Prevention Data Set (PDS) to collect process data, which has been effective for both state and community-level data collection. In addition to basic information related to core strategies and demographic information of the recipient, evidence-based programs are reported to the PDS. In the future, this system is planned to be expanded to allow pre- and post-assessment of program effectiveness and to track perception of harm, 30-day use, and behavior changes tied to national outcome measures. Currently, outcome data is collected on past 30 day use alcohol among youth; perception of risk among youth that 5+ drinks/weekend is moderate or great risk; Synar compliance; and alcohol related traffic crash deaths. It is anticipated these outcome measures will continue to be monitored. In addition, two outcome measures will be added in ten target communities in the state as part of the PFS II project: past 30 days prescription drug misuse/abuse and family communication.

Site visits are conducted by CAs to their providers, and by BHDDA to the CAs. The focus of these site visits is to assure contract compliance, as well as provide technical assistance and quality assurance monitoring consistent with the fifth step of the SPF SIG planning framework. BHDDA has also developed a closer collaboration with Wayne State University to strengthen our evaluation processes.

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

As previously noted, CAs are contractually required to submit multiple year Action Plans to BHDDA, which address priority problems identified by the state, and target specific interventions related to the appropriate intervening variables in their region. These prevention strategies are to illustrate evidence of the five-step SPF planning process by utilizing local community coalitions, and parents and youth as part of this ongoing planning process. The CAs must complete a comprehensive strategic plan based on this data-driven planning model process. By doing the Action Plan in this manner, the SPF has been institutionalized as "the" process to be used in Michigan for prevention services.

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

In FY2012, 20.8% of the prevention set-aside went to community based processes. Of this amount, about half of it stays with the licensed providers, while the other half funded community organizations.

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies?

In FY2012, 96.7% of prevention set-aside was directed toward evidence-based practices. This high percentage is due, in part, to Michigan's requirement for a number of years that 90% of funded services be evidence-based.

In FY2012, 5.12% of prevention set-aside was directed toward environmental strategies.

IV: Narrative Plan

N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

Footnotes:

IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

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 over 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.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with 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 answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with 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?

Footnotes:

O. Children and Adolescents Behavioral Health Services

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with 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 Community Health (MDCH) contract with the Pre-Paid Inpatient Health Plans (PIHPs) and with the Community Mental Health Services Providers (CMHSPs). And in fiscal year 2009, the SOC planning process was formally incorporated into the public mental health system through the Program Policy Guidelines (PPGs) through which MDCH requires CMHSPs to provide an assessment of their local SOC and how they plan to move forward to improve outcomes for children with SED and their families and children with developmental disabilities and their families. MDCH is working individually with PIHPs to provide technical assistance regarding progressing to more comprehensive SOC. 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 is requiring that each Coordinating Agency (CA) be incorporated into an existing PIHP to formally integrate mental health and substance use disorder services statewide by October 1, 2014. Many CAs have already merged into the PIHP system, however some have not. This transition is currently underway and will impact the way service providers are structured into FY14-15 and provide for the development of a formally integrated behavioral health service network statewide. Some PIHPs have already placed a specific focus on training on COD for 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 their substance use. Several other PIHPs use Multi-Systemic Therapy (MST) as a strategy for addressing CODs. 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. The integration of the CAs into the public mental health system statewide may contribute to additional solutions in this area as well. The state also plans to use the treatment guidelines in the process of being developed at the national level to develop local policy that governs adolescent substance use disorder treatment.

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 FY14-15. 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 FY14-15. 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 mental, substance use and co-occurring disorders?

MDCH 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 MDCH 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, initially issued September 2006 and 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.)?

MDCH has been a leader in increasing collaboration with other state agencies, local communities, and families. MDCH participates in many interagency groups and emphasizes collaboration for children's services. Through these groups, the SOC has improved through the elimination of duplicative efforts and new projects being planned with joint efforts in development, implementation, and evaluation of services. More work is being planned to further improve the SOC, increase parent leadership development, and increase and maintain youth involvement on interagency committees. FY14-15 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.

MDCH has been particularly interested in increasing access to specialty mental health services and supports for Medicaid eligible children/youth with SED in child welfare (i.e., abuse/neglect, foster care and/or adopted children/youth) and juvenile justice. 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, an official MDCH 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 MDCH, and training began in 2010 and will continue in FY14-15. The child welfare and judicial systems have also begun including family-driven and youth-guided concepts in their routine operations.

Most collaboration efforts take place at the local level. Regional Coordinating Agencies 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?

MDCH is supporting with block grant funds the statewide implementation of two evidence-based practices Parent Management Training-Oregon Model (PMTO) (Bank, Rains, & Forgatch, 2004; Forgatch, 1994)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 from MDCH to train CMHSP staff in EBPs that will meet the needs of their local communities. These have included joint projects with CMHSPS and local courts/DHS to serve youth involved with the juvenile justice system with relevant EBPs.

The MI-PTE (Michigan Institute of Prevention and Treatment Education), Michigan's SUD Training Project, provides support in this area as well. Each year, the SUD field is given the

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.

opportunity to request training on specific topics in addition to the topics identified as a need at the state level.

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. MDCH has a contract with Dr. John Carlson at Michigan State University who analyzes statewide CAFAS and PECFAS 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 MDCH regarding service utilization and cost and annual reports are generated by the Performance Measurement and Evaluation Section of MDCH. 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 Regional Coordinating Agencies to review this information and provide technical assistance where needed.

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.

IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation 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.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between 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.

For the context of the Block Grants 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. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. 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. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: <u>10 - 13</u>	2. STATE: <u>Michigan</u>
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH FINANCING ADMINISTRATION DEPARTMENT OF HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2010	

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a)(73)	7. FEDERAL BUDGET IMPACT: a. FFY 10 _____ \$ -0- _____ b. FFY 11 _____ \$ -0- _____
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Preprint page 9, <i>page 9 continuation</i>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Preprint page 9
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See per State approval

10. SUBJECT OF AMENDMENT:
Tribal consultation requirements

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Stephen Fitton, Director
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL: <i>Stephen Fitton</i>	16. RETURN TO: Medical Services Administration Program/Eligibility Policy Division - Federal Liaison Unit Capitol Commons Center - 7 th Floor 400 South Pine Lansing, Michigan 48933 Attn: Nancy Bishop
13. TYPED NAME: Stephen Fitton	
14. TITLE: Director, Medical Services Administration	
15. DATE SUBMITTED: August 31, 2010	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: <i>September 1, 2010</i> 8-31-10	18. DATE APPROVED: MAR 30 2011
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: <i>July 1, 2010</i>	20. SIGNATURE OF REGIONAL OFFICIAL: <i>Verlon Johnson</i>
21. TYPE NAME: Verlon Johnson	22. TITLE: Associate Regional Administrator
23. REMARKS:	

MICHIGAN MEDICAID STATE PLAN

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Michigan

Citation
42 CFR
431.12(b)

1.4.a. State Medical Care Advisory Committee

There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.

42 CFR
438.104

The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.

B. Tribal consultation requirements

Section 1902(a)(73) of the social security act (the act) requires a state in which one or more indian health programs or urban indian organizations furnish health care services to establish a process for the state medicaid agency to seek advice on a regular, ongoing basis from designees of indian health programs, whether operated by the indian health service (ihs), tribes or tribal organizations under the indian self-determination and education assistance act (isdeaa), or urban indian organizations under the indian health care improvement act (ihcia). Section 2107(e)(i) of the act was also amended to apply these requirements to the children's health insurance program (chip). Consultation is required concerning medicaid and chip matters having a direct impact on indian health programs and urban indian organizations.

The tribal liaison is to be informed of all proposed state plan amendments, proposals for demonstration projects, waiver requests, renewals, extensions or amendments that may have a direct impact on services provided for native americans, indian health programs or urban indian organizations. This would apply to any changes that are more restrictive for eligibility determinations, changes that reduce payment rates or changes in payment methodologies to providers, reimbursement to providers, or reductions in covered services.

The tribal chairperson, tribal health directors, urban indian health director, and indian health services representative will receive written notification from the tribal liaison of all proposed state plan amendments, proposals for demonstration projects, waiver requests, renewals, extensions or amendments that may have a direct or adverse effect on native americans, indian health programs or urban indian organizations.

The notice will be sent sixty (60) days prior to the submission date and provide a brief synopsis of the proposal and impact on the native american beneficiaries, tribal health clinics and urban indian organizations. In situations where it is not possible to adhere to the sixty (60) days notification, the tribes will be notified as soon as possible. The procedures and timeline for submitting comments on the proposed changes will also be addressed in the notice. Additional information for a proposal will be provided by the liaison upon request. A cover letter is included in the correspondence encouraging input regarding the proposed changes through in person consultation or by telephone conference depending on the tribe's preference. A consultation meeting is set up either as a group or individually, again according to the tribe's preference. During the consultation, concerns are addressed and any suggestions revisions or objections voiced by the tribes are noted and relayed to the author of the proposal.

TN No.: 10-13
Supersedes
TN No.: 03-13

Approval Date MAR 30 2011

Effective Date: 07/01/2010

MICHIGAN MEDICAID STATE PLAN
9 (continued)

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Michigan

Occasionally, federal policy changes require immediate implementation. When this occurs, tribes are notified as soon as the tribal liaison is made aware of the proposed changes. Consultation is then held within twenty-one (21) days of notification.

Consultation with tribal chair representatives, tribal health directors, and indian health services representatives will be conducted at the quarterly tribal health director meetings, or another venue at the request of the tribes. Consultation may be in person or by conference call.

The tribal liaison will acknowledge electronic mail or regular mail, all comments received during the consultation period.

All comments submitted by tribes will be forwarded by the tribal liaison to the medicaid policy staff responsible for the proposed changes.

The tribal liaison will ensure that tribes commenting on proposed changes receive a response to their concerns arising from the proposed changes.

Tribes requesting changes to the proposed state plan amendment, waiver request, renewal, or amendment will receive confirmation from the tribal liaison regarding their request, and whether their comments have been included in the proposals submitted to cms. If the tribe's comments are not included in the proposed changes when submitted to cms, it is the liaison's responsibility to explain why their comments were not included.

Tribes will be informed by the liaison when cms approves or denies state plan or waiver changes. The liaison will also be responsible for including the rationale for cms denials.

The tribal liaison will be responsible for maintaining records of the notification process, consultation process, all written correspondence from tribes and tribal representatives, meeting notes, and all other discussions such as conference calls for all state plan or waiver changes that may impact the tribes. The tribal liaison will also document the outcome of the consultation process.

The spa was sent to all of the tribes for review in march 2010. Consultation with the tribal health directors was held in april 2010 at the quarterly tribal health directors meeting and discussed at length. The tribal health directors concurred that the proposed spa language was acceptable with no objections or revisions.

TN No.: 10-13
Supersedes
TN No.: New

Approval Date MAR 30 2011

Effective Date: 07/01/2010

IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

Q. Data and Information Technology

Each state should:

Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data:

The capacity to provide unique, client level data already exists. The Michigan Department of Community Health (MDCH) is developing a Master Person Index (MPI) that will serve as the single identifier across all systems. This will allow analysts to make better use of the full MDCH Data Warehouse. The target date for the full implementation of the MPI is January 1, 2014.

List and briefly describe all unique information technology systems maintained and/or utilized by the state agency:

The systems identified and described in the prior application remain unchanged.

Substance Abuse Prevention and Treatment Statewide Provider Search

The Department of Licensing and Regulatory Affairs (LARA) continues to maintain the JavaScript-enable Oracle database of all licensed sites for Substance Use Disorders. This database is accessed via the internet at http://www.dleg.state.mi.us/bhs_car/sr_sal.asp. The system is searchable by license number, county, city, zip code, program name, or clickable map. The database contains contact info (address, phone, and director). It also stores information on the licensed services and accrediting bodies. Client Enrollment, Demographics, and Characteristics and Admission, Assessment, and Discharge:

Treatment Episode Data Set (TEDS) Collection System

A web-enabled Substance Abuse Treatment Oracle 10G platform (JavaScript SATWEB) processes, collects, and stores TEDS Admission and Discharge data for services funded in whole or in part by the SAPT Block Grant. This system processes electronically submitted text files and either accepts or rejects each record. Accepted records are stored in a data repository. Rejected ones go to an error master where the submitter has the opportunity to use an On-Line Error Correction System (OEC) to fix the errors. CA submitters can access the application on-line via the State Single Sign On.

Community Health Automated Medicaid Processing System (CHAMPS)

The Community Health Automated Medicaid Processing System (CHAMPS) processes submitted claims and encounters and stores the HIPAA 837 encounter information. CHAMPS collects all reported encounters (HCPCS and CPT codes) for persons served with MDCH-administered dollars. The standard HIPAA 837 transaction is utilized. That transaction contains complete information on the clients, payers, and rendering providers. CHAMPS interfaces with the MDCH Data Warehouse. CHAMPS was certified by CMS in 2011.

Prevention Data System (PDS)

Michigan has gone live in late 2012 with a new and improved Prevention Data System that collects information on prevention activities, including dates of service, strategies, IOM categories, and evidence-based practices. This is a subscriber-based web application that is used by all regional CAs. This system allows Michigan to collect the required data to complete all the required prevention tables in the Block Grant Report.

The Michigan Automated Prescription System (MAPS) --Prescription Drug Utilization

The Michigan Automated Prescription System (MAPS) is the prescription monitoring program for the State of Michigan. Prescription monitoring programs are used to identify and prevent drug diversion at the prescriber, pharmacy and patient levels by collecting Schedule 2-5 controlled substances prescriptions dispensed by pharmacies and practitioners. Collection of this prescription information allows physicians, dentists, pharmacists, nurse practitioners, physician's assistants, podiatrists and veterinarians to query this data for patient-specific reports which allow a review of the patient's Schedules 2-5 controlled substance prescription records. This enables the practitioner to determine if patients are receiving controlled substances from other providers and to assist in the prevention of prescription drug abuse.

Mental Health Quality Improvement File

PIHPs are required to report to the MDCH warehouse demographic or quality improvement (QI) data for every PIHP and affiliate CMHSP consumer served using an MDCH proprietary format and process. This information is linked via the data warehouse to the encounter and claim information submitted to CHAMPS via the 837. This file includes individual client information such as residential living arrangement, employment status, involved with criminal justice and level of education.

PIHP Event Reporting System

The MDCH Event Reporting System is a file-based system to submit consumer-specific information about five specified events on a timely and regular basis from CMHSP's/PIHP's to MDCH. The five specific reportable events are: Suicide, Non-suicide Death, Emergency Medical Treatment due to Injury or Medication Error, Hospitalization due to Injury or Medication Error and Arrest of Consumer. Each type of Reportable Event has a "reportable population." While some of these events are reported for all active consumers, others are only reported for certain identified groups of consumers. For instance, many types of events are only reported for populations considered especially vulnerable.

Provide information regarding its current efforts to assist providers with developing and using EHRs; identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment:

There are no barriers here. Michigan moved to collecting full encounter data on SAPT Block Grant in 2001 and mental health encounters in 2004. Encounter data contains information on the service provider, the service recipient, the date(s) of service, the procedure code, the code modifiers, and the charged and paid amounts. The CHAMPS system collects only valid, national HCPCS and CPT codes in either claims or encounters.

Since 2012, the estimated percentage of providers utilizing an Electronic Health Record (EHR) has increased from approximately 15% to nearly 35%. The regional Coordinating Agencies (CA), Northern Michigan Substance Abuse Services (NMSAS) has contracted with CORE Solutions to implement both its 360 Provider Connect and 360 Payer Connect HER solutions. These products now services 30 of Michigan's 83 counties. There are currently several well-

developed CMHSP/PIHP projects to exchange information with the six Michigan Health Information Network (MiHIN) “Sub-State” Health Information Exchanges.

Identify the specific technical assistance needs the state may have regarding data and information technology.

No specific technical assistance needs are requested at this time.

IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, 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, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

**STRATEGY FOR ASSESSING AND IMPROVING THE QUALITY OF MANAGED
SPECIALTY SERVICES AND SUPPORTS
FY'12 through FY'14
Revision 2/16/13**

[Note: Revisions are noted in bold type and are highlighted in yellow]

The following strategy is designed to assess and improve the quality of specialty services and supports managed by the Prepaid Inpatient Health Plans (PIHPs). The state agency responsibility for the components of the quality management system listed here resides in the Michigan Department of Community Health (MDCH), **Behavioral Health and Developmental Disabilities Administration (BHDDA)**, Division of Quality Management and Planning, except where otherwise noted.

I. BACKGROUND: PROCESS FOR QUALITY STRATEGY REVIEW AND REVISION

This quality strategy builds upon and improves the initial strategy developed for the 1915(b)(c) waiver application in 1997, and revised for each subsequent waiver renewal application. As with the previous quality strategies, this quality strategy was developed with the input of consumers, and the Mental Health Quality Improvement Council (QIC) that is comprised of consumers and advocates, and representatives from the Provider Alliance and the Michigan Association of Community Mental Health Boards. This revised and improved strategy also reflects the activities, concerns, input or recommendations from the MDCH Encounter Data Integrity Team, the **External Quality Review (EQR) activities**, and the **recommendations for improvement** from the Centers for Medicare and Medicaid Services (CMS) **previous** waiver approvals. **The Quality Strategy is intended to address the quality of all specialty supports and services covered by the 1915(b)(c) waiver for all adults and children served.**

II. CERTIFICATION, ACCREDITATION, AND LICENSURE

A. Community Mental Health Services Program Certification: The approved Plan for Procurement and the subsequent Application for Participation (2002) (AFP) required that each PIHP be a community mental health services program (CMHSP). The Michigan Mental Health Code (Code) requires that every CMHSP be certified by MDCH in order to receive funds. The certification consists of two elements:

1. Each CMHSP must be determined to have a local recipient rights system that is in substantial compliance with the requirements of the Recipient Rights Chapter 7 of the Code. This compliance is determined by on-site visitation by the MDCH Office of Recipient Rights.
2. Each CMHSP must be in compliance with a set of organizational standards established in Michigan's Administrative Rules, which have the effect of law. The rules cover the following dimensions:

Governance, mission statement, community education, improvement of program quality, personnel and resource management, physical/therapeutic environment, fiscal management, consumer information, education and rights, eligibility and initial screening, waiting lists, alternative services, array of services, medication, and individual plan of service.

It is required that the CMHSP and each of its subcontracting providers of mental health services meet these standards. If a CMHSP or its sub-contracting provider is accredited by a national organization, a limited review of the accredited agency is conducted by MDCH beyond assuring the existence of said accreditation. MDCH has granted deemed status to four national accrediting bodies: Joint Commission (JC), CARF, The Council on Accreditation (COA), and The Council. Certification may be granted for up to three years. CMHSPs must be certified prior to entering into a prepaid contract for services and supports for beneficiaries.

B. Provider Networks:

1. CMHSPs as “Affiliates” and other providers: Affiliates and sub-contracting providers must meet the certification requirements stated in A above.
2. Substance Abuse Coordinating Agencies and Providers: PIHPs may subcontract with Substance Abuse Coordinating Agencies (CAs) to manage the substance abuse treatment benefit. Eight PIHPs are currently CAs. CAs are not licensed or accredited for ongoing treatment services, but all of their subcontracting providers of outpatient, residential, intensive outpatient, sub-acute **detoxification** and methadone substance abuse services are required to be licensed under the Michigan Public Health Code. CAs must be appropriately licensed if operating their own **Access Management System**. In addition, state and federal funds administered by MDCH for treatment services may be contracted only with licensed providers accredited by one of the following national accrediting bodies: JC, CARF, COA, National Council on Quality Assurance (NCQA), **Accreditation Association for Ambulatory Health Care (AAAHC)** and the American Osteopathic Association (AOA). Licensing actions are the responsibility of the **Michigan Department of Licensing and Regulatory Affairs**, Bureau of Health Systems, who consults with the CAs and the **Behavioral Health and Developmental Disabilities Administration (BHDDA)** and shares with, and consults on, all licensing findings to the administration.

Persons seeking substance abuse treatment must be assessed by **an appropriately trained and credentialed** professional and authorized for treatment. [Please see provider qualifications in the Medicaid Provider Manual] In completing the assessment, the American Society for Addiction Medicine (ASAM) Patient Placement Criteria must be applied to determine the appropriate level of treatment. These criteria are also **utilized** for continuing stay and discharge decisions by the treatment and/or assessment program.

3. Certification and Licensing for Settings Where Services are Provided:

- a. **Specialized Mental Health Residential Certification:** All adult residential service providers who receive funds for the provision of specialized mental health services must be certified by the Michigan Department of Human Services (MDHS). These standards address issues such as: accessibility, facility environment, fire safety, and staffing levels and qualifications. Specifically, these rules require that all staff who work independently and who function as lead workers must complete training which covers eight areas, including the role of residential care workers, introduction to the special needs of adults with developmental disabilities and mental illness, basic interventions for maintaining and caring for a recipient's health, basic first aid and CPR, medications, environmental emergencies, recipient rights, and non-aversive techniques for preventing or managing challenging behaviors. While these rules do not require a schedule of re-training, PIHPs will be required to assure that these staff be re-trained whenever the treatment needs of the resident(s) change and whenever there is a significant change in MDCH policy which would affect the delivery of services. In addition, PIHPs are required, as part of the CMHSP certification, to have a local process to assure that persons providing services and supports are competent to perform their duties.
 - b. **Adult Foster Care Licensing:** The MDHS also acts as the licensing agent for Adult Foster Care settings.
 - c. **Protective Services:** MDHS also has responsibility for Adult and Child Protective Services. PIHPs, along with their subcontracting provider networks, have a legal responsibility to report potential violations to the local MDHS offices
4. **Coordination On Issues Involving Adult Foster Care Settings**
- a. Staff from the MDCH **BHDDA** meet **monthly** with MDHS central office staff to share information, jointly revise policies, and trouble-shoot on various issues including self-determination, individuals' own homes, state plan home help services, critical incidents and sentinel events. For example, licensing problems identified by MDHS are forwarded to MDCH for follow-up as part of its contractual or site visit processes. PIHPs, in turn, and/or their subcontracting provider networks, have the responsibility to report potential problems to the MDHS for follow-up.

III. AFP AND CONTRACTUAL REQUIREMENTS FOR PIHPS' QUALITY MANAGEMENT SYSTEMS

Three areas addressed by the BBA and reviewed as part of the quality management system are: customer services, grievance and appeals mechanisms, and the CMS-approved Quality Assessment and Performance Improvement Programs. These elements were required as part of the 2002 AFP, are now part of the MDCH/PIHP contracts, and they are reviewed by MDCH staff and/or the EQR organization.

A. Customer Services

Customer services is required by the MDCH/PIHP contract to be an identifiable function of the PIHP that operates to enhance the relationship with the community, as well as with the beneficiary. Customer services is frequently a function delegated by the PIHP to affiliates or providers, including the substance abuse network. When delegated, the PIHP must monitor the entity to which the function is delegated. In 2006, MDCH developed Customer Services Standards and standard language for their Customer Services handbooks. The Standards and handbook language were included in the FY2007 MDCH/PIHP contract and are located on MDCH's web site at www.michigan.gov/MDCH, click on Mental Health and Substance Abuse, then Mental Health and Developmental Disabilities, then Customer Services. In addition, MDCH provided training to 110 customer services representatives in September 2006.

MDCH reviews and approves each of the PIHP's customer services handbooks and requires the PIHPs to resubmit the handbooks for review and approval anytime a substantive change is made.

PIHPs found out of compliance with these standards by the External Quality Review must submit plans of correction. MDCH staff and the EQRO follow up to assure that the plans of correction are implemented. Results of the MDCH on-site reviews and the EQRs are shared with MDCH **BHDDA** Management Team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

B. Appeals and Grievances Mechanisms

CMS approved the BBA revision of the appeals and grievance procedures, required by MDCH/PIHP contract. The EQR reviews the process for providing information to recipients and contractors, method for filing, provision of assistance to beneficiaries, process for handling grievances, record keeping, and delegation. In addition, the logs of appeals and grievances and their resolutions at the local level are subject to on-site review by MDCH. MDCH uses its Fair Hearings database to track the trends of the requests for fair hearing and their resolution and to identify PIHPs that have particularly high volumes of appeals. Results of the MDCH on-site reviews and the EQRs are shared with MDCH **BHDDA** Management Team and with the QIC). Information is used by MDCH to take contract action as needed, or by the QIC to make recommendations for system improvements.

C. Quality Assessment and Performance Improvement Programs

The MDCH contracts with PIHPs require that the QAPIP be developed and implemented. **There are planned changes for the QAPIP for the coming waiver period (see Attachment A.III.1.a).** The EQR monitors on-site the PIHPs' implementation of their local QAPIP plans that must include the 14 QAPIP standards. In addition, MDCH reviews on-site implementation of the following standards: VIII Sentinel Events, IX Behavior Treatment Review and XI Credentialing of providers. MDCH collects data for Standard VI, Performance

Indicators, VII Performance Improvement Projects, and XII Medicaid Services Verification, as described below.

1. Performance Indicators

Please see section VI.A of this Quality Strategy.

2. Performance Improvement Projects

The **BHDDA** Management Team, the QIC, and Division of Quality Management and Planning staff collaborate to identify the performance improvement projects for the each waiver period. Justification for the projects was derived from analyses of quality management data, EQR findings, and stakeholder concerns. For the upcoming waiver period Michigan will require all PIHPs to conduct a minimum of two performance improvement projects:

- a. All PIHPs conduct one mandatory two-year performance improvement project assigned by MDCH as identified above. In the case of PIHPs with affiliates, the project is affiliation-wide.
- b. PIHPs that have continued difficulty in meeting a standard, or implementing a plan of correction, may be assigned a specific project topic relevant to the problem. At the present time, PIHPs were allowed to choose a second performance improvement project in consultation with their QAPIP governing body.

PIHPs report semi-annually on their performance improvement projects. The EQR validates the PIHP's methodologies for conducting the projects. Results of the MDCH performance improvement project reports are shared with MDCH **BHDDA** Management Team and with the QIC **that meets every other month to review the outcomes of monitoring various aspects of the quality strategy.** Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

3. Medicaid Services Verification

PIHPs are required to develop and maintain a system for verifying that Medicaid-funded services identified in the plan of service were actually rendered. PIHPs submitted their plans for the Medicaid verification system to MDCH for initial approval in 2001 and are periodically asked to resubmit their methodologies. PIHPs report to MDCH annually on the results of their Medicaid verification systems.

4. Credentialing Policy

The External Quality Review Organization, Health Services Advisory Group, recommended that MDCH develop a state level credentialing policy. That was done and attached to the FY 2007 amendment to the MDCH/PIHP contract. The policy is in Attachment A.III.1.b

IV. EXTERNAL QUALITY REVIEW

- For FY'12 and FY'13 MDCH will continue to** contract with Health Services Assessment Group (HSAG) to conduct the EQR. The BBA compliance monitoring portion of the EQR consists of desk audits of PIHP documents and also includes either a two-day on-site visit or telephone conference with each PIHP. The decision to conduct an on-site review versus a telephone conference is based on past PIHP performance on the EQR BBA compliance monitoring reviews.
- The contents of the review for **FY'12-13** are:
- a. Validation of Performance improvement projects:
 - i. For **FY'12-13**, the EQR **will** focus on the methods PIHPs employed to implement the MDCH-required project –**Increasing the proportion of Medicaid eligible adults with mental illness who receive at least one peer-delivered service or support. The PIP validation process included reviews of the following activities:**
 - 1. Choosing the study topic**
 - 2. Defining the study questions**
 - 3. Selecting the study indicators**
 - 4. Using a representative and generalized study population**
 - 5. Using sound sampling methods**
 - 6. Using valid and reliable data collection procedures**
 - 7. Including improvement strategies and implementing interventions**
 - 8. Describing data analysis and interpreting study results**
 - b. Validation of performance indicators:
 - i. **In FY'12-13 EQR will look at data collection methods for all fifteen performance indicators and perform an ISCAT.**
 - ii. **EQR will review the results for each indicator and note areas for improvement and areas of strength for each PIHP.**
 - c. Compliance with Michigan's Quality Standards per BBA:
 - i. **In FY'12-13 the EQR will focus on reviewing compliance with the following standards:**
 - 1. QAPIP and Structure**
 - 2. Performance measurement and improvement**
 - 3. Practice guidelines**
 - 4. Staff qualification and training**
 - 5. Utilization management**
 - 6. Customer services**
 - 7. Recipient grievance process**
 - 8. Recipient rights and protections**
 - 9. Subcontracts and delegation**
 - 10. Provider networks**
 - 11. Access and availability**
 - 12. Coordination of care and care management**
 - 13. Psychiatric advanced directives**
 - 14. Service authorization and appeals**
 - 15. Credentialing**

During the biennial comprehensive review, the team meets with a group of consumers, advocates, providers, and other community stakeholders to determine the PIHP's progress to implement policy initiatives important to the group (e.g., person-centered planning, self-determination, employment, recovery, rights, customer services); the group's perception of the involvement of beneficiaries and other stakeholders in the QAPIP and customer services; and the PIHP's responsiveness to the group's concerns and suggestions.

D. Consumer Interviews

Review team members conduct interviews with a sample of those individuals whose clinical records were reviewed, using a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-centered planning, independent facilitation of person-centered planning, self-determination arrangements and individual budgets, access to transportation, psychiatric advanced directives, and satisfaction with services. Interviews are conducted where consumers live and in a variety of other locations including PIHP offices, service sites or over the telephone.

A report of findings from the on-site reviews with scores is disseminated to the PIHP with requirement that a plan of correction be submitted to MDCH in 30 days. Reports on plans of correction are submitted to MDCH. On-site follow-up is conducted the following year or sooner if non-compliance with standards is an issue. Results of the MDCH on-site reviews are shared with MDCH BHDDA Management Team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

Overall PIHP site review responsibility is located in the Division of Quality Management and Planning. The PIHP site review team is currently composed of MDCH **professional** staff **who include** nurses, social workers, analysts, and individuals who have a mental illness and meet the qualifications for, and are employed as, state civil servants. The Office of Mental Health Services to Children and Families provides additional staff to conduct the portion of the review that focused on the Children's **Home and Community Based** Waivers.

VI. DATA SUBMISSION AND ANALYSES

A. Performance Indicators

Medicaid performance indicators measure certain aspects of performance of the PIHPs. The specific Medicaid performance indicators (listed in Attachment A.III.1.c) have been extracted from the more comprehensive Michigan Mission-Based Performance Indicator System that has evolved since 1997 based on adoption of core indicators by national organizations or federal agencies (e.g., Center for Mental Health Services and Center for Substance Abuse Treatment). The performance indicators were revised in 2005 by the QIC. The indicators are categorized by domains that include access, adequacy, appropriateness, effectiveness, outcomes, prevention, and structure/plan management.

Indicators are used to alert MDCH management of systemic or individual PIHP issues that need to be addressed immediately; to suggest that there are trends to be watched; to monitor contractual compliance; and to provide information that the public wants and needs. Most of the information used in these indicators is generated from the encounter and QI data located in the MDCH data warehouse. Any data that are submitted by PIHPs, and the methodologies for doing so, are validated **through** the EQR. Analyses of the data result in comparisons among PIHPs and with statewide averages. Statistical outliers are determined for the identification of best practices or conversely, opportunities for improvement. Those entities found to have negative statistical outliers in more than two consecutive periods are the focus of investigation, leading up to PIHP contract action. Technical information from the performance indicators is shared with the PIHPs; user-friendly information is shared with the public using various media, including the MDCH web site. Results of the performance indicators are shared with MDCH **BHDDA** Management team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements. *February 6, 2013 note: This same process noted above is used to collect and analyze data for the Habilitation Supports Waiver performance measures, and will be used for the performance measures required by the State Plan Amendment(i) for the Autism benefit.*

B. Encounter and Quality Improvement Data

Demographic characteristics as well as summary encounter data have been reported to MDCH annually for each mental health service recipient since the early 1990s. Individual level demographic data and admission and discharge records for persons receiving substance abuse treatment services have been collected by MDCH since 1980. Beginning in FY'03, individual level encounter data were reported electronically in HIPAA-compliant format each month for all services provided in the previous month and for which claims have been adjudicated. "Quality improvement" or demographic data were also reported monthly for each individual. **Beginning in FY'11, PIHPs began reporting on certain individual-level health conditions (e.g., obesity, diabetes) for all populations served, and an expanded version of developmental disabilities characteristics in order for MDCH to know what beneficiaries are most vulnerable and to be able to compare that information with service utilization.** Data are stored in the MDCH data warehouse where Medicaid Health Plan and Pharmacy encounter data are also stored. MDCH **BHDDA** staff with access rights to the warehouse analyze mental health, substance abuse, pharmacy and health plan data to evaluate appropriateness of care, over- and under-utilization of services, access to care for special populations, and the use of state plan service versus 1915(b)(3) services.

Aggregate data from the encounter data system are shared with MDCH **BHDDA** Management Team, the Encounter Data Integrity Team (EDIT), and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

C. Medicaid Utilization and Net Cost Data

PIHPs are required by contract to submit Medicaid Utilization and Net Cost Reports annually. The cost reports provide numbers of cases, units, and **total Medicaid** costs for each covered service provided by PIHP. The report also includes the total Medicaid managed care administrative expenditures and the total Medicaid expenditures for the PIHP. This data enables MDCH to crosscheck the completeness and accuracy of the encounter data. Cost data are shared with MDCH **BHDDA** Management Team, the EDIT, with the State's actuary, and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

D. Event Reporting System

The Event Reporting System captures information on five specific reportable events: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrest of consumer. The populations on which these events must be reported differs slightly by type of event. For example, suicides and non-suicide deaths must be reported for a broader population (any consumer who is actively receiving services) than emergency medical treatment due to injury or medication error (consumers residing in specialized residential settings, child caring institutions, and consumers receiving Habilitation Supports Waiver, Children's Waiver, or SED Waiver services). This system was designed to replace the Department's previous sentinel event reporting process as well as a separate death reporting process.

PIHPs were contractually required to report events into the system beginning October 1, 2010.

The Department implements formal procedures for analyzing the event data submitted through this system. This includes criteria and processes for Department follow-up on individual events as well as processes for systemic data aggregation, analysis and follow-up. Information will also be used by the Department to take contract action as needed or to make recommendations for system improvements.

Note: Sentinel events involving persons who receive Targeted Case Management, or are enrolled in the Habilitation Supports Waiver, or live in 24-hour specialized residential settings, or live in their own homes receiving ongoing and continued personal care or community living supports services are reported, reviewed, investigated and acted upon at the local level by each PIHP or its delegated agent. Sentinel events include, but are not limited to: death of the recipient, any accident or physical illness that requires hospitalization, incidents that involve arrest or conviction of the recipient, emergency physical management interventions used for controlling serious

challenging behaviors and medication errors. MDCH reviews each PIHP's sentinel event process during its biennial visit.

Michigan law and rules require the mandatory reporting of the issues above to the Adult Foster Care Licensing Division of MDHS within 48 hours for **adults** in licensed residential settings (**and for children in foster care, 24 hours**), and to the CMHSPs' Office of Recipient Rights for all others. There is specific language in law to establish the duty to report to law enforcement suspected abuse and neglect. The reporting of sentinel events is the primary responsibility of residential workers for persons in licensed settings, and case managers or supports coordinators for all others. This information is reviewed for trends, and becomes a focus of the on-site visitation conducted by MDCH to PIHPs.

Aggregate data are shared with MDCH **BHDDA** Management Team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

E. Recipient Rights

Local CMHSP offices of recipient rights report semi-annually summaries of numbers of allegations received, number investigated, number in which there was an intervention, and the numbers that were substantiated. The summaries are reported by category of rights violations, including: freedom from abuse, freedom from neglect, rights protection systems, admission/discharge/second opinion, civil rights, family rights, communication and visits, confidentiality, treatment environment, suitable services, and treatment planning. An annual report is produced by the state Office of Recipient Rights and submitted to stakeholders and the Legislature. Data collection improvements will distinguish Medicaid beneficiaries from other individuals served. This information is aggregated to the PIHP level where affiliations of CMHSP exist. Aggregate data are shared with MDCH **BHDDA** Management Team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

G. Administrative Cost Report

In FY'10 MDCH developed and implemented a uniform administrative cost report requirement for identifying and reporting the administrative costs associated with managing this and all other Medicaid waivers within the Mental Health and Substance Abuse administration. The methodology as reported for the previous waiver cycle was revised for FY09 reporting to: consistently apply the same administrative function definitions across the various waivers and funds administered by MDCH; to be consistent with the managed care administrative functions which are: quality management; customer services; utilization management; provider network management; information systems management; financial management and general management.

All PIHP cost allocation methodologies must be consistent with OMB Circular A-87 requirements and the annual compliance exam tests for compliance. Reports are due annually to MDCH and reviewed for: compliance exam findings; reasonableness and consistency with other financial reports. For reporting integrity and consistency, training is provided and a workgroup is charged with identifying ways to present the information such as conference panel discussion and mentor across PIHPs. Annual training on preparation of the report is available.

VII. FINGER TIP REPORTS

Performance information on the 18 PIHPs is published in a series of summary tables that include **such things as:** expenditures of Medicaid funds, service utilization, MDCH site review scores, external quality review scores, , reporting timeliness, and Medicaid performance indicators. The information is used internally by MDCH for **tracking, trending, follow-up, policy development** and decision-making. **PIHPs and their provider networks use the information for benchmarking. The general public can access the information** on the MDCH web site at www.michigan.gov/mdch click on Mental Health and Substance Abuse, the Mental Health and Developmental Disabilities, then Statistics and Reports.

VIII. STATE WIDE SURVEY

An annual statewide consumer satisfaction survey is conducted of adults with mental illness using the Mental Health Statistics Improvement Program (MHSIP) 44-item adult questionnaire and the 26-item MHSIP Youth Services Survey for families of children with serious emotional disturbance. Michigan uses a convenience sample of individuals who receive services during one month of the year

VIII. MENTAL HEALTH SYSTEMS TRANSFORMATION

In 2009 MDCH issued an Application for Renewal and Recommitment (ARR) that solicited responses from the 18 PIHPs on how they planned to improve their services systems in eleven topic areas¹. Since then, teams of MDCH staff meet regularly with the PIHPs, mostly via telephone, to discuss progress on achieving their goals. This quality improvement effort will be continued during the upcoming waiver period. Most PIHPs have incorporated their QI activities into their Quality Assessment and Performance Improvement Programs.

Creating a “Culture of Gentleness” has been an ongoing training effort to improve the skills of direct care workers and their supervisors in their support of people with developmental disabilities who have behaviors that put themselves or others at risk of harm. Since this initiative began two years ago, over 2,700 staff have been

¹ Topic areas are partnering with stakeholders in design, delivery and evaluation of services, improving the culture of the system of care, assuring active engagement of the people served, supporting maximum consumer choice and control, expanding opportunity for integrated employment, treatment for people in the criminal justice system, assessing needs and managing demand, coordinating and managing care, improving, the quality of supports and services, developing and maintaining a competent workforce, and achieving administrative efficiencies,

trained. The results have been positive: of the 120 people with developmental disabilities who had previously resided in the ICF/MR unit at the Mt. Pleasant Regional Center, those who went to small homes with staff trained in culture of gentleness approaches have been successful in their communities. For the upcoming waiver period, MDCH intends to expand the training in order to build statewide capacity of trained workers.

MDCH requires PIHPs and their provider networks to promote and support family-driven and youth-guided practice at the child and family level, system level and peer-delivered level.

XI. **CONTRACT COMPLIANCE REVIEW AND ACTION**

The controlling document to assure that quality mental health and substance abuse services will be maintained is the contract between the MDCH and the PIHPs. The contract includes specific language regarding issues of general compliance, the compliance review process, and the dispute resolution process. Specific language allows for emergency reviews by MDCH whenever there is an allegation of fiscal impropriety, or endangerment of health and safety of beneficiaries. The contracts make clear that MDCH may utilize a variety of remedies and sanctions, ranging from the issuance of a corrective action plan to withholding payment to contract cancellation.

IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#) available on the SAMHSA website at [here](#).

Footnotes:

S. Suicide Prevention

The Suicide Prevention Plan for Michigan was released in 2005 by The Michigan Association for Suicide Prevention (MASP). It reflects the input of dozens of people from across the state, and incorporates some of the work from the state's first effort in the 1990s at developing a plan. It is based on the most valid information we now have about how to reduce suicide deaths and attempts using a community-based, public health approach.

Six years into the implementation of *The Suicide Prevention Plan for Michigan*, two statewide surveys were completed and were attempting to assess the implementation successes, identify the gaps, and make recommendations for moving the plan forward. MASP realized after a period of time that their work was lacking concrete data with which to make recommendations. In November 2011, MASP commissioned ReFocus, L.L.C. to conduct a data based evaluation of the plan. This result of this effort was released on May 1, 2012, in the *Suicide Prevention Plan for Michigan Evaluation*.

MDCH staff has worked with MASP regarding the evaluation of the plan, the Suicide Prevention Community Conference (October 2012) and other training activities. In early 2013, work on revising *The Suicide Prevention Plan for Michigan* began with a review of the activities of last year and the evaluation and what it tells us. Decisions were made to work on education for males ages 22-45 whose death rate is very high. One of the MASP members will be facilitating discussion of the plan revision. At the time of this writing, there is no completion date.

SUICIDE
PREVENTION
PLAN
for
MICHIGAN

2005

Developed by the
Michigan Suicide Prevention
Coalition



One Year Later

I've Learned

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

That life can be tough even when you are faithful

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

Hell can exist on earth

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

Grief can overtake you ... but only temporarily

That everyone grieves differently

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

That silence is the most wicked sound I have ever heard

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

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

and everything

Elly, 2004

Table of Contents

Introduction	1
Suicide as a Public Health Problem in the United States	4
Suicide as a Public Health Problem in Michigan	8
References	11
Goals and Objectives	13
<i>Goal #1 Reduce the Incidence of Suicide Attempts and Deaths Across the Lifespan</i>	13
<i>Goal #2 Develop Broad Based Support for Suicide Prevention</i>	14
<i>Goal # 3 Promote Awareness and Reduce the Stigma</i>	15
<i>Goal #4 Develop and Implement Community-Based Suicide Prevention Programs</i>	17
<i>Goal #5 Promote Efforts to Reduce Access to Lethal Means and Methods of Suicide</i>	19
<i>Goal #6 Improve the Recognition of and Response to High Risk Individuals Within Communities</i>	19
<i>Goal #7 Expand and Encourage Utilization of Evidence-based Approaches to Treatment</i> .	21
<i>Goal # 8 Improve Access to and Community Linkages With Mental Health and Substance Abuse Services</i>	22
<i>Goal #9 Improve and Expand Surveillance Systems</i>	23
<i>Goal #10 Support and Promote Research on Suicide and Suicide Prevention</i>	24
Recommended Resources	26
Appendix A: Senate Resolution No. 77	27
Appendix B: Michigan Suicide Prevention Coalition	28

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

Michigan Suicide Prevention Coalition

INTRODUCTION

MICHIGAN NEEDS A SUICIDE PREVENTION PLAN...

Suicide is preventable, yet suicide trends in Michigan are headed in the wrong direction. From 2001 to 2002 alone, the state moved up six spots—from 38th to 32nd—in the rate of suicides in the population when compared to the other states. As we learn more about what communities can do to prevent suicides, it is time for our state to adopt a comprehensive suicide prevention strategy that offers the hope of reducing the number of suicides in Michigan by at least 20% in the next five years.

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

The Michigan Department of Community Health (MDCH) responded to the state resolutions by forming a work group to begin drafting a state suicide prevention plan. Work continued until the end of 2000, but the group was unable to complete a plan before it became inactive. Michigan communities also responded. Small, community-based groups have addressed suicide in a number of ways, but the work is often fragmented, and has had little impact on overall state suicide rates.

The publication of the National Strategy for Suicide Prevention¹ in 2001 renewed efforts by states to develop their own suicide prevention plans, which are also a prerequisite to access Federal suicide prevention funding. Elsewhere in the nation, 24 state task forces and coalitions now have approved state plans.

In every year since the Michigan legislature approved the suicide prevention resolutions, more than 1,000 Michigan residents have died by suicide. And, each year, an estimated 25,000 more make attempts that often require medical intervention and which can result in short and long-term disability.

Almost five times as many suicides occur each year in this state as deaths from HIV/AIDS, and over one and a half times more suicides than homicides take place annually. In those startling statistics, Michigan is not alone—our experience mirrors the nation’s.

It is past time for Michigan to construct, approve, and begin implementation of a

Suicide Facts²

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

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

Elderly are the highest risk group per capita.

For youth, suicide is the 3rd leading cause of death.

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

Firearms are the most frequent method used.

coordinated, effective, and proven approach to reducing suicide deaths and attempts, using the National Strategy as a blueprint.

The Michigan Suicide Prevention Coalition (MiSPC), which formed in October 2003, has taken on the task. Our broad-based membership includes public and private organizations and agencies, foundations, individuals involved in suicide prevention, survivors (those who have lost a loved one to suicide), and professionals from around the state (see Appendix B). We have used our combined experience with survivorship, advocacy, and service to present an honest and critical assessment of what prevention efforts in Michigan require.

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

MiSPC members are very aware of the scarcity of state resources to initiate and support new programs. However, coalition members strongly feel that there are steps set forth in this plan that can be undertaken and accomplished with little or no new monetary resources. Successful initiation of the objectives in this plan will build a strong foundation for future efforts and place the State of Michigan and its communities in an excellent position to capitalize on upcoming opportunities for federal funds.

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

<i>Did You Know</i>	
U.S. Deaths in 2002 ³	
Suicide:	31,655
Homicide:	17,638
HIV/AIDS	14,095

- Suicide is the third leading cause of death for 15 to 19 year-olds; and the second leading cause of death for college age young people;⁴
- Like the rest of the nation, the largest number of suicide deaths occurs among our workforce, primarily men ages 25– 64.;⁵
- And the highest rate (measured in number of suicides per 100,000 population) is among our oldest residents.⁶

There are many at-risk populations within Michigan and the nation. This plan is meant to encompass all of these populations and address suicide risk across the lifespan. However, it does not include specific objectives for each special population. We continue to seek new and emerging practices that have potential for inclusion in future versions of this plan. The focus of this initial version is on building the infrastructure necessary to support prevention efforts across the state and on assisting communities in developing and initiating their own action plans. Every effort was made to assure that the strategy is:

- prevention-focused
- 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 goals. This will enable us to provide accurate feedback to government leaders, policy makers, organizations, advocates, and all those involved in implementation of the Michigan Plan for Suicide Prevention. It will also provide the information needed to revise objectives over time, enabling the Michigan Plan to evolve as goals are reached and new “best practices” information becomes available. Thus, in keeping with recommendations described in the National Strategy, all objectives in the Michigan Plan include measurable outcomes or targets that specifically identifying what is to be achieved. All objectives in the Michigan Plan indicate the “data source” for monitoring progress, and one set of objectives is dedicated solely to improving and expanding state surveillance systems related to suicide prevention, so the best possible data for the state is available.

The primary goals of the Michigan Plan for Suicide Prevention are to increase awareness across the state, to develop and implement best clinical and prevention practices, and to advance and disseminate knowledge about suicide and effective methods for prevention. There is full recognition that the goals and objectives overlap and contribute to a unified, integrated, and coordinated effort. Furthermore, given the ongoing research and evaluation of suicide prevention programs and strategies, we can expect this plan to change and evolve as knowledge is advanced and best practices emerge.

We Present ...

Michigan’s Suicide Prevention Plan reflects the input of dozens of people from across the state, and incorporates some of the work from the state’s first effort in the 1990s at developing a plan. It is based on the most valid information we now have about how to reduce suicide deaths and attempts using a community-based, public health approach.

SUICIDE AS A PUBLIC HEALTH PROBLEM IN THE UNITED STATES

Suicide has been one of the leading causes of death in the United States for decades. Rates of suicide have been relatively constant over the last sixty years, although the last decade shows some encouraging, but modest, decline in rates (see Table 1). Still, the nation experiences more than 30,000 suicide deaths each year, and an estimated 750,000 attempts⁷. The U.S. Centers for Disease Control and Prevention says that suicide is under-reported. The cost in terms of pain and suffering, loss of life, medical payouts and lost productivity, and the impact upon the survivors of suicide, is immeasurable.

Survivors

- *It is estimated that each suicide death intimately affects at least six other people.*
- *Based on the more than 745,000 suicides from 1978 through 2002, there are at least 4.47 million survivors in the U.S. (1 of every 64 Americans in 2001).*
- *In 2002 alone, that number grew by nearly 190,000.*
- *There is a suicide—and six new survivors created—every 16.6 minutes.*

• **IMPACT**

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

• **RISK FACTORS**

While suicide is closely correlated with mental illnesses (studies indicate that in well over 90% of all suicide deaths, there is a diagnosable and treatable illness of the brain present^{8,9}), there

are other risk factors that contribute to suicide deaths and attempts as well. For example, elderly persons are the highest risk population age group for suicide, and frequency of suicide tends to increase with age (see Table 2). In general terms, the highest demographic risk group of non-institutionalized Americans is elderly white males, living alone, with a diagnosable and treatable mental illness and a substance abuse problem.

Those incarcerated in jails are one of the populations at highest risk for suicide in the United States with rates of 54 per 100,000^a (the national average is less than 12 per 100,000). Another very high risk group are gay, lesbian, and bisexual (GLB) youth. Studies have shown that GLB youth have suicide attempt rates of 3.6-7.1 times higher than their heterosexual peers^{10,11}. There are multiple other groups at elevated risk for suicide across the life span. Untreated or under-treated depression is highly correlated with suicide. Around a third of those who die by suicide have an identifiable diagnosis of clinical depression at the time of death. Other mental illnesses also are associated with increased risk including, among others, schizophrenia, bi-polar disorder,

^a Calculated from data available in: Stephan JJ. *Census of Jails, 1999* (NCJ 186633). Washington, D.C.: U.S. Dept. of Justice, Bureau of Justice Statistics, 2001.

Table 1. US Suicide Rates, 1993–2002
(rates per 100,000 population)

Age/Group	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
<i>5-14</i>	0.9	0.9	0.9	0.8	0.8	0.8	0.6	0.8	0.7	0.6
<i>15-24</i>	13.5	13.8	13.3	12.0	11.4	11.1	10.3	10.4	9.9	9.9
<i>25-34</i>	15.1	15.4	15.4	14.5	14.3	13.8	13.5	12.8	12.8	12.6
<i>35-44</i>	15.1	15.3	15.2	15.5	15.3	15.4	14.4	14.6	14.7	15.3
<i>45-54</i>	14.5	14.4	14.6	14.9	14.7	14.8	14.2	14.6	15.2	15.7
<i>55-64</i>	14.6	13.4	13.3	13.7	13.5	13.1	12.4	12.3	13.1	13.6
<i>65-74</i>	16.3	15.3	15.8	15.0	14.4	14.1	13.6	12.6	13.3	13.5
<i>75-84</i>	22.3	21.3	20.7	20.0	19.3	19.7	18.3	17.7	17.4	17.7
<i>85+</i>	22.8	23.0	21.6	20.2	20.8	21.0	19.2	19.4	17.5	18.0
Total	12.1	12.0	11.9	11.6	11.4	11.3	10.7	10.7	10.8	11.0
Men	19.9	19.8	19.8	19.3	18.7	18.6	17.6	17.5	17.6	17.9
Women	4.6	4.5	4.4	4.4	4.4	4.4	4.1	4.1	4.1	4.3
White	13.1	12.9	12.9	12.7	12.4	12.4	11.7	11.7	11.9	12.2
Non-white	7.1	7.2	6.9	6.7	6.5	6.2	6.0	5.9	5.6	5.5
Black	7.0	7.0	6.7	6.5	6.2	5.7	5.6	5.6	5.3	5.1

Table 2. Suicides in the United States, 2002

	<u>Number</u>	<u>Avg./day</u>	<u>Rate</u>	<u>% of all deaths</u>
<i>Nation</i>	31,655	86.7	11.0	1.3
<i>Males</i>	25,409	69.6	17.9	2.1
<i>Females</i>	6,246	17.1	4.3	0.5
<i>Whites</i>	28,731	78.7	12.2	1.4
<i>Non-whites</i>	2,924	8.0	5.5	0.9
<i>Blacks</i>	1,939	5.3	5.1	0.7
<i>Native Americans</i>	324	0.8	10.5	---
<i>Asians/Pacific Islanders</i>	661	1.8	5.2	---
<i>Elderly (65+ years)</i>	5,548	15.2	15.6	0.3
<i>Young (15-24 years)</i>	4,010	11.0	9.9	12.1

some anxiety disorders, and borderline personality disorder.^{8,9} Co-morbidity with other psychiatric diagnoses is known to increase risk for suicide.

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

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

• PREVENTION

While there are few research based suicide prevention programs that are proven to reduce suicidal behaviors, several are worth noting. Approaches that utilize integrated suicide prevention efforts that include education, increased identification and referral, increased access to care, reduction of stigma, and the application of effective clinical interventions have been shown to reduce deaths and attempts and are promising for the future. A major United States Air Force study¹² and multiple school evaluations have demonstrated positive results at the community level. Other major studies are currently underway to evaluate and replicate programs with potential. One-time and isolated prevention efforts may have some value, but have not demonstrated sustainable positive impact on suicide behaviors. Recent evidence suggests that effective suicide prevention programs also reduce other violent behaviors. Some interventions have shown promise for the treatment of depressed, despondent or suicidal individuals; however, major efforts are necessary to implement quality care throughout the healthcare delivery system from general medical practice to professional mental health practices. Standards of care for the treatment of disorders with high suicide risk are not clearly defined, disseminated, or widely practiced across the nation.

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

• MEANS OF DEATH

In the U.S., the method used in more than 50% of suicide deaths is firearms. The 2002 data Table 3 is consistent with data over the past decade. Some studies have demonstrated that voluntary removal of firearms from homes of persons at risk has a positive impact on suicide rates and that substitution of methods does not necessarily occur.

Table 3. Suicide Methods, United States, 2002

<i>Suicide Method</i>	<i>No.</i>	<i>Rate</i>	<i>% of total</i>
Firearms	17,108	5.9	54.0
Suffocation/Hanging	6,462	2.2	20.4
Poisoning	5,486	1.9	17.3
Falls	740	0.3	2.3
Cut/Pierce	566	0.2	1.8
Drowning	368	0.1	1.2
Fire/burn	150	0.1	0.5
All other	775	0.3	2.5
Total	30,622		100.0

SUICIDE AS A PUBLIC HEALTH PROBLEM IN MICHIGAN

Did You Know?

At least 6,108 people became suicide survivors in Michigan in 2003

Did You Know?

Michigan Deaths In 2003¹³

Suicide	1,018
Homicide	644
HIV/AIDS	237

What is a public health problem? It is anything that affects or threatens to affect the overall health and well-being of the public. Compared to causes of death such as heart disease or cancer, suicide as a manner of death is a relatively rare event. And yet, on average, more than 1,000 Michigan residents take their lives each year (see Table 4). This makes suicide the tenth leading cause of death in the state for 2003. For some groups, such as white males ages 10-34 years, suicide is the second or third leading cause of death. In this state, suicide is among the top five leading causes of years of potential life lost below age 75^{b,14}.

Suicide rates, methods, risk factors and at-risk populations in Michigan closely parallel national trends and statistics (see Figure 1). Annual estimated economic costs^c associated with completed and attempted suicide in Michigan are over \$1.1 billion annually¹⁵.

The average annual suicide rate^d for the state has remained relatively flat for more than a decade. Men account for 81% of suicides deaths in Michigan. The highest average annual suicide rate per capita (38.5 per 100,000) is actually among white males ages 75 and older. Other groups of men with high rates are black males ages 30-34 (26.7/100,000), and white males ages 35-54 (24.9/100,000), 25-29 (23.7/100,000), 65-74 (23.7/100,000), and 30-34 (23.2/100,000). The lowest suicide rates are among black women, who have an average annual rate of 2.2 per 100,000 persons.

An analysis of the 2003 Michigan Youth Risk Behavior Survey data found that 18% of Michigan's 9th-12th graders seriously considered attempting suicide at some point during the 12 months preceding the survey¹⁶. More than one out of every ten students indicated they actually attempted suicide during that time. The number of young people in the state who die by suicide increases dramatically over the adolescent years (see Figure 2).

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

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

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

Table 4. Average Annual Number of Suicides By Age, Race, and Sex, Michigan Residents, 1999-2002⁵

Age	White			Black			Other			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
10-14	6	3	8	1	0	2	-	-	-	7	3	10
15-19	41	7	48	6	1	7	2	1	3	49	9	58
20-24	56	9	64	10	1	11	2	1	2	67	10	77
25-29	59	12	71	10	2	12	3	1	3	71	14	85
30-34	65	12	77	13	2	16	1	0	1	80	15	94
35-44	164	46	210	16	5	20	3	1	3	182	52	234
45-54	142	38	181	10	4	14	1	1	2	153	43	196
55-64	73	23	95	3	1	4	1	1	1	77	24	101
65-74	61	11	71	4	1	5	1	1	2	65	12	77
75+	73	14	87	2	1	3	0	0	1	75	15	90
Total	738	174	911	75	17	91	12	6	18	826	196	1,021

Decedents with unknown race (n=5) not illustrated but included in totals.

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

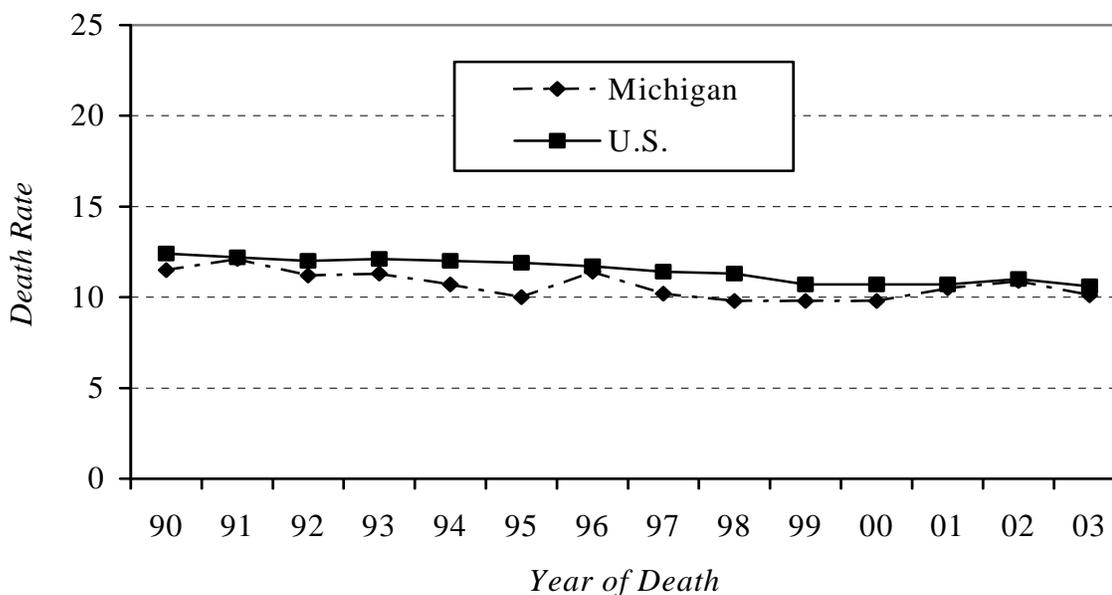


FIGURE 1. Suicide rates, Michigan and U.S. Residents, 1990-2003¹⁷

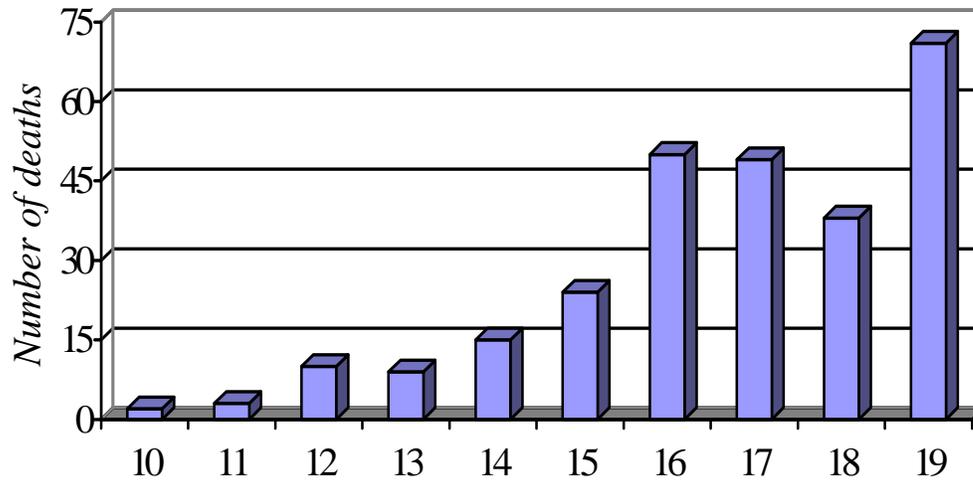


Figure 2. Adolescent suicide deaths, Michigan, 1999-2002¹⁸

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GOALS AND OBJECTIVES

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

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

Goal #1 Reduce the Incidence of Suicide Attempts and Deaths Across the Lifespan

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

DATA SOURCE: Youth Risk Behavior Survey results and emergency services surveillance systems.

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

DATA SOURCE: Michigan Department of Community Health vital records

AWARENESS

Broaden the Public Awareness of Suicide and its Risk Factors

Goal #2

Develop Broad Based Support for Suicide Prevention

- Objective 2.1** Identify and support a state-level management/leadership structure for oversight of the Michigan Suicide Prevention Plan.
- 2.1.1** Establish and staff an Office of Suicide Prevention (OSP) in Michigan. This Office should be embedded within the Michigan Department of Community Health with a reporting relationship to the Department Director in order to foster a collaborative, public/private partnership between the Department and the Michigan Suicide Prevention Coalition, as well as support collaboration across administrations and offices within MDCH.
 - 2.1.2** Within one year, establish a Michigan Suicide Prevention Advisory Council (Michigan SPAC) comprised of a broad coalition of public and private sector representatives to oversee the implementation of the Michigan Suicide Prevention Plan.

DATA SOURCES: State organizational chart, membership roster and record of meetings of the Michigan SPAC, record of MDCH and Michigan Suicide Prevention Coalition joint meetings. This objective will be evaluated jointly by the MDCH and the Michigan Suicide Prevention Coalition.

- Objective 2.2** Utilize the state's existing Community Collaboratives to take the lead to identify the appropriate leadership in each community to establish Local or Regional Suicide Prevention Coalitions and to seek broad and diverse participation at the local level. While the process can begin immediately, these coalitions should be established within 18 months.

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

- Objective 2.3** The OSP, in collaboration with local coalitions, will utilize broad based public-private support to blend resources of stakeholders in support of suicide prevention.

DATA SOURCE: Record of OSP initiatives involving public/private support for prevention strategies or programs

Objective 2.4 The OSP, in collaboration with local planning efforts, will utilize broad-based public-private support to seek additional funds for suicide prevention.

DATA SOURCE: Record of OSP collaborative initiatives that seek funding, and which result in funds for suicide prevention

Objective 2.5 The OSP will compile and make publicly available a Resource Directory that includes state and community reports referenced in the Plan.

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

Goal # 3

Promote Awareness and Reduce the Stigma

Objective 3.1 The OSP will develop, within its first year and by coordinating with public and private sectors and assisting in local efforts, a comprehensive plan to implement a state-wide campaign promoting awareness that suicide is a preventable public health problem that reaches all citizens in Michigan.

This would be followed in year two by implementation of at least one component of the comprehensive plan—a public awareness campaign that promotes the concept that suicide is preventable and that focuses on reducing the stigma of mental illness and improving help-seeking behaviors.

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

Objective 3.2 Within one year, the OSP, in partnership with the Michigan Association of Suicidology (MAS), the Michigan Chapter of the Suicide Prevention Action Network (SPAN), and other public and private entities, will expand participation in symposiums held within the state on suicide prevention.

DATA SOURCES: Number of symposiums throughout the state on suicide prevention, their geographic locations, attendance and program content.

Objective 3.3 The OSP, during year one, will assist with educating the media on their critical role in suicide prevention, including mental illnesses and substance abuse, and collaborate to ensure responsible media practices in the coverage of these topics. Use of the nationally recognized *Reporting on Suicide*:

Recommendations for the Media (U.S. Centers for Disease Control and Prevention) will be encouraged. OSP will assist with availability of curriculum for state journalism schools.

DATA SOURCE: Documentation of dissemination of media guidelines

Objective 3.4 Within one year, the Suicide Prevention Advisory Council will increase the awareness of policy makers by educating officials on the impact that suicide, mental illnesses, and substance abuse have on other policy areas, such as health care, law enforcement, and education.

DATA SOURCE: Documentation of dissemination of educational materials to policy makers.

Objective 3.5 Within two years, the OSP will identify and encourage the use of effective, best practices in prevention and awareness programs to mental health agencies, educational settings, law enforcement agencies, and other involved programs.

DATA SOURCE: Documentation of “best practices” information disseminated in regional and state conferences, workshops, etc.

Objective 3.6 Expand public awareness efforts that contribute to this goal and seek public and private partnerships to encourage help-seeking behaviors and to represent mental illnesses as diseases that are treatable.

DATA SOURCE: Reports from relevant state offices, the OSP, and the Michigan SPAC.

INTERVENTION

Enhance Services and Programs, Both
Population Based and Clinical Care

Goal #4

Develop and Implement Community-Based Suicide Prevention Programs

Objective 4.1 In each of the next five years, increase the number of local and/or regional suicide prevention collaboratives.

DATA SOURCE: Annual reports from OSP of Community Collaborative involvement.

Objective 4.2 Within the next two years, through collaboration and partnerships, increase the number of communities or counties that are implementing an evidence-based early intervention strategy for children who have experienced significant childhood trauma.

DATA SOURCE: Local and community data on program implementation gathered by Community Collaboratives and provided to OSP.

Objective 4.3 Encourage all communities to develop services for survivors of suicide and promote utilization of these services.

DATA SOURCES: Evidence that guidelines and technical assistance with provision of survivor services were made available to communities.

Objective 4.4 Within the next three years, the OSP and the Michigan Department of Education will partner to develop legislative proposals for state policy best practice guidelines that support schools in implementing and expanding evidence-based suicide prevention and response policies and programs.

4.4.1 Disseminate information to raise awareness among Michigan legislators, school administrators, educational associations, public and mental health advocacy groups, and parent groups regarding the impact of mental health on learning and lifelong health outcomes, and the role

of coordinated school health and safety programs in addressing mental health problems in schools.

- 4.4.2** Develop proposed policies for the State Board of Education that encourage coordinated, evidence-based suicide prevention and response policies and programs, identify the characteristics of effective suicide prevention and response strategies, and further the Board's existing policies on coordinated school health and safety programs.

DATA SOURCES: Documentation of stated policies, legislative proposals and outcomes; Michigan SPAC reports on each point.

Objective 4.5 Within two years, frame guidelines for evidence-based suicide prevention programming using a collaboration of school health partners, including the Michigan Departments of Education and Community Health, the Comprehensive School Health Coordinators Association, local school districts, community mental health agencies, Community Collaboratives, parent groups, suicide prevention advocacy groups, and others interested in the health and well-being of Michigan children and youth. The guidelines will be disseminated statewide to public and private education settings and will address objectives and resources for:

- Healthy environment and positive school climates that embrace the broad diversity of all youth and include sequential social-emotional skills curriculum addressing problem solving, help seeking, and decision making; physical and emotional safety for all students; proactive and positive school-wide discipline; and healthy and orderly physical environment
- Measures that decrease risk factors and enhance protective factors.
- Identification of students at-risk for suicide, including gatekeeper training for staff and students, screening, and peer support.
- Administrative issues, including policies and procedures, program support and maintenance, broad based diversity training, crisis response teams, evaluation of programs, duty, responsibility and liability
- Intervention strategies, involving school-community partnerships which facilitate referrals, 24 hour crisis response, and student re-entry support following a crisis
- Responding to a death by suicide, including to the needs of the school community and working with media – recommend using the CDC Guidelines for containment of suicide clusters and Guidelines for Media Coverage of Suicide.
- Family and community partnerships

- Dissemination to all Michigan Public and Private educational settings

DATA SOURCES: Record of collaboration (described above) in developing guidelines; and publicly available, comprehensive guidelines for evidence-based suicide prevention programming in schools

Goal #5

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

- Objective 5.1** Within three years, the OSP working in collaboration with the appropriate professional organizations, will increase the proportion of primary care clinicians, other health care providers, and health and safety officials who routinely assess the presence of lethal means (including firearms, drugs, and poisons) in the home and educate about actions to reduce associated risks.

DATA SOURCE: Establish baseline data (OSP, the Michigan SPAC and/or Community Collaboratives) for at least one category of health provider, enabling an evaluation of outcomes for this group(s) within three years.

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

DATA SOURCE: Record of penetration of public information campaigns

Goal #6

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

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

- 6.1.1** Within three years, expand the number of gatekeepers.

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

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

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

Objective 6.2 Within two years, the OSP and the Michigan SPAC will develop and disseminate a model for community “capacity assessment” for suicide prevention. This will include a template for resource identification. Its purpose will be to not only assist communities in identifying all available assets related to suicide prevention and intervention, but also any critical gaps and deficits.

DATA SOURCE: Documentation of dissemination of the model to communities.

Objective 6.3 Within one year the OSP and the Michigan SPAC will identify and distribute guidelines for suicide risk screening to primary care settings, emergency departments, mental health and substance abuse settings, senior programs, and the corrections system.

DATA SOURCE: Publicly available copies of materials and distribution lists

Objective 6.4 Within three years, the Michigan Department of Corrections will adopt and disseminate system wide policies and practices for suicide prevention in accordance with the American Correctional Association Standards for

Emergency Care and Training, or the National Commission on Correctional Health Care.

DATA SOURCE: Record of policies and practices for suicide prevention

Objective 6.5 Within three years, require that all state funded colleges and universities develop suicide prevention policies, and implement one or more prevention strategies patterned after evidence-based approaches

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

Objective 6.6 Within two years, require Community Mental Health programs to implement suicide prevention training for all direct service personnel. They will also adopt policies and practices for suicide prevention/intervention including identification, intervention, discharge, and tracking of outcomes.

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

Goal #7

Expand and Encourage Utilization of Evidence-based Approaches to Treatment

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

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

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

DATA SOURCE: Evidence of distribution

Objective 7.3 Within 18 months, MDCH, in collaboration with the Michigan Association of Community Mental Health Boards (MACMHB), will identify quality care/utilization management guidelines for effective response to suicidal risk or

behavior and assure that these guidelines are incorporated into the state managed care plan.

DATA SOURCE: Identification of guidelines and incorporation into the managed care plan

Goal # 8

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

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

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

Objective 8.2 Support policies and/or legislation that provide coverage for evaluation and treatment of mental illnesses and substance abuse that is equal with coverage of other illnesses and conditions.

DATA SOURCE: Policy and/or legislative outcomes

Objective 8.3 Within each of the next five years, increase the number of communities promoting the awareness and utilization of 24-hour crisis intervention services that provide full range crisis and referral services. These services may be locally based or linked to the national hotline. It is desirable that these services be AAS certified.

Once the baseline is established the annual cumulative goal increases will be as follows:

2006	20%
2007	30%
2008	40%
2009	50%
2010	60%

DATA SOURCE: MDCH mental health services audit

METHODOLOGY

Advance the Knowledge of
Suicide and Best Practices for
Prevention

Goal #9

Improve and Expand Surveillance Systems

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

DATA SOURCE: MDCH reports

Objective 9.2 Promote the use of standardized protocols for death scene investigations throughout Michigan.

DATA SOURCE: MDCH implementation report

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

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

9.3.1 Biannually, within one year of data collection, fact sheets related to the results of the 2003 Michigan YRBS most pertinent to depression and suicide, by age, gender, and race, will be widely disseminated in printed format and on-line.

- 9.3.2** Within two years, disseminate fact sheets related to the results of the 2005 Michigan YRBS, adding rates for Native American youth, in printed format and on-line.

DATA SOURCE: Report of YRBS results and records of dissemination

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

DATA SOURCE: Copies of written plans and evaluation reports.

Goal #10

Support and Promote Research on Suicide and Suicide Prevention

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

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

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

DATA SOURCE: Evidence of collaborative efforts to seek funds

- Objective 10.3** Determine the social and economic costs of untreated mental illnesses and substance abuse, and support strategies for reducing these costs.

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

DATA SOURCE: Publicly available report on social and economic costs

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

DATA SOURCE: Publicly available cost benefit report

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

DATA SOURCE: The OSP's annual reports

RECOMMENDED RESOURCES

- The American Association of Suicidology: www.suicidology.org
- American Foundation for Suicide Prevention: <http://www.afsp.org/index-1.htm>
- The Canadian Association for Suicide Prevention: <http://www.suicideprevention.ca/>
- Centers for Disease Control and Prevention <http://cdc.gov/ncipc/factsheets/suicide-overview.htm>
- Children's Safety Network: <http://www.childrensafetynetwork.org/>
- Children's Safety Network, Economics & Data Analysis Resource Center: <http://www.edarc.org/>
- Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE (eds.). *Reducing Suicide: A National Imperative*. Washington, D.C.: The National Academies Press, 2002.
- Michigan Department of Community Health, Vital Records and Health Data Development Section: <http://www.mdch.state.mi.us/pha/osr/index.asp?Id=4>
- Michigan State University, School of Journalism. Victims and the Media Program: <http://victims.jrn.msu.edu/>
- National Strategy for Suicide Prevention: Goals and Objectives for Action*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 2001.
- U.S. Centers for Disease Control and Prevention. *Web-based Injury Statistics Query and Reporting System (WISQARS)*: <http://www.cdc.gov/ncipc/wisqars/default.htm>
- National Commission on Correctional Healthcare: <http://www.ncchc.org/index.html>
- American Foundation for Suicide Prevention, American Association of Suicidology, Annenberg Public Policy Center. *Reporting on Suicide: Recommendations for the Media*: <http://www.afsp.org/education/recommendations/5/1.htm>
- National Institute of Mental Health—Suicide Prevention: <http://www.nimh.nih.gov/suicideprevention/index.cfm>
- New Zealand Ministry of Youth Development—Youth Suicide Prevention: <http://www.myd.govt.nz/sec.cfm?i=21>
- Schneidman, Edwin. *The Suicidal Mind*. New York: Oxford University Press, 1996.
- Suicide Prevention Action Network: <http://www.spanusa.org/>
- Suicide Prevention Resource Center: <http://www.sprc.org/>
- World Health Organization. *SUPRE—the WHO worldwide initiative for the prevention of suicide*: http://www.who.int/mental_health/prevention/suicide/supresuicideprevent/en/

APPENDIX A: SENATE RESOLUTION NO. 77^e

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

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

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

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

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

Resolved by the Senate, That we

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

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

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

APPENDIX B: MICHIGAN SUICIDE PREVENTION COALITION

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

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

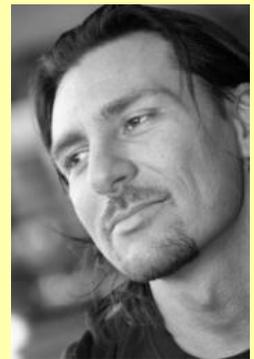
Mary Gallinagh Beghin	October 25 1967	Curtis Joseph Stucki	February 2 1998
Danny Sullivan	1970	Greg Pascoe	February 2 1998
Robert Taylor	1970	Jason Michael Harrold	June 27 1998
Laura LaCharite	February 25 1971	Todd Stackowicz	October 28 1998
Thomas J. Caldwell	April 15 1972	William Henry Hebert	October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

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

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

Michigan Association for Suicide Prevention
Suicide Prevention Plan for Michigan Evaluation

May 1, 2012



Developed in consultation with



September 2011 – May 2012

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Report cover designed by Joy M. Klingeman, Marketing Specialist – ReFocus, L.L.C.

Six years into the implementation of *The Suicide Prevention Plan for Michigan*, we had two statewide surveys completed and were attempting to assess the implementation successes, identify the gaps, and make recommendations for moving the plan forward. We realized after a period of time that our work was lacking concrete data with which to make our recommendations. In November 2011 the Michigan Association for Suicide Prevention commissioned ReFocus, L.L.C. to conduct a data based evaluation of the plan. This document is the result of this effort.

In 2011, Jack Calhoun of Refocus, L.L.C., worked with Cheryl King, PhD and Cindy Ewell Foster, PhD at the University of Michigan Depression Center to develop a plan for completing an evaluation of *The Suicide Prevention Plan for Michigan*. They also revised a brief internet survey that we used twice previously to obtain information on suicide prevention activities being conducted locally across the state. The survey was opened for responses for approximately two months and promoted to individuals in communities statewide. The evaluation team at ReFocus, L.L.C. also obtained data from the National Suicide Prevention Lifeline, a national crisis line that re-routes calls to the closest Crisis Center according to calls' area codes. In addition, the evaluation team was provided with suicide statistics from the Michigan Department of Community Health. The use of these data and more allowed the evaluation team to provide us with state maps showing us counties where suicide prevention was active and make recommendations to strengthen our efforts to address this important public health problem.

It will be up to all of us to look at this document and data to project the future of suicide prevention in Michigan. With the end of the state's federal grant for youth suicide prevention in the fall of 2012, we know that funding for state and local efforts is likely to be even more scarce than it has been in recent history. It will be up to all of us to make sure we do not lose the momentum to keep our plan on track. We hope this document will help us see where best to put our limited resources and will inspire you to join us in our forthcoming effort to update and revise *The Suicide Prevention Plan for Michigan*.

Sincerely,

Larry G. Lewis, MSW
Chairman Michigan Suicide Prevention Coalition
Michigan Association for Suicide Prevention

Acknowledgements

The Michigan Association for Suicide Prevention would like to acknowledge the support and contributions of two individuals and their respective agencies that have made to this effort, in not only the initial stages of forming our statewide coalition, but assisting with getting our state plan adopted as the official suicide prevention plan for Michigan.

Pat Smith, Violence Prevention Program Coordinator in the Injury & Violence Prevention Section of the Michigan Department of Community Health, wrote the state youth suicide prevention grant that was funded under the Garrett Lee Smith Memorial Act. This grant allowed us to provide resources for community suicide prevention programs, trainings, media, and community coalitions.

Mary Ludtke, Consultant in the Mental Health Services to Children and Families Division of the Michigan Department of Community Health, is the state-level person who supports the coordinators of Michigan's Community Collaboratives. The Collaboratives provided an already existing structure at the grassroots level on which to build and focus our efforts. Additionally, we would like to thank all the original members of the Michigan Coalition for Suicide Prevention (listed in the appendix), many of whom worked diligently on and gave many hours to the development of the state plan. Our thanks also go out to the many individuals and organizations in communities across the state that have joined with us to reduce the attempts and suicides in Michigan.

Our hearts go out to all survivors and Michiganians touched by suicide—we pledge to continue our efforts.

Goal of the Suicide Prevention Plan for Michigan: It is the primary goal of the Suicide Prevention Plan for Michigan to increase awareness across the state, to develop and implement best clinical and prevention practices, and to advance and disseminate knowledge about suicide and effective methods for prevention.

Introduction: In 2005 the Michigan Suicide Prevention Coalition completed a suicide prevention plan that was modeled after the National Strategy for Suicide Prevention. That plan was accepted by the Michigan Department of Community Health as the suicide prevention plan for the state. Through the emphasis of ten goals and related objectives, the plan was designed to encompass all of the many at-risk populations and “address suicide risk across the lifespan.” The focus of the plan was “on building the infrastructure necessary to support prevention efforts across the state and on assisting communities in developing and initiating their own action plans,” and based on a set of assumptions concerning recommendations involving local efforts:

1. Much of the final planning and execution must occur at the local level;
2. All tools and protocols must be appropriate for the local community and its diverse members;
3. There should be uniform messages and language across all activities, across all locations, and across all priority groups;
4. Only the local communities themselves can establish what their priorities will be; and
5. All prevention programs and interventions must be delivered in appropriate ways given the specific community and its diversity.

In April, 2011, the Michigan Association for Suicide Prevention produced the “Status of the State Plan” report, which was intended to present a progress report on the implementation of the state’s suicide prevention plan. The document reviewed the plan on a goal by goal basis, identifying some relevant successes and gaps in achieving the respective goals. It is the intention of this evaluation to augment that status report and quantifiably evaluate the plan.

According to the “Status of the State Plan” report, when the “plan was formulated it set many objectives to be accomplished within 18 months to 3 years. With dwindling human resources available for implementation the timelines for many of the objectives were unrealistic.” Thus, it is not the intention of this evaluation to assess, by each objective, whether the specific action was completed on time or completed at all. Rather this evaluation addresses each goal and seeks to assess the degree to which progress has been made over the five-year life of the plan.

Evaluation Methodology: The purpose of this evaluation is four-fold:

1. To determine the degree to which the Suicide Prevention Plan for Michigan goals have been achieved.
2. To identify and recommend actions to improve the plan.
3. To maintain accountability to funding sources and other stakeholders.
4. To demonstrate the program’s value and increase support among Michigan communities.

Therefore, this evaluation uses a Behavioral-Objectives approach, focusing primarily on the degree to which the goals of the plan have been achieved. The evaluation is structured in order to answer the following questions:

1. To what degree has Michigan’s suicide prevention plan been implemented?

In addition to the statewide survey, the evaluation team gathered information from other sources to perform this evaluation, including the National Suicide Prevention Lifeline (SAMHSA), the Michigan Profile for Healthy Youth (MiPHY), local Health Departments, the Centers for Disease Control and Prevention, the United States Census Bureau, the Transforming Youth Suicide Prevention in Michigan program, and the Suicide Prevention Resource Center.

The Michigan Association for Suicide Prevention obtained the services of ReFocus, L.L.C. to perform this evaluation. Prior to forming the organization in 2005, the ReFocus, L.L.C. partners worked for more than thirty-six combined years within local community mental health systems in the State of Michigan as both clinicians and administrators. ReFocus, L.L.C. provides strategic planning and program evaluation services, focusing primarily on not-for-profit and governmental entities, including mental health agencies, Substance Abuse Coordinating Agencies, community coalitions, school districts and circuit and family courts. Thus, Refocus, L.L.C. was uniquely positioned to evaluate the Suicide Prevention Plan for Michigan's scope and impact across the state from a community collaboration perspective.

Goal #1: Reduce the incidence of suicide attempts and deaths across the lifespan

According to the "Status of the State Plan" report, goal #1 represents the "first and foremost" impact the framers of the State Suicide Prevention Plan wished to have: to ultimately "help reduce the rates" of suicide across the state. Objectives under the goal address the number of suicide attempts among Michigan youth and to reduce suicide deaths among all Michigan populations utilizing evidence based best practices.

In order to evaluate the incidence of suicide attempts among youth, this evaluation looked at the Michigan Profile for Healthy Youth (MiPHY), which was developed by the Michigan Department of Education in collaboration with the Michigan Department of Community Health. The MiPHY is an online, anonymous student survey available to all Michigan schools on a biennial basis to assess risk behaviors, risk factors, and protective factors in Grades 7, 9, and 11. The evaluation team obtained county-level MiPHY data published for 2007 and 2009 (the two survey administrations that have occurred since the State Suicide Prevention Plan was implemented.¹) Three items are important to remember when reviewing the MiPHY data. First, there is not one hundred percent participation across the state. Not all counties are represented in the datasets nor are all school districts within counties for which data are reported represented. For purposes of this evaluation the MiPHY information should be considered a sample of youth across the state of Michigan. Second, MiPHY data have not been published for the State of Michigan in aggregate. Thus, the data presented here represents the sum of county-level data published by the State of Michigan (See Attachments A and B for MiPHY data by county for 2007 and 2009). Third, these data represent participating students' self-report and are not verified as to accuracy.

As figure 2 displays, the MiPHY questions are based on an understanding of the progression of suicidal behavior, from feelings of depression to taking action to end one's own life.

¹ For county-level MiPHY results see Appendix A (2007) and Appendix B (2009).

Figure 2. Progression of suicidal behavior

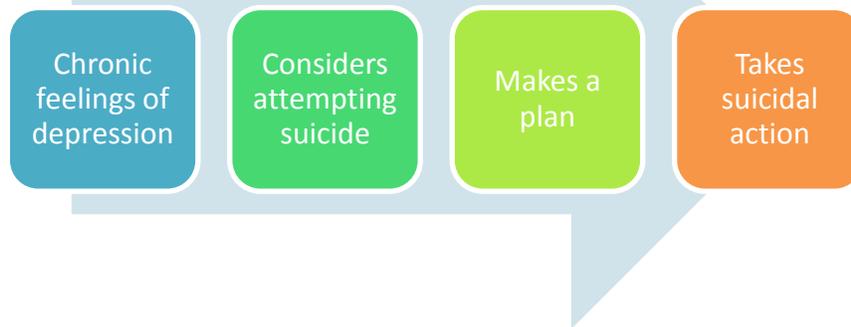


Figure 3 compares 2007 and 2009 MiPHY results for questions that address suicidal behavior. It shows a large increase from 2007 to 2009 in the number of Middle and High School students that took the MiPHY survey. It also shows a slight decrease in the percent of Middle School students who ever seriously considered attempting suicide (from 21.59% to 21.3%) as well as a slightly larger decrease in the percent of High School students who made a plan about how they would attempt suicide during the past 12 months. It shows that the percent of High School students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months increased in 2009 from the 2007 results. Overall, this analysis would indicate that the percent of students considering suicide to the point of making a plan has remained stable.

Figure 3. 2007 and 2009 MiPHY results: suicidal behavior

	Middle School Number MiPHY Respondents	High School Number MiPHY Respondents	Percent of Middle School respondents who ever seriously considered attempting suicide	Percent of Middle School respondents who ever made a plan about how they would attempt suicide	Percent of High School respondents who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	Percent of High respondents who seriously considered attempting suicide during the past 12 months	Percent of High School respondents who made a plan about how they would attempt suicide during the past 12 months
2007	18933	34911	21.59%	13.22%	29.14%	14.60%	12.93%
2009	34430	61231	21.30%	13.36%	32.33%	16.24%	12.00%
+/-	15497	26320	-0.003	0.001	0.032	0.016	-0.009

Figure 4 compares 2007 and 2009 MiPHY results for questions that address student reported suicide attempts. It shows slight increases in the percent of Middle and High School students reporting that they had attempted suicide. (Note the variation between the questions asked to Middle and High School students. While Middle School students are asked if they *ever* tried to kill themselves, High School students were asked if they had attempted suicide *during the past 12 months*.)

Figure 4: 2007 and 2009 MiPHY results: suicide attempts

	Middle School Number MiPHY Respondents	High School Number MiPHY Respondents	Percent of Middle School respondents who ever tried to kill themselves	Percent of High School respondents who actually attempted suicide one or more times during the past 12 months	Percent of High School respondents whose suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse during the past 12 months.
2007	18933	34911	7.44%	9.03%	3.60%
2009	34430	61231	7.86%	9.39%	3.90%
+/-	15497	26320	0.004	0.004	0.003

These data should be compared to the results of the 2011 MiPHY administration, which is due for public release in June 2012; however, based upon the analysis above there does not appear to have been significant shifts (positively or negatively) in the percent of youth considering, planning, nor taking suicidal action between the 2007 and 2009 survey administrations.

According to state vital records data, there were 1,265 suicides in the state of Michigan in 2010 (the most recent year for which data have been published). Figure 5, below, displays the counts of suicides in Michigan by year and age grouping between 2005 and 2010. Figure 6 displays the distribution of persons by age grouping who died by suicide between 2005 and 2010. It shows that 38.0% of persons that died by suicide in the time period were between the ages of 45 and 64 and 12.5% were among persons age 24 and under. There were no suicides by persons under the age of 5 years during the period under review.

Figure 5. Counts of suicides in Michigan by year and age grouping²

Michigan	Total Count of Suicides	5-14	15-24	25-44	45-64	65 and Older
2005	1,103	6	136	423	378	160
2006	1,132	8	114	414	437	159
2007	1,123	7	129	380	437	170
2008	1,173	7	138	431	431	166
2009	1,164	10	131	360	472	191
2010	1,265	11	171	411	490	182
Totals	6,960	49	819	2,419	2,645	1,028

² Michigan Department of Community Health, <http://www.mdch.state.mi.us/pha/osr/chi/FATAL/DX09LTN4.ASP>.

Figure 6. Distribution of age groupings of persons committing suicide between 2005 and 2010

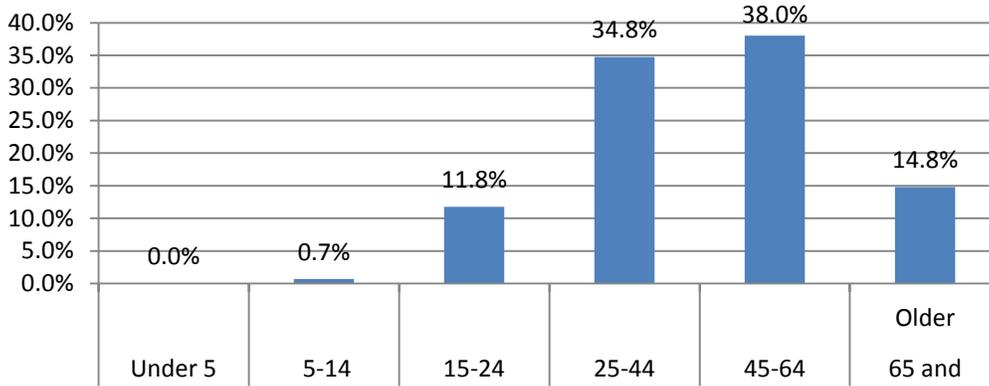


Figure 7 displays the suicide trends of persons in Michigan by age grouping between 2005 and 2010 using state vital records data (shown above). It shows that while the count of suicides among adults ages 25 to 44 is stable; the count of suicides among adults ages 45 to 64 and adults age 65 and older are increasing. The count of suicides among youth between ages 15 and 24 has remained stable throughout the five years.

Figure 7. Suicide Trends by Age Grouping 2005 - 2010

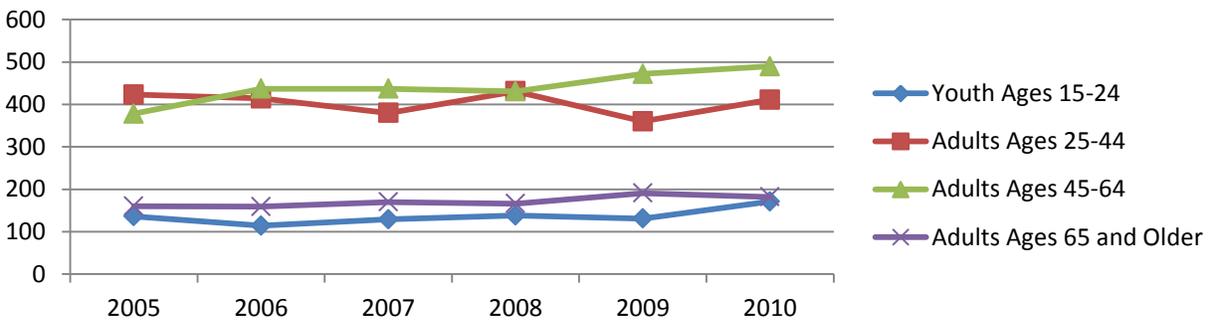
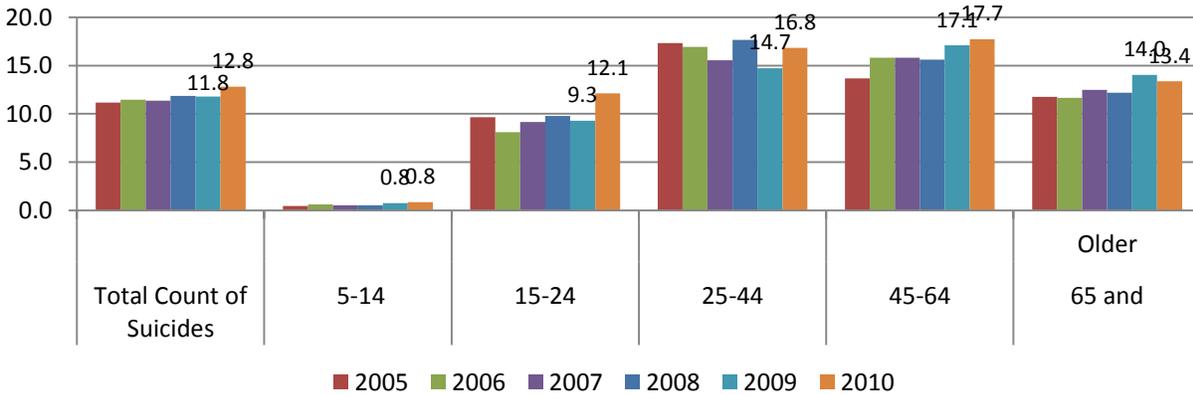


Figure 8, below, displays suicides in Michigan per 100,000 residents for each year between 2005 and 2010.³ This analysis is used to account for variations in the sizes of age groupings relative to the other age groupings and the population of the state as a whole. For example, if there are twice as many persons over the age of 65 in the State of Michigan than there are children between ages 5 and 14, one would expect the number of suicides to be twice as high for the more aged group than for the children. By accounting for the size of each age demographic, one can more easily identify variations in the rates of suicides between the age groupings. Figure 8 displays that in 2010 there were 17.7 suicides per 100,000 persons age 45-64 and 13.4 suicides per 100,000 persons age 65 and older. Suicides per 100,000 residents increased in 2010 for all age groupings between ages 15 and 64 as well as for the state as a whole. When evaluated per 100,000 Michigan residents, there has been a steady increase in the annual rate of suicides since 2005.

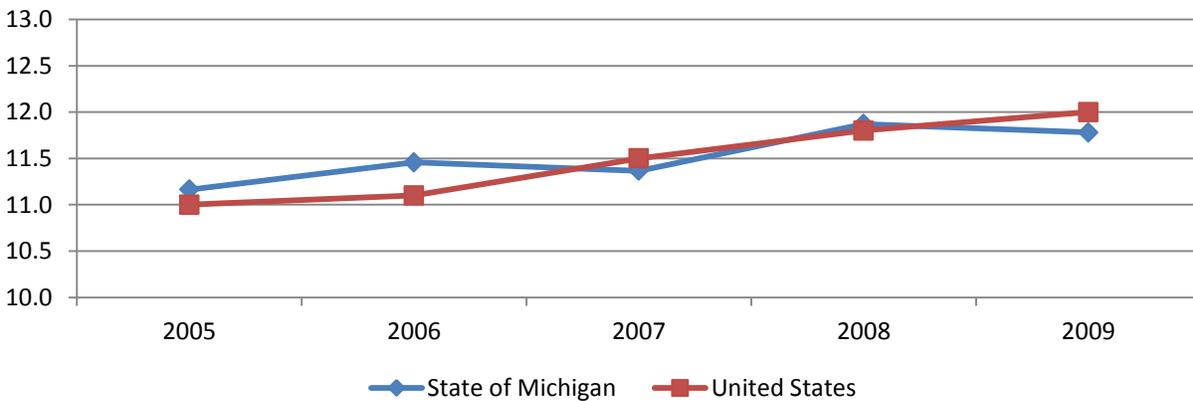
³ Census data used in this analysis is taken from the 2010 United States Census, published by the U.S. Census Bureau.

Figure 8. Michigan Deaths by Suicide per 100,000 residents by year



One must ask, then, how does Michigan compare to the United States as a whole. The last year for which national statistics are available from the Centers for Disease Control and Prevention is 2009⁴. In that year suicides per 100,000 residents in the United States was 12.0; the rate in Michigan was comparable at 11.8. Figure 9, below, displays the suicide rates per 100,000 residents for Michigan and the United States, trended between 2005 and 2009. It shows that the suicide rates for both the United States and Michigan have been increasing at a comparable rate. In 2009 Michigan’s rate was slightly lower than that of the United States as a whole.

Figure 9. U.S. & MI Suicides per 100,000 residents, trended over time



Based on the fact that the age grouping with the highest rate of suicide in Michigan is adults between the ages of 45 and 64, Figure 10, below, compares deaths by suicide per 100,000 residents in Michigan to the United States as a whole in 2008.⁵ It shows that in that year deaths from suicide in Michigan for persons aged 45 -64 per 100,000 residents was well below the rate for the same age grouping across the country. Based upon the increase of suicides within this age grouping in Michigan in 2009, however, the rate within the state may be catching up to the national rate (assuming it has not significantly shifted).

⁴ National Vital Statistics Reports, 60(3). 5 January 2012.

⁵ 2008 figures are used in this analysis because it is the most recent year for which U.S. statistics for the comparable age grouping can be obtained. U.S. Suicide data is from the Centers for Disease Control and Prevention. According to the CDC, “the suicide death rate for persons aged 45 – 64 years increased overall (from 13.2 [in 1999] to 17.6 per 100,000 population)” National Vital Statistics System. CDC Health Data.

Figure 10. Deaths from Suicide Among Persons Aged 45 - 64/per 100,000 (Michigan vs. United States)

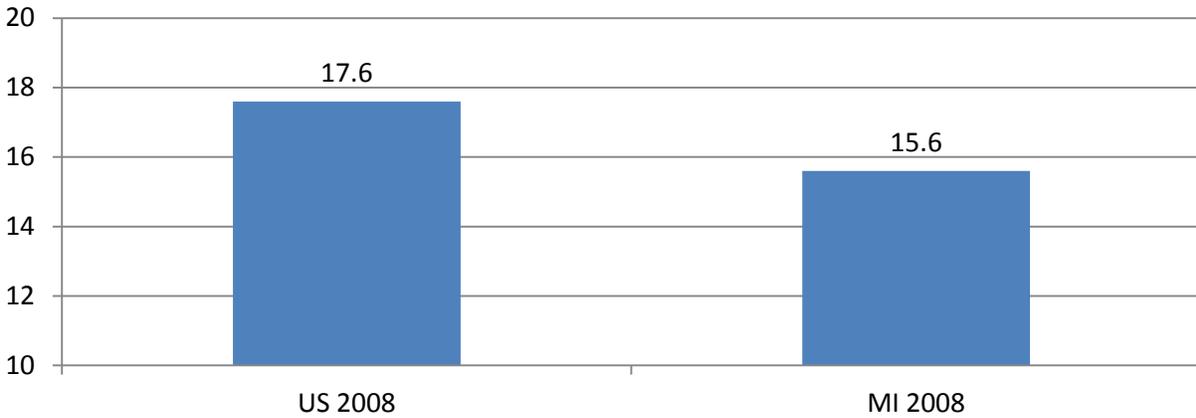
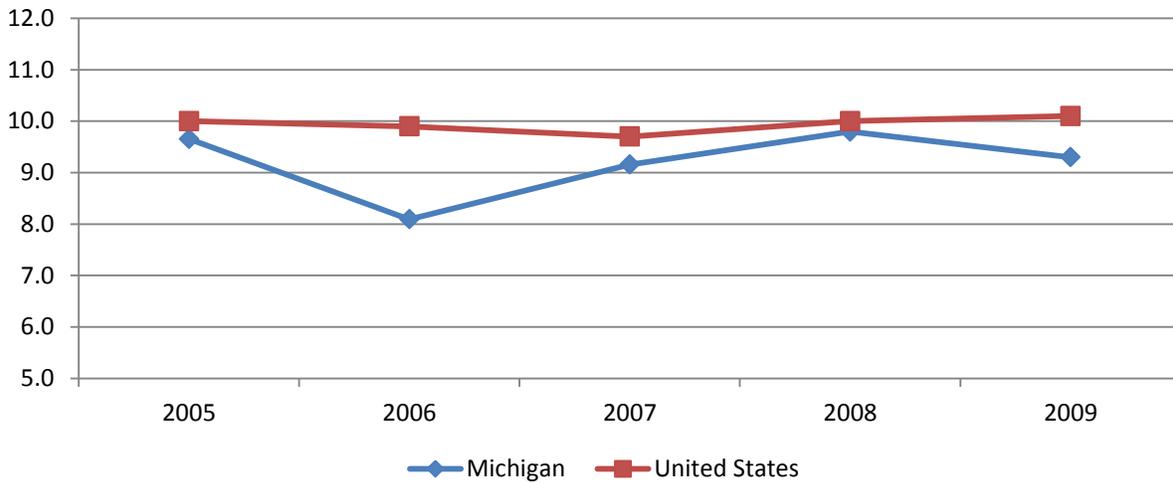


Figure 11, below, displays suicide rates per 100,000 residents between ages 15 and 24, trended between 2005 and 2009 for both the United States and Michigan. It shows that Michigan’s suicide rate among this age group has consistently trended below the United States as a whole and that there was a positive downward shift in 2009.

Figure 11. US & MI Suicides per 100,000 residents between ages 15 & 24, trended over time



It is difficult to evaluate suicides and suicidal ideation and behaviors due to two factors. First, it is difficult to obtain recent suicide data. Thus, the impact of current interventions may not be statistically noted for several years. The Michigan Department of Community Health has implemented the Michigan Violent Death Reporting System, which collects data about violent deaths that occur in the State of Michigan, including suicide. This system is new and the first year’s data (2010) may be released this year. This will be a significant step in facilitating the evaluation of the state suicide prevention plan and the impact local coalitions are having upon their communities. Second, while the MiPHY data suggests that

significantly more youth think about and develop suicide plans than actually attempt or die by suicide, similar data are not yet available regarding suicidal behaviors in adults. Through local coalitions, some communities in Michigan are working to address this issue through the implementation of surveillance systems, however, these systems are new and there are relatively few across the state (surveillance systems development will be discussed in greater detail later in this evaluation). *It is recommended that the Michigan Association for Suicide Prevention should, with the assistance of the Michigan Department of Community Health, continue to support the implementation of local surveillance systems across the state and promote the development of a process that facilitates the reporting of all surveillance data collected to a central data repository. It is further recommended that the Michigan Association for Suicide Prevention update the portion of this evaluation after the 2012 MiPHY data is released.*

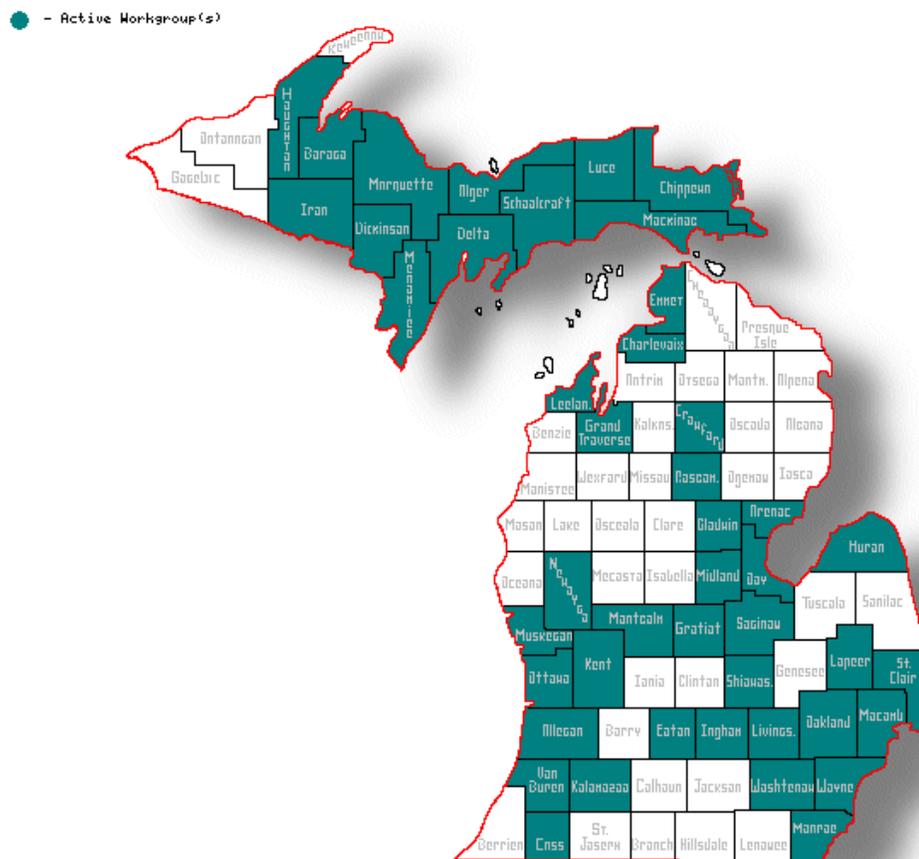
Goal #2: Develop broad-based support for suicide prevention.

According to the *State of the State Plan* document, “the state plan was developed with the knowledge that the State of Michigan would have little or no money to contribute toward the implementation of a broad-based state-level support for suicide prevention. However, plan developers felt very strongly that there needed to be strong leadership at the state level to effectively and efficiently coordinate the implementation effort.” Goal #2 in the state plan includes five objectives, one of which calls for the establishment of an Office of Suicide Prevention (OSP) within the Michigan Department of Community Health. Economic conditions within the state over recent years have prohibited the realization of this objective. As the *State of the State Plan* document identifies, however, there is an MDCH staff member who works predominantly within the area of suicide prevention. *It is recommended that the Suicide Prevention Plan for Michigan be revised to identify and plan for implementation of a sustainable method for state-level support of local suicide prevention efforts that is feasible based upon the current economic environment.*

While the OSP was not developed, the remaining four objectives under goal #2 focus on the support of local coalitions in Michigan communities. As noted earlier, this evaluation was based, in part, on survey responses from across the state. Several questions from that survey are used to measure the use of coalitions to lead the suicide prevention efforts. The first of those questions was, “does your community have a formal group working on suicide prevention activities?” Figure 12, below, displays the counties in Michigan that have at least one formal workgroup that is currently active. It shows that at least one suicide prevention workgroup is active in 45 out of the 83 Michigan counties (54.2%). Following the close of the survey the evaluation team learned of three additional counties that have active suicide prevention coalitions that did not complete the survey as requested. Thus, there are currently active suicide prevention workgroups in at least 48 of Michigan’s 83 counties (57.83%). It is noteworthy that all counties that include larger metropolitan areas in the state are known to have at least one suicide prevention workgroup with the exception of Genesee County (Flint) and Calhoun County (Battle Creek).

It is also interesting to note that 80% (12 of 15) of counties in the Upper Peninsula are known to have at least one active workgroup, while only 33% (11 of 33) of counties in the northern half of the Lower Peninsula are known to have active workgroups.

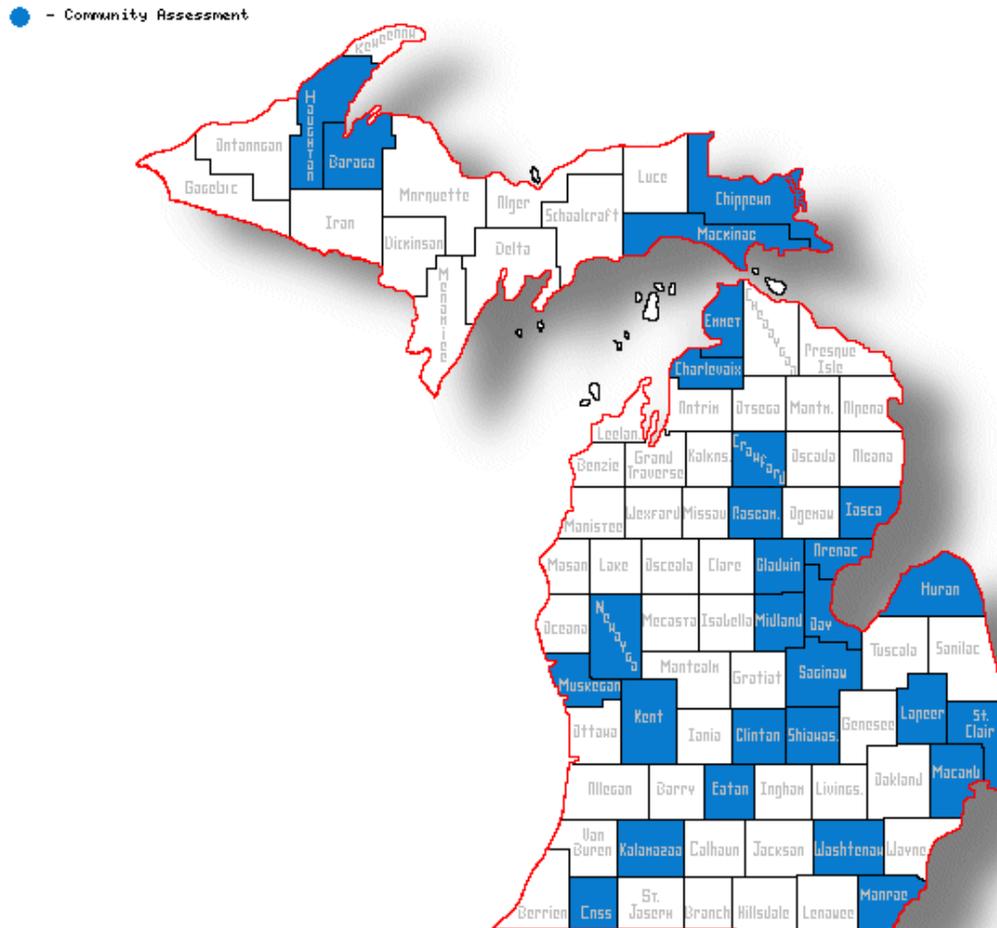
Figure 12. Michigan Counties with formal suicide prevention workgroups



With the exception of three, all respondents who indicated there was a suicide prevention workgroup within their county identified a broad coalition of community representatives including hospitals, substance abuse coordinating agencies and providers, Community Mental Health (and mental health services practitioners), schools (including Intermediate School Districts), law enforcement, human services agencies (including the Department of Human Services), universities and colleges, the National Guard, local Health Departments, women’s services providers, survivors of suicide, the faith community, Youth focused organizations, Tribal services, courts, the United Way, community businesses, media, Area Agencies on Aging, Veterans’ service providers, and bereavement support services. Respondents to the 2011 survey also indicated that community assessments have been completed in 28 counties (see Figure 13, right). Thus, of the 45 counties represented in the survey that currently have an active Suicide Prevention Coalition, 62.2% have completed a community assessment. Likewise, of the 40 counties

represented in the survey that have an active suicide prevention plan or a suicide prevention plan currently under development, 70% have completed a community assessment as a part of the development of that plan.

Figure 13. Counties where community assessments have been completed



Based upon coalition planning best practices, this information should be of concern to state and local stakeholders. While planning can be a time consuming and costly endeavor, especially for local coalitions with a hodge-podge of limited (and frequently focused) resources, a plan of action that is not based upon (and, therefore, likely does not address) assessed community needs and gaps will most likely prove ineffective in adequately addressing genuine issues within the community. Among the survey respondents, it is especially surprising that several indicated that they did not see a need for community assessment. Given that several community based organizations in every community that are likely to participate in suicide prevention planning routinely complete community assessment activities (including the United Way, Community Mental Health, Substance Abuse Coordinating Agencies, and

most Health Systems), much of the coalitions' work has already been completed and may require only some limited analysis. *It is recommended that the Michigan Association for Suicide Prevention 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 which includes establishment of baseline information, quantifies the problem, identifies gaps and evaluates plan effectiveness.*

The survey process through which the evaluation team collected data for this strategic plan evaluation revealed another area of weakness where the Michigan Association for Suicide Prevention can have a significant, positive impact. The survey process made clear that in many areas of the state the lack of information sharing is a barrier to addressing suicide prevention in an effective, coordinated manner. Several counties in the state were represented by several survey respondents. There were several instances where respondents from the same county would provide opposing answers. For example, one respondent in County X would indicate that there was an active suicide prevention plan in place, while another respondent from that same county would indicate that no plan existed. In several of these instances it was clear that the active suicide plan addressed a single system (e.g. a public school system) or population group. It appears that suicide prevention plans may not be publicized and/or coordinated as broadly within a county as they should be. Even when plans are developed to address only a portion of a county's geography and/or population, persons who are sufficiently involved within the suicide prevention system to be invited to respond to the evaluation survey should minimally have knowledge of that plan's existence. *It is recommended that the Michigan Association for Suicide Prevention provide technical assistance to groups that have implemented a suicide prevention plan to assist them in marketing their plans to community leaders and social service organizations to encourage understanding and assistance with its success.*

In order to measure objective 2.4 (The OSP, in collaboration with local planning efforts, will utilize broad-based public-private support to seek additional funds for suicide prevention), the evaluation survey asked the question, "What resources is your community currently using to support suicide prevention efforts?" Figure 14, below, displays the count and percent of valid responses from across the state. It shows that the highest percentage of resources used by local coalitions and workgroups is in the form of in-kind donations (predominantly agency staff time and printed materials). This is followed by grants from local agencies and state departments (12.3% respectively).

Figure 14. Resources	Count of Responses	Percent of Responses
Private Donations	3	4.6%
Community Agencies (CMH, CA)	8	12.3%
In-Kind Donations	22	33.8%
Community Businesses	1	1.5%
Local Grant Making Organizations (United Way, Community Foundations)	5	7.7%
Grants from State Departments (DHS, MDCH [Excluding Garrett Lee Smith])	8	12.3%

Figure 14. Resources	Count of Responses	Percent of Responses
Fundraising	5	7.7%
SAMSHA (Free Materials)	2	3.1%
Garrett Lee Smith Youth Suicide Prevention Grant	3	4.6%
Lifeline partnership	2	3.1%
Survivors' Support Groups	1	1.5%
Suicide Prevention Resource Center	1	1.5%
Suicide Prevention Fund	2	3.1%
Training Registration fees	1	1.5%
Local Schools and Universities	1	1.5%

Because of the way this question was asked (and respondents answered), it is difficult to evaluate what effect any potential reduction in state grant funding might have on coalitions' sustainability. The scope of resources identified suggests, however, that most local coalitions have broad local community support.

Goal #3: Promote awareness and reduce the stigma.

Six objectives were organized under goal #3 of the Suicide Prevention Plan for Michigan, all addressing various facets of promoting awareness among the general public and public policy makers about issues related to suicide prevention. Among these objectives was a state-wide "campaign promoting awareness that suicide is a preventable public health problem that reaches all citizens in Michigan." A media campaign was implemented during Mental Health Awareness Week in September 2007. The campaign was initiated to "help young adults learn what to do when confronted with suicidality – refer those in need to trained crisis intervention professionals."⁶ Figure 15, below, displays the reach of the ads aired. It shows that the paid radio spots and public service radio announcements (total = 5232) provided good (although time limited) coverage across most areas of the lower half of the lower peninsula. The radio spots were aired during the same week in September 2008.

Figure 15.

Market	Total Paid Spots	Total PSAs	Sponsor ships	Reach/ Frequency	Gross Rating Points	Net Impressions	Gross Impressions
Lansing	530	511	0	58.6%/11.0	761	43800	481800
Grand Rapids	438	320	0	67.3%/10.5	711.2	62200	653100
Kalamazoo	138	138	0	51.9%/11.7	713.4	19000	222300
Battle Creek	67	64	0	19.9%/14.4	327.3	3200	46080

⁶ Transforming Youth Suicide Prevention in Michigan – Campaign Evaluation.

Market	Total Paid Spots	Total PSAs	Sponsorships	Reach/Frequency	Gross Rating Points	Net Impressions	Gross Impressions
Berrien County	80	80	0				
Detroit	428	155	41	51.6%/8.0	533.4	278800	22300400
Ann Arbor	44	30	0	12.0%/4.3	75.6	8700	37410
Flint	361	327	0	60.4%/10.3	750.3	31200	321360
Saginaw	262	234	0	58.7%/9.3	670.9	28500	265050
Northern Michigan	589	436	0	36%/18.5	894.4	9800	181300
Total	2937	2295	41		5437.5	485200	24508800

Although this media campaign was time limited and did not have the geographic reach apparently envisioned in the strategic plan, the goal was, in part, to advertise a crisis intervention hotline. Figure 16, displays the total number of calls to the crisis intervention hotline, the National Suicide Prevention Lifeline, per 1,000 Michigan residents. It shows significant growth in the number of calls from Michigan residents between 2006 and 2008, with continued annual increases through 2010. While there cannot be a direct correlation drawn between the media campaign and the growth in the use of Lifeline around the state, along with the promotion efforts of local coalitions, the goal to increase public awareness of the crisis intervention hotline among Michigan residents was clearly achieved.

Figure 16. Lifeline Calls per 1,000 residents in Michigan, trended over time

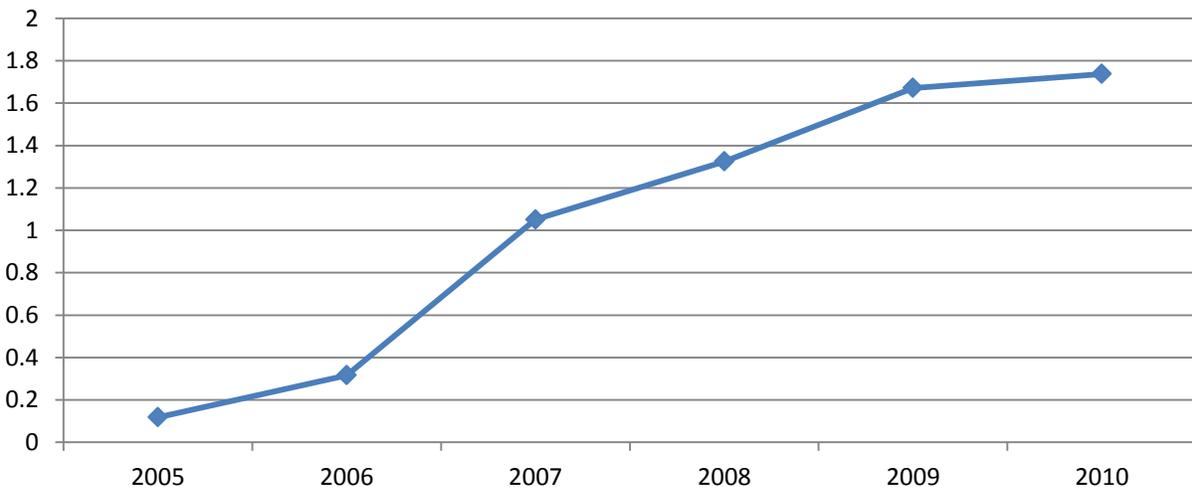
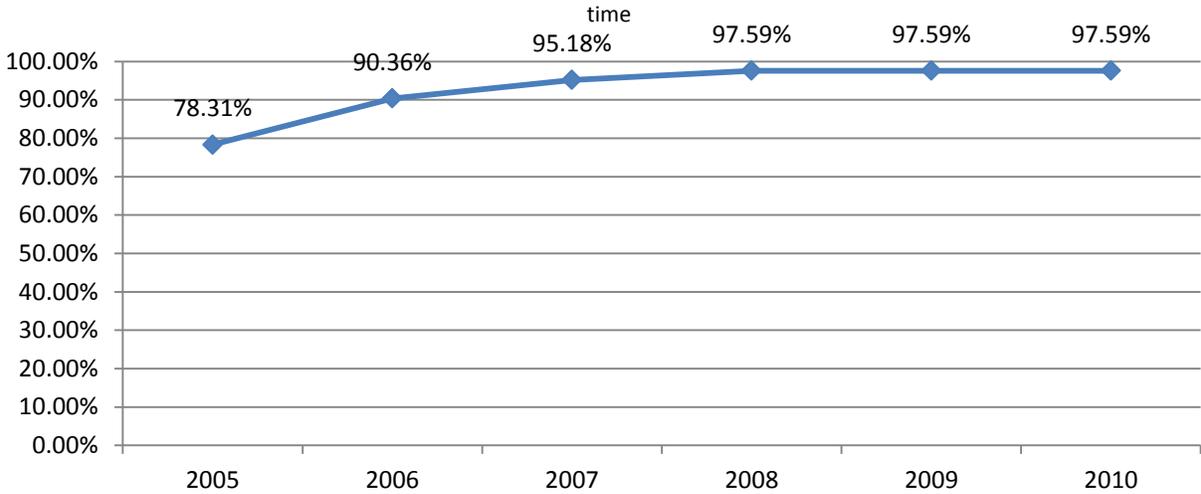


Figure 17 displays the percent of Michigan counties from which at least one Lifeline call was originated by year since 2005. It shows the same positive increase between 2006 and 2008 that was noted above. By 2008, at least one lifeline call was generated from nearly 98% of Michigan counties. (See Attachment C for Lifeline call data by Michigan County.)

Figure 17. Percent of Michigan Counties where at least one Lifeline call originated, trended over



Figures 18 and 19, below, display Lifeline call data on calls from Michigan veterans, trended over time. Like calls from Michigan residents in general, calls from veterans have increased significantly since July 2007. Figure 19 shows that more than 20% of Lifeline calls from Michigan were from veterans during 2011.

Figure 18. Lifeline Calls from Veterans

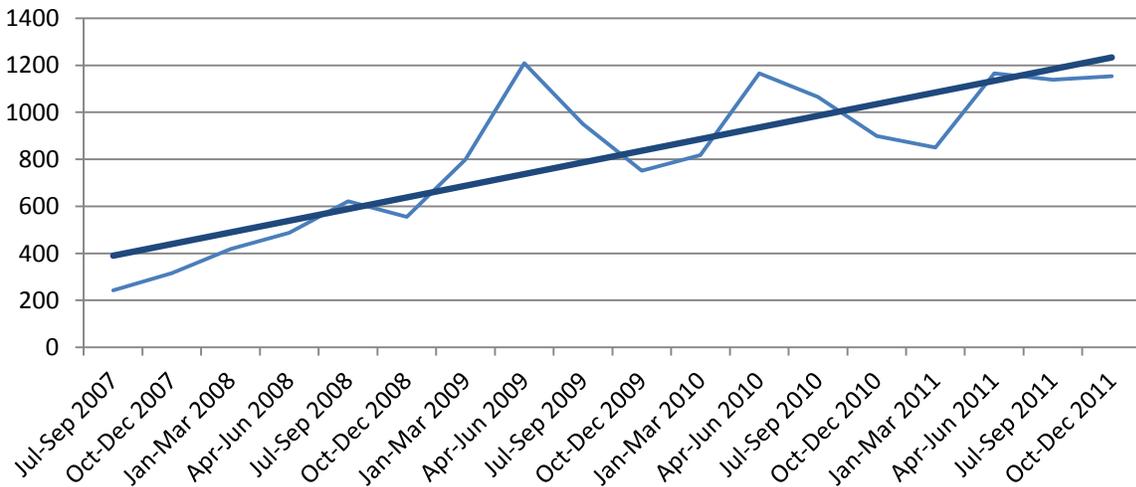
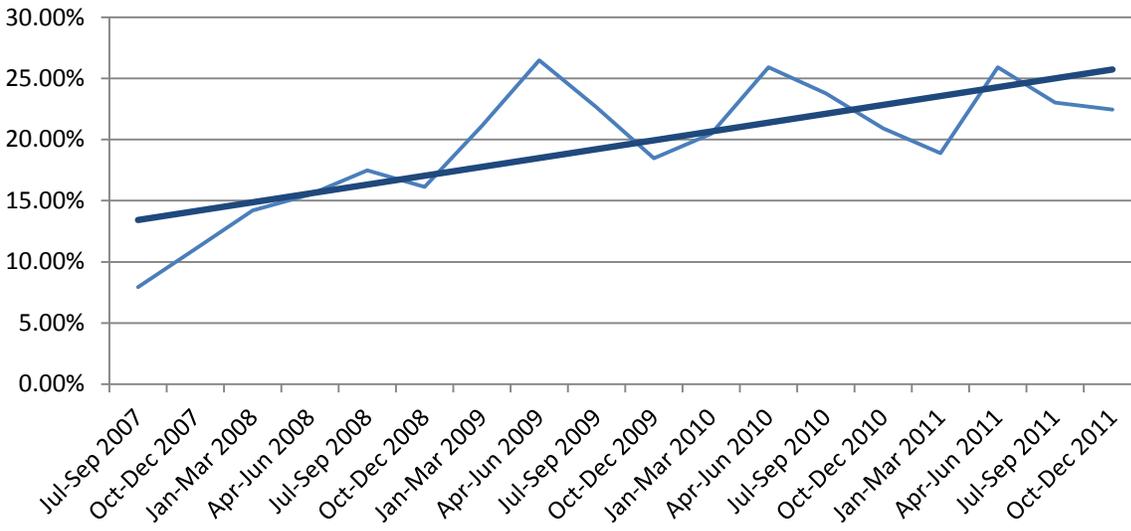


Figure 19. Percent of Michigan Lifeline calls that are from Veterans



These data suggest that Veterans may be an emerging area of focus for local suicide prevention coalitions. *It is recommended that the Suicide Prevention Plan for Michigan be revised to include a focus on soldiers returning from active combat as well as veterans in general.*

As a part of the evaluation survey, respondents were asked, “what, if any, public awareness activities related to suicide prevention have been conducted in your community in the last 12 months?” Figure 20, below, displays an analysis of the answers to that question based upon the current status of coalitions’ Suicide Prevention Plans. Two points are noteworthy based upon this information. First, the largest percentage of public awareness activities among respondents was through the use of individual speakers (22.7% of all activities reported), followed by newspaper articles (21.1%) and suicide prevention week activities (12.4%). More passive public awareness activities, such as distribution of brochures, and purchase of billboard space were reported less often than these more active and time intensive methods.

Figure 20.

	Active Plan	Inactive Plan	Plan Under Development	Plan Not Stated	Status of Plan Not Indicated	Totals	Percent of Activities
Count of Respondents	33	3	13	12	9	70	
Public service announcements on TV and/or radio	11	1	0	2	2	16	8.6%
Billboards	5	0	3	0	0	8	4.3%
Newspaper Articles	22	1	9	3	4	39	21.1%
Individual Speaker(s)	27	2	7	5	1	42	22.7%
Suicide Prevention Week activities	16	2	3	2	0	23	12.4%
Suicide Prevention Conference/Symposium	9	1	6	1	0	17	9.2%

	Active Plan	Inactive Plan	Plan Under Development	Plan Not Stated	Status of Plan Not Indicated	Totals	Percent of Activities
Provide education for local elected officials (and/or other policy makers) on the impact of suicide, mental illness and substance abuse	13	1	2	2	1	19	10.3%
Distributed brochures or information handouts	5	0	1	0	0	6	3.2%
Training Events	4	0	3	1	0	8	4.3%
Awareness Events	3	1	1	1	0	6	3.2%
Email & other forms of communication	0	0	0	0	1	1	0.5%
Average Count of Promotional Activities	3.5	3.0	2.7	1.4	1.0	2.6	

Second, the focus provided by a Suicide Prevention Plan is clearly noted. Coalitions that have an active Suicide Prevention Plan engage in public awareness activities nearly three times more often than coalitions that do not have a plan. Even coalitions that are in the process of developing their Suicide Prevention Plan or had a plan previously engage in public awareness activities twice as often as coalitions that have not begun plan development.

Goal #4: Develop and implement community-based suicide prevention programs

Goal #6: Improve the recognition of and response to high risk individuals within communities.

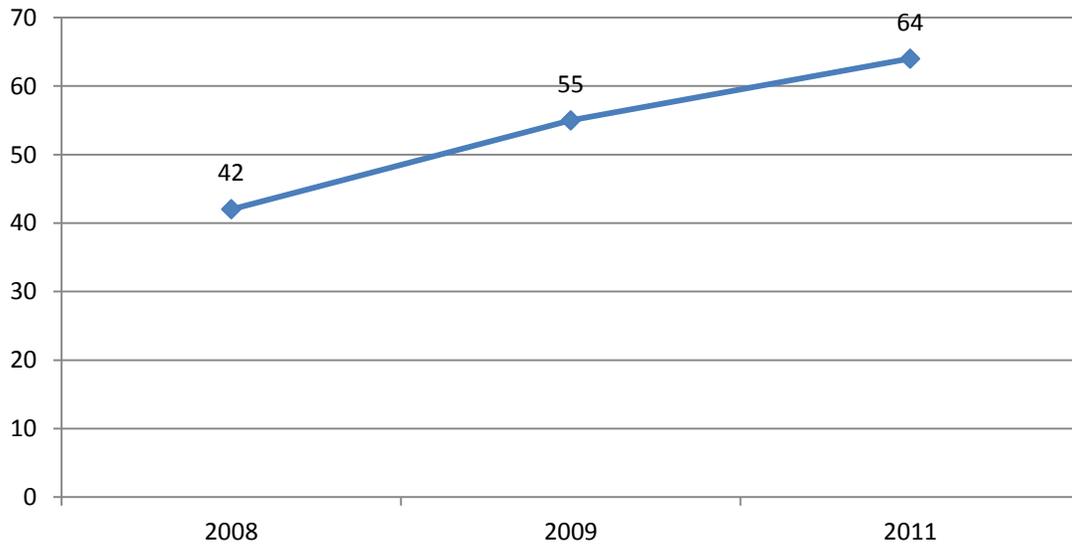
Goal #7: Expand and encourage utilization of evidence-based approaches to treatment.

Goal #10: Support and promote research on suicide and suicide prevention.

This section of the evaluation addresses three goals in the Suicide Prevention Plan for Michigan. Five objectives are organized under goal #4 of the plan. These objectives address methods for supporting the expansion and strengthening of suicide prevention activity in communities across the state. Primary among the activities the plan seeks to expand are early intervention strategies for children, services to survivors of suicide, development of state policies that support schools in implementing and expanding suicide prevention policies and programs, and collaboration of school health partnerships. Goal #6 includes six objectives, addressing identification of and increasing the number of gatekeepers, capacity assessment, suicide risk screening in primary care settings, suicide prevention policies development and suicide prevention training for community mental health direct service personnel. Goal #7 includes three objectives addressing the identification and distribution of evidenced based approaches to treatment. Goal #10 includes four objectives addressing supporting use of the National Suicide

Figure 22, below, displays the growth in suicide prevention activity across the three survey administrations. It shows that over the three year period between 2008 and 2011 the percent of counties known to have suicide prevention activities increased from 50.6% in 2008 to 77.1% in 2011.

Figure 22. Count of Counties With Suicide Prevention Activity



To gain a deeper understanding of the types of suicide prevention activities occurring across the state, survey respondents were asked the question “*what services does your community have available specifically for survivors of suicide?*” Survey respondents of 36 out of 54 counties (66.7%) represented in the cohort identified at least one service available in their county for survivors of suicide. Figures 23 and 24, below, display responses to that question.

Figure 23 Answer Key Description:

- Support Groups Only* – the only service identified by the respondent was support groups
- Sup Groups/Outreach* – respondent identified support groups as well as Individual and Group Outreach programs (such as CISM)
- Sup Groups/Emerg Rsp* – respondent identified support groups as well as individuals/groups going with police when responding to potential suicide
- Emergency Response* – Individual/groups going with police when responding to potential suicide
- Sup Groups/Resp Plan* – respondent identified support groups as well as a school district response plans
- Outreach/Emerg Rsp* – respondent identified individual and group outreach programs (such as CISM) as well as individuals/groups going with police when responding to potential suicide

Services Available to Survivors of Suicide

Figure 23.

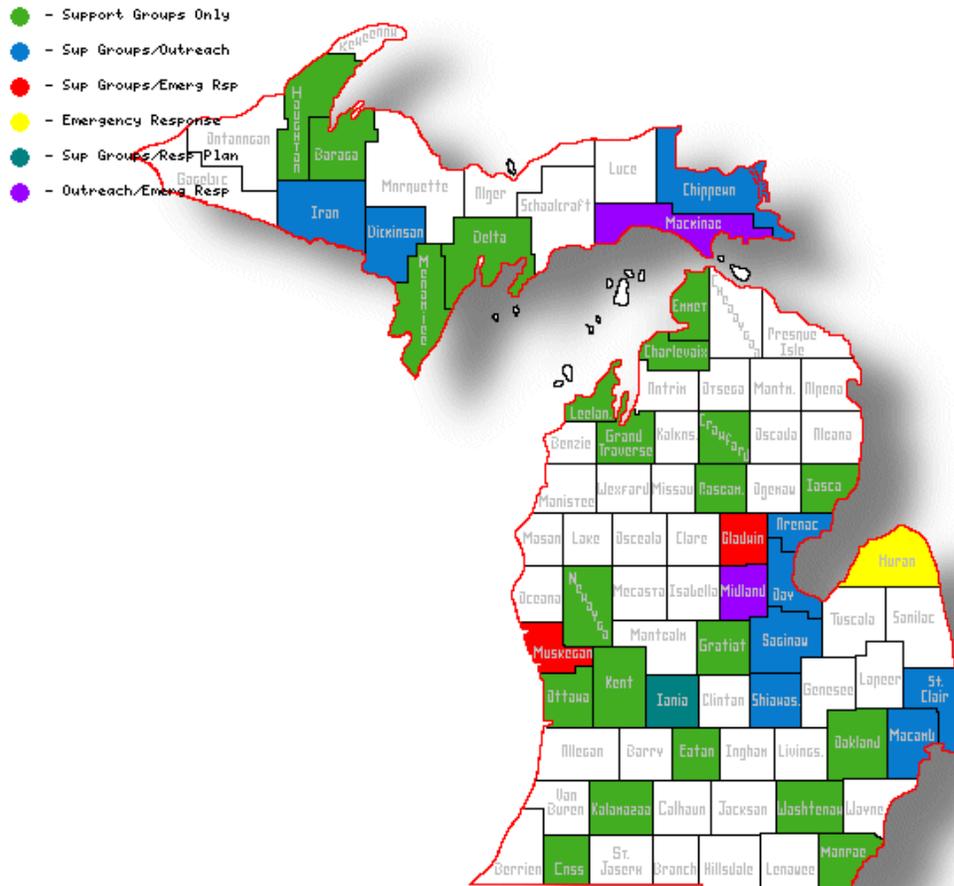
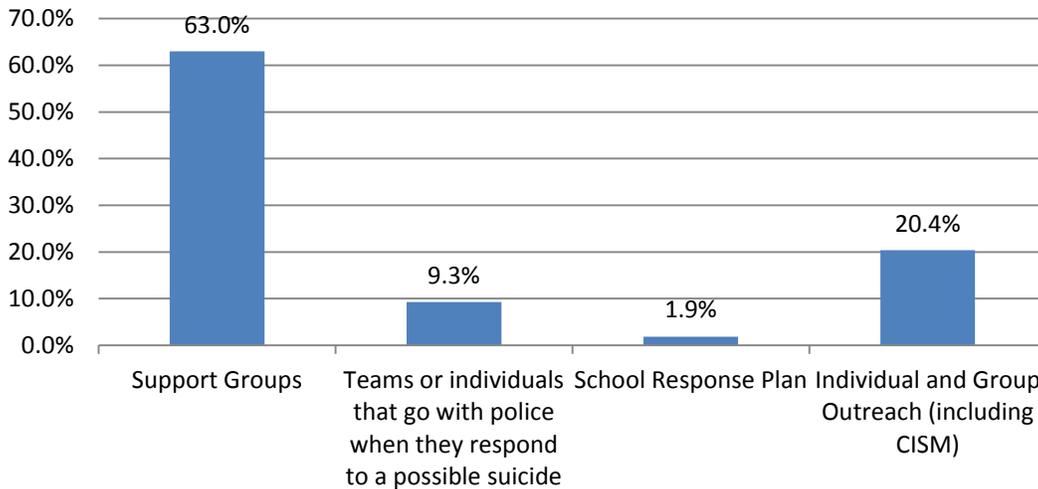


Figure 24. Percent of Counties with Survivor Services, by type



Sixty-three percent of counties represented by a survey respondent reported that support groups were available within their county. The second most common service to survivors of suicide identified was individual or group outreach programs such as CISM (Critical Incident Stress Management).

As a part of the suicide prevention coalition survey, respondents were asked to indicate the number of persons served in the past twelve months using evidence-based practices. Evidence-based practices were taken from the registry published by the Suicide Prevention Resource Center.⁷ This registry is an online resource that fulfills the intent of objective 7.1. Figure 25, below, displays the best practices that have been implemented around the state (among counties represented by respondents), including the name of the best practice, an estimate of the number of persons trained or materials distributed, and the number (and percent) of counties where the best practice is being implemented. These data should be used with caution. The counts of persons trained/materials distributed are presented as estimates for several reasons. First, because multiple survey respondents may have represented the same coalition, some counts may be duplicates. The evaluation team was careful to evaluate and clean duplication from the data set and it occurs minimally, if at all. However, it is important to note that duplication may still exist. Second, most respondents reported “ballpark” figures rather than actual counts of persons trained/materials distributed. Third, the survey did not proscribe a methodology for counting persons and materials and, therefore, it is likely that the various respondents used different methods to establish the counts reported. For example, it is possible with reporting materials distributed to schools that some respondents reported the number of students that received the materials while other respondents reported the number of schools. Therefore, this information is best used to, first, evaluate the breadth of best practices being implemented across the State of Michigan and, second, to evaluate those best practices which are most commonly being implemented. Finally, it should be noted that the counts reported by survey respondents are not representative of all suicide prevention activities which have occurred in the state over the last twelve months. For example, according to statistics reported by the Suicide Prevention Resource Center, 417 persons received Assessing and Managing Suicide Risk: Core Competencies (AMSR) training in Michigan in the twelve month period for which the survey requested data. Survey respondents identified a total of 254 persons trained.⁸

Based upon this analysis, nearly forty-three percent of counties represented among survey respondents have used the ASIST program in the last twelve months, with an estimated count of 629 persons receiving the training. While used in just under fifteen percent (14.8%) of counties reporting, the Ask 4 Help program has been received by more than twelve thousand persons in eight counties.

⁷ www.sprc.org/bpr

⁸ According to the Suicide Prevention Resource Center, 1733 persons have received AMSR Training in Michigan between September 30, 2008 and July 23, 2012. Likewise, 144 ASIST workshops have occurred since 2004, having reached 3024 persons in Michigan.

Figure 25. Evidence-Based Practice	Estimate Number of Persons Receiving/ Materials Distributed in most recent 12 months	Number of Counties Reporting Use/Distribution in most recent 12 months	% of Michigan Counties
After a Suicide: A Toolkit for Schools	113	14	25.9%
After an Attempt: A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt Survivors	383	10	18.5%
After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department	460	11	20.4%
After an Attempt: A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department	445	10	18.5%
American Indian Life Skills Development/ Zuni Life Skills Development	23	9	16.7%
Applied Suicide Intervention Skills Training (ASIST)	629	23	42.6%
Ask 4 Help Suicide Prevention for Youth	12,214	8	14.8%
Assessing and Managing Suicide Risk: Core Competencies (AMSR)	254	10	18.5%
At-Risk for High School Educators	70	4	7.4%
At-Risk for University and College Faculty: Identifying and Referring Students in Mental Distress	28	1	1.9%
At-Risk for University and College Students	250	4	7.4%
Be A Link Suicide Prevention Gatekeeper Training	430	4	7.4%
Gryphon Place Gatekeeper Suicide Prevention Program-A Middle School Curriculum	2393	1	1.9%
High School Gatekeeper Curriculum	2560	2	3.7%
How Not To Keep A Secret	*	1	1.9%
Late Life Suicide Prevention Toolkit	24	1	1.9%
LifeSavers Training	80	1	1.9%
More Than Sad: Suicide Prevention Education for Teachers and Other School Personnel	32	2	3.7%
More Than Sad: Teen Depression	247*	5	9.3%
Preventing Transgender Suicide: An Introduction for Providers	90	1	1.9%
QPRT Suicide Risk Assessment and Management Training	12	1	1.9%

Figure 25. Evidence-Based Practice	Estimate Number of Persons Receiving/ Materials Distributed in most recent 12 months	Number of Counties Reporting Use/Distribution in most recent 12 months	% of Michigan Counties
Question, Persuade, Refer (QPR) Gatekeeper Training for Suicide Prevention	1207	8	14.8%
School Suicide Prevention Accreditation	8	2	3.7%
SOS: Signs of Suicide	324	9	16.7%
SOS Signs of Suicide Middle School Program	47	4	7.4%
Suicide Alertness for Everyone (safeTALK)	375*	7	13.0%
Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)	50	1	1.9%
Supporting Survivors of Suicide Loss: A Guide for Funeral Directors	42	4	7.4%
What Is Depression? How to Treat It and What to Do--A Suicide Prevention Guide for Young People	*	1	1.9%
Working Minds: Suicide Prevention in the Workplace	*	2	3.7%
Youth Suicide Prevention School-based Guide Checklists	39	1	1.9%
Youth Suicide Prevention, Intervention, and Postvention Guidelines: A Resource for School Personnel	39	1	1.9%

**Indicates that one or more respondent did not indicate a number but wrote the word “many” or some other non-quantifiable indicator.*

Utilizing these data helps to evaluate progress under plan goal #6: Improve the recognition of and response to high risk individuals within communities. Based on the counts reported through this survey process, 6590 persons received training to be gatekeepers during the past twelve months. The Question, Persuade, Refer (QPR) gatekeeper training program was the curriculum reported as being used most broadly across the state (1207 persons trained in eight counties). However, the highest number of gatekeepers was trained using the Gryphon Place Gatekeeper curriculum (4953 persons trained in two counties). While this information cannot be extrapolated across the six year life of the Suicide Prevention Plan, it can provide a one year snap-shot.

While not an exhaustive list, figure 26, below, displays additional activities that respondents reported that were not included on the best practices list.

Figure 26. Other Programs Implemented (not included on best practices list)	Estimate Number of Persons Receiving/ Materials Distributed in most recent 12 months	Number of Counties Reporting Use/ Distribution in most recent 12 months	% of Michigan Counties
Survivor Support Group		4	7.4%
Minds Program	60	1	1.9%
Suicide Awareness Presentations		3	5.6%
Yellow Ribbon Clubs/Campaigns	800*	6	11.1%
Military Family Support Outreach		1	1.9%
Educational programs/forums	1000	8	14.8%
Out of Darkness/Suicide Awareness Walk	1200	2	3.7%
TeenScreen	60	2	3.7%
Means Restriction Education	4	1	1.9%
Local Outreach to Suicide Survivors (LOSS)	6	1	1.9%
Suicide Prevention Among LGBT Youth: A Workshop for Professional Who Serve Youth	90	1	1.9%

**Indicates that one or more respondent did not indicate a number but wrote the word “many” or some other non-quantifiable indicator.*

Goal #5: Promote efforts to reduce access to lethal means and methods of suicide.

Two objectives are organized under goal #5 of the Suicide Prevention Plan for Michigan. These objectives address primary and other healthcare providers routinely assessing the presence of lethal means and exposing households across the state to public information campaigns designed to reduce accessibility of lethal means. Evaluation survey respondents were asked the question, “*what, if anything, has your community done to reduce access by suicidal individuals to lethal means?*” Respondents representing thirty-five counties (64.8% of counties represented among survey respondents) indicated that they were engaging in at least one activity to reduce access to lethal means of suicide. Figure 27, right, displays the distribution of counties across the state where these activities are taking place. Among the thirty-five counties reporting activities to reduce access to lethal means, sixty percent (N=21) reported engaging in two or more activities.

Figure 27. Counties addressing access to lethal means

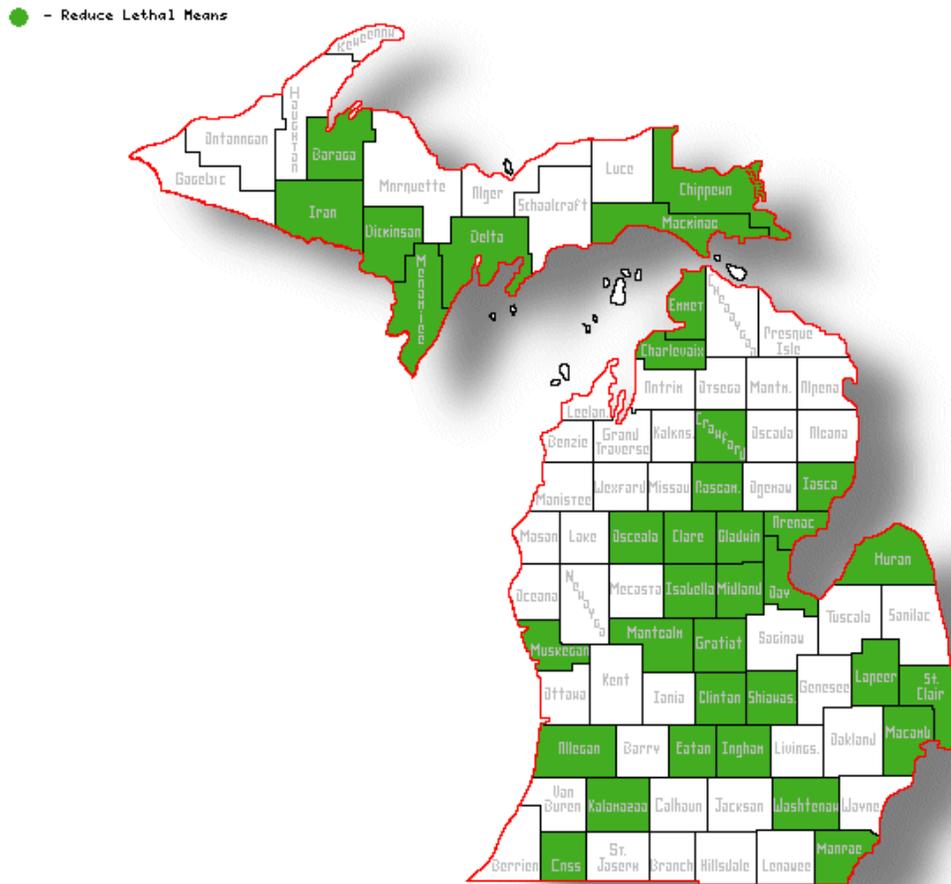
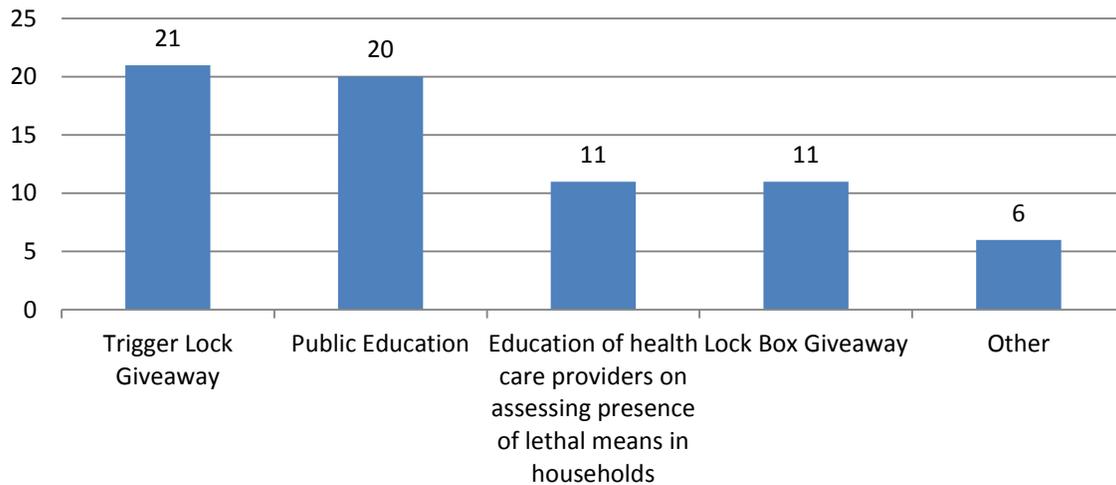


Figure 28, below, shows the number of counties where activities are taking place, by activity type. It shows that the most common activities are trigger lock giveaway programs and public education campaigns. Respondents from six counties identified activities other than those specifically identified on the survey. Respondents from two of those counties identified linking their efforts to limit access to lethal means to efforts to reduce access to prescription medications. Respondents representing four counties identified planning to address access to lethal means as the activity they have engaged in to date.

Figure 28. Count of Counties Acting to Reduce Access to Lethal Means, by activity



Goal #8: Improve access to and community linkages with mental health and substance abuse services.

Goal #8 includes three objectives addressing linkages with mental health and substance abuse services. Those objectives address the identification and dissemination of model programs that address co-occurring disorders, mental health and substance abuse treatment parity, and increasing the number of communities promoting the awareness and utilization of 24-hour crisis intervention services. Related to increasing utilization of 24-hour crisis intervention services, the plan established annual, cumulative goal increases that established the goal of a sixty percent increase over the baseline number of communities where 24-hour crisis intervention services are promoted and utilized. As was discussed earlier in this evaluation document, at least one call to the Lifeline crisis hotline was made in 2010 from nearly ninety-nine percent (98.8%) of Michigan counties. No calls originated from just one county (Keweenaw). In addition to the state wide promotion of the Lifeline crisis hotline, several coalitions promote locally based crisis intervention hotline programs. Call volume to the various local hotline programs was not included as a part of this evaluation; thus Lifeline call data is not indicative of all crisis line calls made in the state.

Evaluation survey respondents were asked the question, “Do people living in your community have access to 24-hour crisis intervention services?” Of the sixty-eight respondents that answered that question, more than eighty-eight percent (88.2%, N=60) responded in the affirmative. Seven of the counties represented by respondents answering this question “no” or “I don’t know” were identified by other respondents as having 24-hour crisis intervention services and all of them are counties where Lifeline calls originated in 2010. Thus, while the baseline does not appear to have been established when the Suicide Prevention Plan for Michigan was written, this plan objective has clearly been met.

Although the objective was met, this analysis as well as 2010 Lifeline data suggests that there is still work to be done in this area. First, as has been noted earlier in this evaluation, respondents from the same counties are not always aware of the activities of their coalition or other coalitions operating within that county. Perhaps more importantly, however, twelve counties originated less than ten calls to Lifeline in 2010, which may suggest the need for additional public awareness activities. Several of these counties are sparsely populated and the number of calls per 1,000 residents is within the average range for Michigan as a whole. Figure 29, below, shows the counties where less than ten calls to Lifeline were originated in 2010 and the number of calls per 1,000 residents is well below the average for Michigan as a whole. Two items are noteworthy here. First, just two of these counties have an active Suicide Prevention Coalition or workgroup; three more had a Suicide Prevention Coalition or workgroup that is now inactive. Second, all of the counties identified in Figure 29 are rural, relatively sparsely populated counties. *It is recommended that the Michigan Association for Suicide Prevention market or support local or state-level marketing efforts of the Lifeline system to rural areas of the state.*

Figure 29.

County	Population	Lifeline Calls 2010	Lifeline Calls per 1,000 residents 2010
Arenac	15899	6	0.377
Keweenaw	2156	0	0.000
Leelanau	21708	1	0.046
Missaukee	14849	4	0.269
Montmorency	9765	2	0.205
Oceana	26570	7	0.263
Oscoda	8640	2	0.231

Goal #9: Improve and expand surveillance systems.

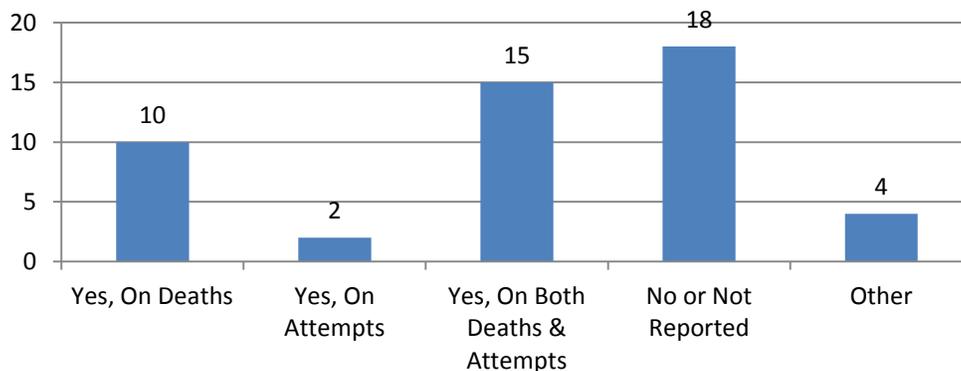
Four objectives are organized under goal #9. These objectives address annual reporting regarding suicides and suicide attempts by the Michigan Department of Community Health, standardized protocols for death scene investigations, surveillance of youth risk behavior, and use of surveillance data in future planning efforts.

The Michigan Department of Community Health has implemented the statewide collection of data regarding violent deaths, including suicides. The Michigan Violent Death Reporting System has reportedly collected a full dataset for 2010. *It is recommended that these data be published in a timely manner and technical assistance provided to local coalitions regarding its interpretation and use at the local level.*

Figure 30, below, displays an analysis of 2011 evaluation survey responses to the question asking whether local coalitions are collecting surveillance data. It shows that at least one respondent from

more than fifty-five percent (55.1%) of local coalitions indicated that their workgroup was collecting surveillance data regarding suicides, attempts, or both. Again, it is interesting to note that respondents from within the same counties did not always answer the same way. This may indicate one of two issues. First, surveillance data collected may not be shared as broadly as it should be and, thus, some members of a coalition may not be aware that surveillance data is being collected. Second, in counties where more than one coalition may be active, surveillance efforts might not be shared between coalitions. This may cause duplication of efforts and may limit the efficacy of both coalitions' efforts.

Figure 30. Coalitions' Local Surveillance Data Collection



Between January 1, 2008 and December 31, 2009 the Center for Disease Control and Prevention conducted a study of *Suicidal Thoughts and Behaviors Among Adults Aged >+18 Years*⁹. This study surveyed a representative sample of the civilian, non-institutionalized U.S. population aged 12 and older. Figure 31, below, displays the results of that study for the United States in general and Michigan specifically (N=118). It shows that, among survey respondents, the percent of Michigan residents that thought about, planned, and/or attempted suicide during the study period was greater than the percent of U.S. residents that thought about, planned and/or attempted suicide. However, the sample gathered in Michigan is small and cannot be considered representative of Michigan.

Figure 31.

Thought	Total	Male	Female	White, Non-Hispanic	Black, non-Hispanic	Hispanic	Asian, non-Hispanic
U.S.	3.7%	3.5%	3.9%	3.9%	3.5%	3.0%	2.1%
MI	4.4%	4.3%	4.6%	4.8%	3.0%	2.5%	3.8%

⁹ Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, Vol. 60, No. 13. October 21, 2011.

<i>Plan</i>	Total	Male	Female	White, Non-Hispanic	Black, non-Hispanic	Hispanic	Asian, non-Hispanic
U.S.	1.0%	1.0%	1.0%	1.0%	1.0%	0.9%	0.4%
MI	1.6%	1.4%	1.7%	1.6%	1.5%	0.7%	--
<i>Attempt</i>	Total	Male	Female	White, Non-Hispanic	Black, non-Hispanic	Hispanic	Asian, non-Hispanic
U.S.	0.5%	0.4%	0.5%	0.4%	0.7%	0.5%	0.2%
MI	0.8%	0.9%	0.7%	0.8%	1.0%	0.5%	0.3%

Recommendation: While the MiPHY survey collects self-reported data from Middle and High School students regarding suicide ideation and attempts, this system is limited by its voluntary nature. The breadth of administration allows a snapshot at the state level, but due to the fact that it is not a randomized sample, it cannot be interpreted as representative of Michigan youth in general. In addition, there is no system to collect information about suicidal ideation or attempts among Michigan adults. As the county survey data reported above shows, several suicide prevention coalitions across the state are collecting data regarding attempts, but methods vary from coalition to coalition (based on local design) and are not broad enough to provide state-level information. MASP should work with local coalitions and the MDCH to establish a standardized data collection methodology that coalitions may utilize as a first step to gathering ideation and attempt data.

Additional Considerations: The Suicide Prevention Plan for Michigan does an excellent job identifying and constructing a framework for organizing the state’s priorities when addressing suicide prevention efforts. It provides initial, supporting data and presents an excellent argument for why suicide prevention is important. Additionally, real or potential data sources are identified under each objective throughout the plan for future measurement of success. The plan, however, has some limitations that, if addressed, may produce greater results. First, while goals and objectives are clearly stated, they are not supported by specific, measurable action steps that will produce the desired results. For example, objective 1.1 states, “*reduce the number of suicide attempts among Michigan youth, a population for which we have baseline data.*” In order for the plan to effectively lead prevention efforts for Michigan youth, it should provide methods to be employed to achieve the desired reduction. Further, it would be beneficial for the baseline data mentioned in the objective to be specifically stated. Second, while data sources are suggested under each objective, the Michigan Association for Suicide Prevention would have served itself well to periodically obtain data updates from those sources or, when the potential sources proved fruitless or non-existent, seek alternative data sources that could be used to measure progress. When action plans are written in a measurable manner, data collection can generally occur with little effort and cost, enabling ongoing measurement to occur. Third, *it is recommended that the Michigan Association for Suicide Prevention develop a revised plan, addressing the limitations noted above as well as revising the direction of several goals that have not been addressed in the manner intended.*

Conclusion: The Suicide Prevention Plan for Michigan was implemented six years ago and has provided a framework for local and state suicide prevention efforts. Each of the areas measured as a part of this evaluation has demonstrated positive results, although it is difficult to draw a direct correlation between the plan and the results. Local suicide prevention activity has expanded across the state, with most metropolitan areas in the state and many rural areas covered by a suicide prevention plan, and some communities have more than one plan (addressing specific populations such as youth, school districts, and Tribal entities). There is some concern that coalitions that have implemented plans and have been successful in addressing suicide prevention issues in the communities they were designed to serve are no longer active, predominantly due to funding issues. *It is recommended that the Michigan Association for Suicide Prevention support local coalitions with methods for post-grant funding sustainability planning that begins in the first year of grant funding and builds throughout the life of the grant.* Additionally, efficiencies could be realized, and efforts better sustained if coalitions with plans addressing populations within the same county—or even in neighboring counties—were to share resources and build upon one another’s strengths.

Appendix A: County-level MiPHY data 2007

County	Population	2007: MS # MiPHY Respondents	2007: HS # MiPHY Respondents	2007: Percent of MS students who ever seriously considered attempting suicide	2007: Percent of MS students who ever made a plan about how they would attempt suicide	2007: Percent of MS students who ever tried to kill themselves	2007: Percent of HS students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	2007: Percent of HS students who seriously considered attempting suicide during the past 12 months	2007: HS % of students who made a plan about how they would attempt suicide during the past 12 months	2007: HS % of students who actually attempted suicide one or more times during the past 12 months	2007: HS % of students whose suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse during the past 12 months.
Antrim	23580	181	279	22.30%	12.60%	8.20%	31.40%	17.70%	17.00%	9.40%	3.00%
Arenac	15899		359	-	-	-	30.10%	17.90%	16.30%	16.20%	6.90%
Baraga	8860	92	194	20.70%	7.60%	2.20%	28.40%	16.20%	16.20%	8.10%	1.40%
Bay	107771	867	1491	36.70%	13.30%	17.20%	40.00%	30.00%	10.00%	20.80%	23.30%
Berrien	156813	124	230	25.00%	16.70%	6.00%	33.00%	20.20%	15.60%	9.10%	4.20%
Branch	45248										
Calhoun	136146	408	774	22.50%	13.90%	7.90%	27.20%	14.10%	11.30%	9.50%	3.60%
Cass	52293										
Charlevoix	25949	183	215	17.10%	14.30%	6.90%	22.50%	14.70%	11.40%	8.40%	3.80%
Cheboygan	26152	0	162				31.00%	14.70%	17.10%	8.60%	0.70%
Clinton	75382	709	672	17.00%	11.90%	5.40%	28.40%	14.60%	13.00%	12.10%	5.10%
Eaton	107759	927	1155	22.20%	14.50%	6.90%	28.90%	14.30%	13.40%	8.50%	14.10%
Gogebic	16427	124	291	15.90%	6.20%	1.80%	30.50%	16.10%	13.60%	7.60%	3.20%
Grand Traverse	86986	125	224	26.40%	14.10%	8.80%	30.40%	15.70%	13.40%	10.30%	2.60%
Gratiot	42476	52	0	38.50%	21.20%	7.70%					
Hillsdale	46688	203	483	27.70%	16.10%	9.10%	25.40%	12.00%	12.60%	8.30%	4.40%
Houghton	36628		535				16.00%	4.00%	4.00%	4.50%	0.00%
Huron	33118	329	680	16.80%	9.20%	5.30%	23.90%	12.10%	10.40%	6.70%	2.50%
Ingham	280895	561	699	17.70%	11.50%	5.80%	32.30%	15.60%	15.50%	9.60%	2.20%
Iosco	25887	384	667	29.80%	18.50%	13.70%	29.70%	15.40%	16.70%	10.50%	3.30%
Isabella	70311		205				26.10%	13.40%	9.90%	6.60%	2.50%
Jackson	160248	1612	2864	24.80%	14.90%	9.00%	31.70%	16.80%	15.10%	10.60%	3.70%

County	Population	2007: MS # MIPHY Respondents	2007: HS # MIPHY Respondents	2007: Percent of MS students who ever seriously considered attempting suicide	2007: Percent of MS students who ever made a plan about how they would attempt suicide	2007: Percent of MS students who ever tried to kill themselves	2007: Percent of HS students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	2007: Percent of HS students who seriously considered attempting suicide during the past 12 months	2007: HS % of students who made a plan about how they would attempt suicide during the past 12 months	2007: HS % of students who actually attempted suicide one or more times during the past 12 months	2007: HS % of students whose suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse during the past 12 months.
Kalkaska	17153		208				30.50%	16.70%	13.40%	10.30%	2.00%
Kent	602622	669	1433	17.90%	10.50%	5.50%	28.10%	14.10%	11.20%	8.90%	4.40%
Leelanau	21708		185				24.50%	14.40%	10.80%	13.70%	4.40%
Macomb	840978	2599	3882	19.50%	13.30%	6.90%	28.50%	13.60%	13.10%	10.30%	4.30%
Midland	83629		951				27.60%	13.70%	14.10%	8.00%	3.10%
Montcalm	63342	380	1511	23.40%	15.50%	11.30%	29.60%	14.20%	12.70%	7.70%	2.70%
Muskegon	172188	445	1090	17.20%	6.90%	4.80%	26.40%	15.40%	12.40%	7.90%	2.90%
Oakland	1202362	3533	6156	19.60%	10.40%	5.30%	27.80%	12.20%	10.90%	6.60%	2.70%
Ontonagon	6780		103				17.50%	7.50%	10.00%	0.00%	0.00%
Saginaw	200169	830	1849	20.00%	12.90%	6.30%	30.20%	14.70%	12.80%	7.90%	3.00%
Sanilac	43114		292				35.40%	20.30%	14.20%	11.80%	5.00%
Tuscola	55729	470	1007	29.00%	18.60%	10.20%	29.40%	15.90%	14.00%	8.60%	3.70%
Wayne	1820584	3126	4065	24.20%	15.60%	10.40%	31.10%	15.50%	13.60%	10.70%	3.60%

Appendix B: County-level MiPHY data 2009

County	Suicide Prevention Plan Active 2009	Suicide Prevention Plan Previously Active	2009: MS # MiPHY Respondents	2009: HS # MiPHY Respondents	2009: MS % of students who ever seriously considered attempting suicide	2009: MS % of students who ever made a plan about how they would attempt suicide	2009: MS % of students who ever tried to kill themselves	2009: HS % of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	2009: HS % of students who seriously considered attempting suicide during the past 12 months	2009: HS % of students who made a plan about how they would attempt suicide during the past 12 months	2009: HS % of students who actually attempted suicide one or more times during the past 12 months	2009: HS % of students whose suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse during the past 12 months.
Alpena, Montmorency, Alcona			443	661	20.70%	12.70%	6.90%	36.00%	14.10%	8.00%	6.00%	0.00%
Allegan	Y		379	459	17.60%	11.90%	5.20%	32.80%	15.00%	12.70%	9.40%	4.10%
Antrim			225	218	25.50%	17.10%	8.60%	31.70%	14.30%	10.70%	5.60%	2.30%
Arenac	Y		151	311	11.60%	4.70%	4.90%	32.20%	17.30%	12.50%	12.70%	6.00%
Baraga	Y		92	172	23.10%	14.30%	6.60%	25.00%	12.60%	9.00%	5.00%	1.20%
Barry			498	875	12.80%	7.30%	3.90%	28.60%	14.90%	9.40%	7.00%	2.80%
Bay	Y		950	1443	18.40%	8.90%	5.90%	33.60%	18.10%	13.10%	8.90%	2.60%
Berrien				401				30.70%	14.30%	9.90%	8.00%	3.60%
Branch			348	597	21.20%	10.80%	5.00%	31.60%	15.50%	12.30%	9.50%	4.50%
Calhoun			1315	1934	22.30%	14.30%	8.80%	34.20%	16.50%	14.00%	11.20%	4.50%
Charlevoix	Y		255	340	19.20%	14.90%	6.10%	34.10%	20.10%	15.60%	9.20%	6.10%
Chippewa, Luce & Mackinac	Y		314	585	16.70%	9.90%	4.60%	30.30%	15.70%	11.50%	8.50%	3.60%
Clinton		Y	467	684	13.50%	8.70%	5.00%	29.40%	16.20%	13.40%	12.50%	5.80%
Crawford, Ogemaw, Oscoda, Roscommon	Y		262	446	23.20%	13.80%	8.70%	36.80%	19.10%	14.50%	9.90%	4.20%
Eaton	Y		779	1832	25.30%	13.90%	8.60%	33.00%	15.50%	12.80%	9.10%	5.20%
Emmet	Y		328	662	21.60%	13.70%	8.00%	25.30%	15.80%	17.60%	9.50%	0.00%
Genesee				578				30.20%	14.10%	10.60%	7.40%	3.60%

County	Suicide Prevention Plan Active 2009	Suicide Prevention Plan Previously Active	2009: MS # MiPHY Respondents	2009: HS # MiPHY Respondents	2009: MS % of students who ever seriously considered attempting suicide	2009: MS % of students who ever made a plan about how they would attempt suicide	2009: MS % of students who ever tried to kill themselves	2009: HS % of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	2009: HS % of students who seriously considered attempting suicide during the past 12 months	2009: HS % of students who made a plan about how they would attempt suicide during the past 12 months	2009: HS % of students who actually attempted suicide one or more times during the past 12 months	2009: HS % of students whose suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse during the past 12 months.
Gogebic			69	116	27.80%	16.70%	11.10%	38.90%	16.70%	11.80%	25.00%	5.90%
Grand Traverse	Y		629	1233				29.80%	13.50%	10.00%	8.50%	3.70%
Hillsdale			262	480	24.20%	16.30%	8.80%	36.30%	17.90%	13.60%	7.80%	4.20%
Houghton	Y		272	343				29.90%	16.50%	5.70%	7.00%	3.20%
Huron	Y		293	707	21.20%	12.30%	8.00%	29.10%	15.20%	13.10%	7.10%	2.60%
Ingham	Y		1198	1922	25.70%	17.80%	12.70%	34.20%	16.30%	13.90%	11.50%	5.10%
Iosco		Y	295	522	21.20%	6.10%	3.10%	34.60%	19.50%	5.60%	10.70%	5.00%
Jackson			1610	2945	21.80%	13.00%	7.90%	33.40%	17.30%	13.20%	10.10%	4.00%
Kalamazoo	Y		1602	3624	17.60%	11.20%	5.40%	28.90%	14.40%	10.40%	8.80%	4.00%
Kent	Y		1509	2952	19.40%	12.30%	4.70%	31.80%	15.60%	10.50%	7.80%	3.70%
Leelanau	Y		92	287				25.40%	10.50%	8.80%	6.30%	2.20%
Lenawee			308	218	15.40%	8.60%	2.70%	30.80%	18.60%	12.20%	9.60%	3.90%
Macomb	Y		3949	6671	21.20%	12.90%	8.30%	32.70%	17.20%	10.70%	9.60%	3.30%
Mason & Lake			107	71	29.10%	24.30%	12.60%	22.20%	7.90%	7.90%	7.30%	3.20%
Midland	Y		842	1732				37.60%	17.10%	21.10%	7.20%	70.00%
Missaukee			145	309	39.20%	25.70%	14.90%	34.40%	22.20%	16.00%	11.80%	3.90%
Newaygo	Y		357	789	32.20%	19.20%	9.60%	33.00%	17.10%	12.70%	10.20%	3.60%
Oakland	Y		5000	8307	19.00%	12.70%	7.50%	32.00%	16.20%	12.00%	9.00%	3.70%
Oceana			129	120	14.80%	9.30%	3.90%	24.50%	10.80%	6.40%	7.30%	1.90%
Ontonagon			46	114	21.40%	7.70%	7.10%	40.50%	18.90%	16.20%	5.90%	0.00%
Osceola			189		28.30%	20.80%	8.40%					
Saginaw	Y		928	1637	21.00%	11.10%	7.20%	32.80%	15.40%	12.40%	8.30%	2.70%
St. Joseph			581	1008	23.10%	13.70%	9.00%	30.10%	13.20%	10.10%	6.30%	2.70%
Sanilac			102	217	14.30%	10.70%	3.60%	39.60%	19.80%	14.30%	10.80%	7.20%

County	Suicide Prevention Plan Active 2009	Suicide Prevention Plan Previously Active	2009: MS # MiPHY Respondents	2009: HS # MiPHY Respondents	2009: MS % of students who ever seriously considered attempting suicide	2009: MS % of students who ever made a plan about how they would attempt suicide	2009: MS % of students who ever tried to kill themselves	2009: HS % of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	2009: HS % of students who seriously considered attempting suicide during the past 12 months	2009: HS % of students who made a plan about how they would attempt suicide during the past 12 months	2009: HS % of students who actually attempted suicide one or more times during the past 12 months	2009: HS % of students whose suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse during the past 12 months.
Tuscola			431	1008	19.40%	11.70%	5.80%	35.70%	20.80%	13.90%	8.00%	4.20%
Washtenaw	Y		549	1026	16.20%	10.40%	4.60%	25.30%	11.20%	9.50%	4.80%	1.90%
Wayne	Y		5840	10036	24.10%	15.40%	10.20%	35.30%	17.50%	13.20%	11.90%	4.40%
Wexford			289	639	22.90%	17.80%	7.10%	36.90%	22.80%	19.00%	11.10%	3.70%

Attachment C: Lifeline calls by Michigan county

County	Population	Lifeline Calls 2005	Lifeline Calls per 1,000 residents 2005	Lifeline Calls 2006	Lifeline Calls per 1,000 residents 2006	Lifeline Calls 2007	Lifeline Calls per 1,000 residents 2007	Lifeline Calls 2008	Lifeline Calls per 1,000 residents 2008	Lifeline Calls 2009	Lifeline Calls per 1,000 residents 2009	Lifeline Calls 2010	Lifeline Calls per 1,000 residents 2010
Alcona	10942	0	0.000	1	0.091	5	0.457	3	0.274	3	0.274	7	0.640
Alger	9601	0	0.000	5	0.521	2	0.208	2	0.208	6	0.625	20	2.083
Allegan	111408	5	0.045	25	0.224	44	0.395	57	0.512	60	0.539	64	0.574
Alpena	29598	4	0.135	10	0.338	46	1.554	66	2.230	52	1.757	332	11.217
Antrim	23580	2	0.085	2	0.085	23	0.975	19	0.806	32	1.357	23	0.975
Arenac	15899	1	0.063	1	0.063	16	1.006	19	1.195	22	1.384	6	0.377
Baraga	8860	0	0.000	1	0.113	3	0.339	9	1.016	24	2.709	14	1.580
Barry	59173	1	0.017	13	0.220	34	0.575	36	0.608	67	1.132	31	0.524
Bay	107771	11	0.102	29	0.269	147	1.364	220	2.041	214	1.986	156	1.448
Benzie	17525	2	0.114	8	0.456	13	0.742	13	0.742	20	1.141	15	0.856
Berrien	156813	17	0.108	78	0.497	158	1.008	200	1.275	211	1.346	301	1.919
Branch	45248	2	0.044	9	0.199	40	0.884	28	0.619	73	1.613	46	1.017
Calhoun	136146	15	0.110	25	0.184	129	0.948	211	1.550	341	2.505	365	2.681
Cass	52293	3	0.057	11	0.210	21	0.402	54	1.033	32	0.612	19	0.363
Charlevoix	25949	1	0.039	3	0.116	17	0.655	16	0.617	10	0.385	16	0.617
Cheboygan	26152	0	0.000	5	0.191	38	1.453	24	0.918	31	1.185	43	1.644
Chippewa	38520	6	0.156	9	0.234	38	0.987	68	1.765	58	1.506	79	2.051
Clare	30926	1	0.032	8	0.259	29	0.938	24	0.776	43	1.390	26	0.841
Clinton	75382	1	0.013	6	0.080	29	0.385	21	0.279	22	0.292	29	0.385
Crawford	14074	0	0.000	0	0.000	22	1.563	32	2.274	33	2.345	32	2.274
Delta	37069	10	0.270	16	0.432	44	1.187	38	1.025	42	1.133	45	1.214
Dickinson	26168	3	0.115	5	0.191	29	1.108	51	1.949	69	2.637	52	1.987
Eaton	107759	10	0.093	10	0.093	78	0.724	76	0.705	65	0.603	65	0.603
Emmet	32694	1	0.031	11	0.336	25	0.765	85	2.600	50	1.529	50	1.529

County	Population	Lifeline Calls 2005	Lifeline Calls per 1,000 residents 2005	Lifeline Calls 2006	Lifeline Calls per 1,000 residents 2006	Lifeline Calls 2007	Lifeline Calls per 1,000 residents 2007	Lifeline Calls 2008	Lifeline Calls per 1,000 residents 2008	Lifeline Calls 2009	Lifeline Calls per 1,000 residents 2009	Lifeline Calls 2010	Lifeline Calls per 1,000 residents 2010
Genesee	425790	40	0.094	162	0.380	507	1.191	659	1.548	721	1.693	921	2.163
Gladwin	25692	2	0.078	0	0.000	12	0.467	14	0.545	25	0.973	24	0.934
Gogebic	16427	3	0.183	5	0.304	12	0.731	10	0.609	29	1.765	20	1.218
Grand Traverse	86986	10	0.115	54	0.621	65	0.747	165	1.897	184	2.115	157	1.805
Gratiot	42476	0	0.000	7	0.165	25	0.589	49	1.154	35	0.824	49	1.154
Hillsdale	46688	3	0.064	3	0.064	46	0.985	47	1.007	47	1.007	52	1.114
Houghton	36628	4	0.109	20	0.546	22	0.601	64	1.747	46	1.256	44	1.201
Huron	33118	5	0.151	0	0.000	13	0.393	33	0.996	33	0.996	35	1.057
Ingham	280895	53	0.189	119	0.424	387	1.378	478	1.702	807	2.873	726	2.585
Ionia	63905	0	0.000	4	0.063	27	0.423	15	0.235	51	0.798	51	0.798
Iosco	25887	1	0.039	5	0.193	15	0.579	52	2.009	61	2.356	92	3.554
Iron	11817	2	0.169	1	0.085	5	0.423	3	0.254	16	1.354	14	1.185
Isabella	70311	0	0.000	16	0.228	38	0.540	37	0.526	28	0.398	45	0.640
Jackson	160248	8	0.050	33	0.206	219	1.367	217	1.354	164	1.023	255	1.591
Kalamazoo	250331	34	0.136	79	0.316	233	0.931	196	0.783	322	1.286	370	1.478
Kalkaska	17153	1	0.058	1	0.058	16	0.933	19	1.108	17	0.991	17	0.991
Kent	602622	31	0.051	66	0.110	399	0.662	629	1.044	763	1.266	981	1.628
Keweenaw	2156	0	0.000	0	0.000	0	0.000	0	0.000	0	0.000	0	0.000
Lake	11539	0	0.000	3	0.260	2	0.173	5	0.433	6	0.520	9	0.780
Lapeer	88319	4	0.045	14	0.159	34	0.385	84	0.951	59	0.668	84	0.951
Leelanau	21708	1	0.046	2	0.092	5	0.230	12	0.553	8	0.369	1	0.046
Lenawee	99892	5	0.050	11	0.110	87	0.871	86	0.861	134	1.341	185	1.852
Livingston	180967	10	0.055	44	0.243	120	0.663	181	1.000	181	1.000	188	1.039
Luce	6631	0	0.000	0	0.000	0	0.000	4	0.603	6	0.905	8	1.206
Mackinac	11113	0	0.000	5	0.450	8	0.720	10	0.900	7	0.630	25	2.250
Macomb	840978	110	0.131	282	0.335	1017	1.209	1199	1.426	1937	2.303	1398	1.662

County	Population	Lifeline Calls 2005	Lifeline Calls per 1,000 residents 2005	Lifeline Calls 2006	Lifeline Calls per 1,000 residents 2006	Lifeline Calls 2007	Lifeline Calls per 1,000 residents 2007	Lifeline Calls 2008	Lifeline Calls per 1,000 residents 2008	Lifeline Calls 2009	Lifeline Calls per 1,000 residents 2009	Lifeline Calls 2010	Lifeline Calls per 1,000 residents 2010
Manistee	24733	0	0.000	21	0.849	41	1.658	30	1.213	20	0.809	15	0.606
Marquette	67077	3	0.045	21	0.313	35	0.522	88	1.312	152	2.266	166	2.475
Mason	28705	1	0.035	5	0.174	24	0.836	51	1.777	41	1.428	80	2.787
Macosta	42798	3	0.070	13	0.304	35	0.818	40	0.935	29	0.678	85	1.986
Menominee	24029	1	0.042	5	0.208	17	0.707	48	1.998	53	2.206	49	2.039
Midland	83629	8	0.096	16	0.191	56	0.670	92	1.100	90	1.076	96	1.148
Missaukee	14849	2	0.135	3	0.202	2	0.135	7	0.471	7	0.471	4	0.269
Monroe	152021	11	0.072	20	0.132	162	1.066	269	1.769	424	2.789	267	1.756
Montcalm	63342	2	0.032	15	0.237	59	0.931	45	0.710	45	0.710	86	1.358
Montmorency	9765	0	0.000	1	0.102	6	0.614	8	0.819	9	0.922	2	0.205
Muskegon	172188	18	0.105	42	0.244	111	0.645	173	1.005	162	0.941	249	1.446
Newaygo	48460	6	0.124	13	0.268	47	0.970	45	0.929	30	0.619	26	0.537
Oakland	1202362	148	0.123	317	0.264	1344	1.118	1642	1.366	2293	1.907	2168	1.803
Oceana	26570	4	0.151	6	0.226	8	0.301	9	0.339	13	0.489	7	0.263
Ogemaw	21699	8	0.369	10	0.461	14	0.645	24	1.106	17	0.783	24	1.106
Ontonagon	6780	0	0.000	1	0.147	0	0.000	3	0.442	6	0.885	8	1.180
Osceola	23528	3	0.128	6	0.255	21	0.893	14	0.595	18	0.765	26	1.105
Oscoda	8640	0	0.000	0	0.000	5	0.579	5	0.579	10	1.157	2	0.231
Otsego	24164	1	0.041	1	0.041	25	1.035	41	1.697	32	1.324	26	1.076
Ottawa	263801	104	0.394	332	1.259	296	1.122	185	0.701	214	0.811	334	1.266
Presque Isle	13376	0	0.000	1	0.075	16	1.196	10	0.748	5	0.374	7	0.523
Roscommon	24449	1	0.041	6	0.245	20	0.818	39	1.595	29	1.186	35	1.432
Saginaw	200169	27	0.135	36	0.180	228	1.139	268	1.339	273	1.364	333	1.664
St. Clair	163040	29	0.178	41	0.251	142	0.871	197	1.208	145	0.889	218	1.337
St. Joseph	61295	0	0.000	10	0.163	60	0.979	128	2.088	80	1.305	164	2.676
Sanilac	43114	2	0.046	11	0.255	36	0.835	21	0.487	61	1.415	87	2.018

County	Population	Lifeline Calls 2005	Lifeline Calls per 1,000 residents 2005	Lifeline Calls 2006	Lifeline Calls per 1,000 residents 2006	Lifeline Calls 2007	Lifeline Calls per 1,000 residents 2007	Lifeline Calls 2008	Lifeline Calls per 1,000 residents 2008	Lifeline Calls 2009	Lifeline Calls per 1,000 residents 2009	Lifeline Calls 2010	Lifeline Calls per 1,000 residents 2010
Schoolcraft	8485	2	0.236	0	0.000	9	1.061	11	1.296	13	1.532	28	3.300
Shiawassee	70648	4	0.057	14	0.198	111	1.571	113	1.599	104	1.472	102	1.444
Tuscola	55729	2	0.036	11	0.197	45	0.807	54	0.969	44	0.790	40	0.718
Van Buren	76258	2	0.026	17	0.223	102	1.338	62	0.813	82	1.075	76	0.997
Washtenaw	344791	27	0.078	105	0.305	499	1.447	609	1.766	639	1.853	708	2.053
Wayne	1820584	322	0.177	778	0.427	2430	1.335	3076	1.690	4082	2.242	4024	2.210
Wexford	32735	1	0.031	19	0.580	36	1.100	48	1.466	40	1.222	47	1.436
Michigan	9883640	1165	0.118	3124	0.316	10386	1.051	13095	1.325	16529	1.672	17176	1.738

Michigan Suicide Prevention Coalition—2005

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

IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

U. Technical Assistance Needs

1. What areas of technical assistance is the state currently receiving?

MDCH is receiving technical assistance through the National Council on Behavioral Health, University of Michigan School of Social Work and PIHP staff experienced in advanced integrated health fieldwork development. This assistance benefits MDCH staff and Michigan Association of Community Mental Health Board Staff through an innovative collaborative effort, which in turn benefits Prepaid Inpatient Health Plan Staff and direct providers. Information and resources are shared, and made available to the field for implementation.

During the first year and a half to two years of Michigan's transformation to a recovery oriented system of care, the state expended a significant amount of money to engage consultants to educate and assist with the needs and directions for transformation. This type of support is costly and the number of groups and types of individuals who need this training is significant. The state has supported this to the best of their ability but their resources are limited. Additionally, training needs to happen at each level of engagement with in the system including: state, regional, and local. Michigan did not have the depth of resources (financially or in personnel) to provide the depth and breadth of education and training needed. And now with the additional demands of primary health care integration and the Affordable Care Act, the state finds itself in even greater need of funding and technical assistance.

2. What are the sources of technical assistance?

In FY13, the National Council on Behavioral Health began providing guidance, technical assistance and individual support as Michigan continues to encourage and enhance PIHP health integration activities with physical healthcare. Activities that include a comprehensive evaluation of both qualitative and quantitative data for the Learning Community are provided through the University of Michigan, School of Social Work. Other assistance to the field comes from MDCH program staff, from the Integrated Health Project Manager and state leaders from the field.

3. What technical assistance is needed by state staff?

There are 12 federally recognized tribes in the state of Michigan, of which 11 are members of the Inter-Tribal Council of Michigan. The state is seeking technical assistance with regard to engagement in tribal consultation and collaboration.

Technical assistance related to understanding the interface of integrated health and the affordable care act would assist state staff greatly.

The state needs training and education to the substance use disorder staff and their state partners on the importance of collaboration around recovery services.

A national view of states progress that includes thorough understanding of integrated health models, the benefits and challenges faced by rural and urban providers with up-to-date information and the opportunity to observe and learn from them.

Assistance to clearly envision the desired outcomes (such as SAMHSA's recovery outcomes) and developed infrastructure to achieve integration would strengthen current efforts to move forward. Assistance addressing the reality that all efforts for truly integrated care must include the ability for providers to use the Medicaid encounter codes and be reimbursed for integrated services. Until such time, even the best efforts are only cooperative.

Recovery to people with working in or substance use disorders means something different than recovery for people with or working with a person with a psychiatric illness; people with co-occurring disorders are caught in between. Assistance in understanding and restructuring to one system that centers on each person's individual needs to recovery is to some degree a change in treatment philosophy. Common definitions and beliefs are different.

4. What technical assistance is most needed by behavioral health providers?

How to utilize, incorporate and manage peer recovery support services at the local levels and how to supervise peer recovery personnel are needed. Transition funding from currently supported services to the new culture and vision of substance use disorder recovery oriented services is also needed. It is difficult to manage change during the transition to ROSC and have the funds to support "new and expanded" types of services while gradually letting go of the "old" types of services.

Behavioral health providers are learning and implementing integrated health on all levels. Understanding case to care management, including integrated goals in behavioral health plans, supporting and modeling healthy behaviors at drop-in centers, clubhouses, FQHCs and Community Mental Health Services Programs/Substance Abuse Coordinating Agencies is in various developmental stages. Technical assistance, resources, training, supervision/coaching, and continued structural building is still needed.

IV: Narrative Plan

V. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.⁴⁵ This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The state justice system authorities that will work 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. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

⁴⁵ SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:

IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that 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 (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Footnotes:



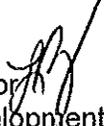
STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

JAMES K. HAVEMAN
DIRECTOR

November 9, 2012

To: Council Members

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

Re: Behavioral Health Advisory Council

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

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

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

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

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

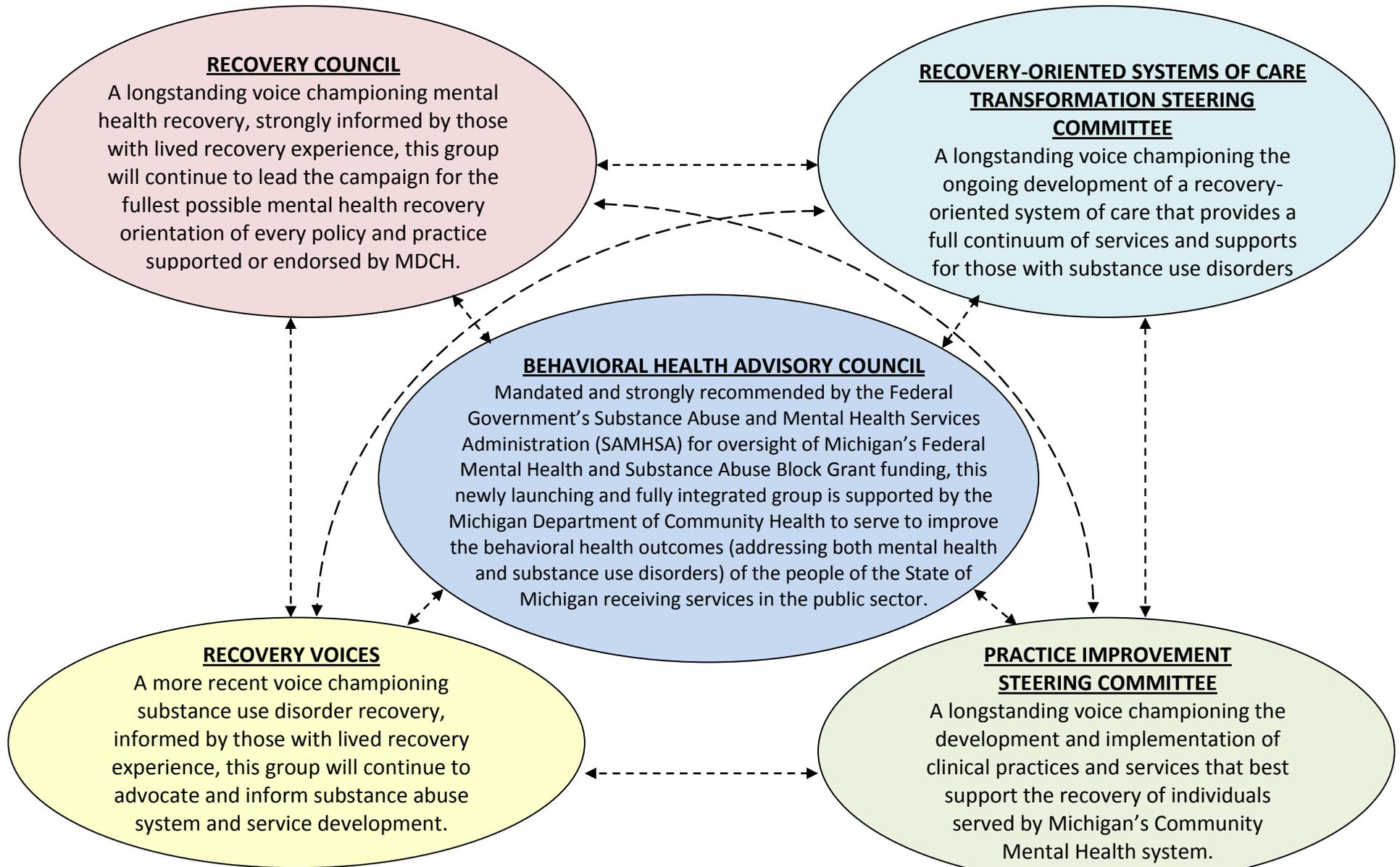
Council Members
November 9, 2012
Page Two

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

Enclosure

PROPOSED ADVISORY STRUCTURE TO ENSURE EFFECTIVE, COORDINATED ADVANCEMENT OF RECOVERY IN MICHIGAN

As we move forward into an increasingly integrated system of care, the following is proposed as 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
January 14, 2013**

Members Present: Lonnetta Albright, Amy Allen, Julie Barron, Joelene Beckett, Linda Burghardt, Elmer Cerano, Mary Chaliman, Becky Cienki, Michael Davis, Norm DeLisle, Elizabeth Evans, Benjamin Jones, Marlene Lawrence, Shareen McBride, Kevin McLaughlin, Chris O'Droski, Kevin O'Hare, Stephanie Oles, Jamie Pennell, Neicey Pennell, Marcia Probst, Mark Reinstein, Ben Robinson, Lori Ryland, Linda Scarpetta (for Pat Smith), Kristie Schmiede, Sally Steiner, Brian Wellwood, Jeff Wieferich, Stephen Wiland, Grady Wilkinson, Cynthia Wright

Members via Teleconference: Sonia Acosta, Lauren Kazee, Jeff Patton

Members Absent: Mary Beth Evans

Others Present: Karen Cashen, Deborah Hollis, Elizabeth Knisely, Alia Lucas, Jane Reagan, Larry Scott, Jennifer Stentoumis, Lynda Zeller

Call to Order

The meeting was called to order by Steve Wiland at 10:05 a.m. Jeff Wieferich and Steve Wiland co-chaired the meeting.

Introductions

Steve welcomed all in attendance and oriented the group to the documents in the meeting binders. The attendees, both in person and on the phone, introduced themselves so that everyone would have a frame of reference for why each member was appointed to the Behavioral Health Advisory Council (BHAC).

Welcome

Lynda Zeller, Director of the Behavioral Health and Developmental Disabilities Administration (BHDDA), welcomed the group and reviewed some of the official duties of the group. She mentioned the Description of Good and Modern Addiction & Behavioral Health Services document developed by the Substance Abuse and Mental Health Services Administration (SAMSHA). The document is available on the SAMHSA website (SAMHSA.gov) and can be used as a reference when discussing integrated services.

Deborah Hollis, Director of the Bureau of Substance Abuse and Addiction Services (BSAAS), welcomed the group and indicated her excitement at utilizing the resources available through the council.

Liz Knisely, Director of the Bureau of Community Mental Health Services, also welcomed the group.

Questions & Answers

Elmer Cerano asked if the BHAC will interface with the Medicaid Dual Eligibles project. Lynda indicated that there is no official “link,” but we have Amy Allen at the table here on the BHAC to get information from the Medicaid system.

Ben Robinson asked about Medicaid Expansion. Amy indicated that no one is likely to know the way this is going to go until the Governor releases his FY14 budget. The Governor is very concerned with adequate service provider network and with the fiscal implications of Medicaid Expansion to the state in future years.

Updates

Lynda talked about how the BHAC is now, in the sense that substance use is now included and that the composition and charge now reflects that. Lynda wanted to provide the group with a “time line” of changes upcoming to the many systems. MDCH staff committed to putting together a timeline to send out to the BHAC membership. Amy indicated that Michigan is going with the Federal Partnership Healthcare Exchange Model. However, the state does have the ability to provide their own customer service and program approval pieces of the model. The deadline for a plan that will explain how this will look in Michigan is October 1, 2013. Not all of the details of the process are confirmed or available to the public currently. The earliest a state can get the 100% Medicaid match for expansion is January 1, 2014. The plan for expanding mental health and substance abuse services is not totally hammered out if Medicaid Expansion does occur. The Essential Health Benefits (EHB) Plan (Priority Health HMO) that Michigan has selected does not appear to meet the requirements for mental health parity, and the state is investigating this. Grady Wilkinson wanted the state to recognize that a comprehensive plan is required, not just episodic periods of care. Amy indicated that any plan would be subject to public comment.

The group took a break for lunch at 11:40 a.m. and reconvened at 12:15 p.m.

History of ACMI/Overview of BHAC

Karen Cashen provided some historical information on how the previous mental health planning council came about and how we have gotten to the development of this current behavioral health advisory council. Steve indicated that SAMHSA has reported that no state is doing a really good job in transitioning mental health planning councils to integrated behavioral health councils, so Michigan could be the first. Karen reviewed the required participants on the BHAC, per the law, and the requirement that at least 50% of the BHAC must be composed of people with lived experience and/or advocates. This is something that we must report to the federal government. There is information regarding the BHAC requirements in the block grant application guidance, which was provided in the BHAC binder.

More Active Involvement in Block Grant Submission

Karen explained the mental health block grant (MHBG) for adults and Jennifer Stentoumis briefly described the children's portion of the mental health block grant.

Larry Scott described the substance abuse prevention and treatment block grant (SAPT BG). The MHBG is about \$13.7 million and the SAPT BG is about \$58 million. Larry also described the SYNAR report, which is a requirement for the receipt of SAPT BG funds from the federal government. The state has decided to submit a combined mental health and substance abuse block grant application for Fiscal Years (FY) 14-15 per SAMHSA's guidance. Ben R. asked how those on the previous council can get up to speed on the SAPT BG. Deborah explained that the SAPT BG has specific regulations that they must follow and is the primary source of funding for substance abuse services whereas Medicaid is the primary source of funding for mental health services. Deborah indicated that BSAAS can provide a reference document to explain the SAPT BG. The funds will remain separate for the foreseeable future and each block grant has its own rules, requirements, and assurances.

Structure, Bylaws, Workgroups

Steve moved the discussion toward the technical aspects of the structure of the BHAC including leadership, workgroups, bylaws, etc. Steve asked if there were any members who wanted to volunteer to work on the bylaws. The following members volunteered: Norm DeLisle, Marcia Probst, Shareen McBride, Jamie Pennell, Chris O'Droski, and Neicey Pennell. Marcia agreed to lead the workgroup, which will draft the bylaws (including leadership, names, etc.). Steve indicated that the hope for the new BHAC is to have standing workgroups to focus on specific areas and/or to identify workgroups as needed to focus on emerging issues. Examples of possible workgroups are: Medicaid expansion eligibility, workforce development, etc. The group discussed how the BHAC wants to approach these issues.

Elmer moved and Ben R. seconded that the BHAC recommend that Director Haveman advise the Governor to participate in Medicaid expansion via a general letter with Elmer to sign the letter, since the current chairs are state employees. There was further discussion about the pros and cons of the possible impact of Medicaid expansion. Amy informed the group that the Medicaid Advisory Council sent a letter similar to what the BHAC is proposing to Director Haveman and the Governor. The workgroup could draft a letter, send it out to the whole group with a 48-hour turnaround time, and then come up with a final draft. The motion passed with all state employees abstaining from the vote. Elmer was elected to write and sign the letter. Sally Steiner read some suggested language for the letter.

Steve refocused the group on deciding whether the group prefers short-term topic focused workgroups versus long-term standing workgroups. Sally indicated there was reference to an "executive committee" that could help structure workgroups. The discussion continued and the work of the other advisory groups mentioned in the diagram provided in the BHAC binder and other advisory groups statewide could be utilized to inform any workgroups

established by BHAC. The topics that require immediate action are: bylaws, Medicaid expansion, and the block grant application.

Updates from the other groups in the chart will be provided by members of those groups who are also members of the BHAC as these updates will be standing BHAC agenda items. The **Practice Improvement Steering Committee (PISC)** meets quarterly, and their next meeting is **April 2nd**. The **Recovery Oriented System of Care Transformation Steering Committee (ROSC TSC)** meetings are quarterly, and their next meeting is **March 20th**. The Recovery Council meets every other month, and their next meeting is **January 18th**. The Michigan Recovery Voices group meets the 2nd Tuesday of each month (next meeting **February 12th**).

Frequency and Times of Meetings

The group discussed the time frame for future meetings. It was decided that they will be from 10 a.m. – 3 p.m., but they may get done early. Karen will look into perhaps identifying a larger room for future meetings. The dates for this year's meetings are March 22nd, June 28th, September 13th and November 22nd.

Karen indicated historically that the advisory council has reviewed the block grant application, and it is hoped that any member of the BHAC could provide input with regard to their own areas of expertise. Larry indicated that some items on the block grant application are required and some are requested. Steve Wiland indicated this information will be provided to the BHAC as soon as possible.

Alternates

Steve indicated that, if possible, each member should have an alternate who can attend the meeting and vote in the member's absence. Information on alternates identified by BHAC members should be communicated to Karen at cashenk@michigan.gov as soon as possible.

Public Comment:

Linda Burghardt reported that the NAMI Conferences is planned for April 19th and 20th at the Lansing Center.

The meeting was adjourned at 1:55 p.m.

Behavioral Health Advisory Council
Meeting Minutes
March 22, 2013

Members Present: Sonia Acosta, Lonnetta Albright, Julie Barron, Joelene Beckett, Linda Burghardt, Karen Cashen, Elmer Cerano, Mary Chaliman, Mike Davis, Norm DeLisle, Jean Dukarski (for Brian Wellwood), Elizabeth Evans, Mary Beth Evans, Benjamin Jones, Lauren Kazee, Marlene Lawrence, Shareen McBride, Chris O'Droski, Kevin O'Hare, Kevin O'Neill (for Kevin McLaughlin), Stephanie Oles, Jamie Pennell, Neicey Pennell, Marcia Probst, Ben Robinson, Lori Ryland, Kristie Schmiede, Sally Steiner, Bill Tennant (for Mark Reinstein), Jeff Wieferich, Grady Wilkinson, Cynthia Wright

Members Absent: Amy Allen, Becky Cienki, Jeff Patton, Patricia Smith

Others Present: Crystal Carrothers, Deborah Hollis, Elizabeth, Knisely, Larry Scott, Jennifer Stentoumis, Lynda Zeller

Call to Order:

The meeting was called to order at 10:10 a.m.

Introduction of Director Haveman

Lynda Zeller introduced Director Haveman.

Behavioral Health & Developmental Disabilities Administration Updates

Director Haveman reviewed some of the key issues that MDCH is addressing currently: the duals project, integrating PIHPs and CAs, Mental Health and Wellness Commission, and high-needs children. He provided a handout on MDCH Strategic Priorities, MDCH service structure, and proposed Medicaid expansion.

Director Haveman stressed that Medicaid expansion is at risk in Michigan as the legislature is not supportive. Advocacy regarding this issue is needed. The MDCH budget is not final, so there is time to impact this issue. Director Haveman took a few questions from the council. He indicated that there may be some new fact sheets/talking points available for advocates and can be sent out to the BHAC. MSHDA has some information to provide about how the medical crises and medical bills contribute to homelessness. Director Haveman asked that the Council communicate the priorities of the BHAC to Lynda to be communicated to the Mental Health and Wellness Council and Diversion Workgroup.

Lynda Zeller spoke more about what is needed from the BHAC: reaction/feedback on MDCH strategic priorities; as the January 1st deadline approaches for the (P.A. 500 & 501) integration of CAs into the mental health system and advisory council to maintain the voice of substance abuse is required and could be informed by this group; also to get feedback as to what the consolidation of the 18 PIHPs and 10 PIHPs really feels like in the field. Elmer asked if some of the consolidation that is

proposed may not have gone far enough and what are the barriers. Lynda pointed out that the Mental Health Code requires local county control of CMHSPs, but Medicaid Managed Care is not required to be done locally in the code. Lynda reiterated that the BHAC needs to define their priorities and recognize all the aspects and repercussions of what the BHAC supports. Lynda asked that people report their personal stories of what the experience of care is like.

Lynda also informed the BHAC that Michigan was chosen to receive a State Transformation Grant (SIM grant). It is a 6-month project that will pull together all relevant healthcare provider systems to envision and plan for a population-based health system for Michigan. They want to answer the question: What is getting in the way of wellness? Lynda will provide information to the BHAC about this grant and what opportunities there may be for input. Melanie Brim at Public Health is the point person for the grant at the state. Lynda also indicated that MDCH is meeting to try to identify ways to “repackage” the Medicaid Expansion message to get through to the legislature. The group went over the specific priorities where BHDDA has the lead, but they are still involved in many of the other priorities as well. Lynda will have Karen send an email to the BHAC with the specifics that BHDDA has developed to address some of the MDCH strategic priorities on which BHDDA is the lead.

The duals project continues. There is money in the Governor’s budget for behavioral health homes, which will proceed if the legislature keeps the money in the final state budget. The state legislature did not approve a state/federal exchange partnership so now Michigan will have to purchase services from the federal system, not a local system. The state will have to look to the federal plan for outreach and education and if the Michigan legislature does not approve any additional state money (which they have not done) for the exchange, the federal plan will be it. Lynda will get the web address for the Michigan Medicaid Expansion web page to Karen to get to the Council. Finally, Lynda spoke about the “assurances” that BSAAS has been developing with MISACA to encapsulate the vital components of substance use disorder services that should not be lost in the consolidation of the MH & SA system. That list of assurances will be sent to the BHAC when it is available. Also, the ROSC plan should be distributed as well. Jamie wanted Lynda to know that transitional age youth is a group that is continually overlooked and the disconnect between services for SED and SMI results in youth being in intense MH services one day and being told they do not qualify in the adult system the next.

Welcome and Introductions

The group introduced themselves.

Member Alternates

Jeff asked members to provide their alternate’s information on a sheet that was passed around.

Approval of the January 14, 2013 Meeting Minutes

Elmer moved, Kevin O'Hare seconded approval of the minutes; minutes approved.

Bylaws Workgroup

Marcia Probst reviewed the work of the workgroup and indicated that the federal law P.L. 102 321 is the current law that the council must operate under. A discussion ensued about including reference to P.L. 102 321 or not as it has not been updated to reflect the inclusion of substance abuse.

P.L. 102 231 – Sally moved that the BHAC vote on including the P.L. 102 231 in the bylaws; Elmer seconded. Four members were in favor of the motion and the rest opposed. The motion did not carry. Linda moved that the reference to P.L. 102 231 be changed to “applicable federal law.” Kevin O'Neill seconded; motion carried unanimously.

Recording Secretary – Elmer moved that the position be retained, but that Article IV, #4 be amended to say “assuring that minutes are recorded” rather than “keeping minutes.” Ben Robinson seconded; motion carried unanimously.

Article IV, Section 2 - Jamie moved to amend the language to say “non-consecutive terms.” Stephanie seconded. Elmer said the motion was worded awkwardly and should say “2 years.” Two members were in favor of the motion and the rest opposed. The motion did not carry. Ben supported 2 consecutive terms. Ben moved that the bylaws be accepted with the above amendments. Kevin O'Hare seconded; motion withdrawn. Karen mentioned having co-chairs with one member from mental health and one from substance abuse. Elmer and Kevin both supported not having co-chairs as this is to be an integrated group. Jean suggested rotating chairs for every other meeting.

Linda moved that the chair not have voting rights as an ex-officio member of any committee formed by the council. Norm seconded. 14 members were in favor, 6 were against, and 2 abstained; motion carried.

Marlene moved to give all the suggestions to the bylaws committee, Lonnetta seconded; Larry indicated that, without bylaws, the group cannot conduct business. Marlene withdrew the motion.

Elmer suggested that the role of the Council be defined as advisory to the Director and the language be sent back to the bylaws workgroup for review.

Article II, #1 - Karen moved to add “only” in this sentence, which reads “...shall be to only advise the...” Kevin O'Neill seconded; motion carried unanimously.

Article III, #3 - Sally moved that we set a maximum of 40 members, Kevin O'Hare seconded. 24 members were in favor and 1 opposed; motion carried.

Elmer asked if clarification can be added to Article VI, #1 to specify how someone could be added to the Executive Committee. Also, on #3 he noted that actions by the Executive Committee may not always be able to be ratified by the entire committee due to time limits. Elmer suggested that these suggestions go back to the bylaws committee to work further on.

Sally reminded everyone that the Director revised the previous group's bylaws and this could happen again.

Ben suggested that the process of the election of the Executive Committee needs to be in the bylaws.

Kristie moved to pass the bylaws with the changes that have been made today and add any additional revisions (including the nominating committee) at a later meeting through an amendment. Kevin seconded; motion carried unanimously. Ben asked if he should forward additional issues to the bylaws committee for future amendments and the answer was yes. Marcia, Jamie, Norm, Chris, and Shareen are on the bylaws committee.

Recovery Committee Updates

Linda moved to have members email updates from other committees to Karen for distribution to the BHAC in order to move on to reviewing the Block Grant application. Norm seconded. Two members abstained, and the rest were in favor; motion carried.

Review Draft FY14-15 Block Grant Application

Karen explained that the due date for the block grant was changed to September 1st, but the Department wants to keep the forward momentum as we were preparing to submit it April 1st. There are several sections requested, but not required, that will be covered at the June 28th meeting. Karen started with the overview document, then reviewed the needs document and then the priority performance indicator document. Jeff and Jennifer assisted with the review. Members can e-mail any comments to Karen. The group decided that the Council should still submit a letter that the block grant application was reviewed even though it is not a requirement anymore. Karen also discussed the cut to the mental health block grant due to the federal sequestration.

Public Comment

Linda announced that the NAMI MI annual conference is going to be at the Lansing Center on April 19th and 20th. Members can go to the NAMI website or email Linda for more information.

Karen announced that the annual Co-occurring Disorders conference is April 30th and May 1st at the JW Marriott Hotel in Grand Rapids. It will be happening at the same time as the MACMHB conference which is located at the Amway Grand Hotel that is connected to the JW Marriott.

Stephanie stated that the 2013 Campaign to End Homelessness Summit is on September 18th and 19th in Frankenmuth.

Karen asked Chris, Marlene, and Kevin O'Hare to email her their updates from the committees to be sent to the Council.

Jeff moved to adjourn the meeting; Norm seconded. The meeting was adjourned at 2:55 p.m.

DRAFT
Behavioral Health Advisory Council
Meeting Minutes
June 28, 2013

Members Present: Julie Barron, Joelene Beckett, Karen Cashen, Elmer Cerano, Becky Cienki, Mike Davis, Norm DeLisle, Elizabeth Evans, Benjamin Jones, Janet Kaley (for Mary Chaliman), Lauren Kazee, Marlene Lawrence, Shareen McBride, Chris O'Droski, Kevin O'Hare, Stephanie Oles, Jeff Patton, Jamie Pennell, Marcia Probst, Mark Reinstein, Ben Robinson, Lori Ryland, Kristie Schmiede, Patricia Smith, Sally Steiner, Jackie Termeer (for Kevin McLaughlin), Brian Wellwood, Jeffery Wieferrich, Grady Wilkinson, Cynthia Wright

Members Absent: Sonia Acosta, Lonnetta Albright, Amy Allen, Linda Burghardt, Mary Beth Evans, Neicey Pennell

Others Present: Lt. Governor Brian Calley, Crystal Carrothers, Deborah Hollis, Elizabeth Knisely, Alia Lucas, Katherine O'Hare, Larry Scott, Felix Sharpe, Jennifer Stentoumis, Lynda Zeller

Call to Order

The meeting was called to order at 10:07 a.m.

Welcome and Introductions

Everyone introduced themselves.

Approval of the March 22, 2013 Minutes:

Elmer moved and Marcia seconded to approve the minutes. The minutes were approved.

Bylaws Workgroup

Mark suggested amending the language on Article II, #2 to read "... people of the State of Michigan receiving behavioral health services." Marcia wanted the council to review Article IV, #6. Lori moved and many seconded to remove "the meeting previous to the date of election." Jeff Wieferrich also mentioned that today's date needs to be added at the bottom of page 5. Joelene moved and Norm seconded to approve the bylaws as amended. The bylaws were approved unanimously.

Election of Officers

Elmer nominated Mark Reinstein for Chairperson; Kevin nominated Norm DeLisle for Vice-Chairperson; Becky nominated Marlene Lawrence for Secretary (she declined); Marlene nominated Lori Ryland for Chairperson or Secretary; Karen nominated Marcia Probst for Chairperson; Jeff Patton nominated Jamie Pennell for Chairperson. Marlene asked that the four nominees for Chairperson give the group a short speech about who they are and who they represent. Norm removed his name for consideration for Vice-Chairperson. Elmer moved and Kevin seconded to close nominations for the Chairperson. The motion was approved unanimously. The candidates gave their speeches. The Council members submitted their votes on

paper, and those on the webinar submitted theirs on the webinar chat. Marcia Probst was elected Chairperson of the BHAC.

Chris O'Droski is now the only candidate for Vice-Chairperson. Lori mentioned that those not elected from the Chairperson candidates be considered for other offices. Jamie was the only Chairperson candidate that indicated that she would accept Vice-Chairperson. A vote was taken for Vice-Chairperson the same way. Chris O'Droski was elected Vice-Chairperson of the BHAC.

Lori Ryland was the only member nominated for Secretary. Chris moved and Kevin seconded to close secretary nominations and have Lori Ryland become secretary. The motion was approved unanimously making Lori Ryland the Secretary of the BHAC.

Review Draft FY14-15 Block Grant Application

Karen walked the Council through some issues surrounding the block grant, the changes made by SAMHSA, the changes to the BHAC requirements, and the sections that MDCH was going to submit, but are not now. She noted that there are still going to be some changes to these sections, and she will send the revised sections to the Council by email.

The group reviewed the various sections. Becky will provide some language to Karen for section K. MDCH staff will make sure mental health court information, information on electronic health records, and #2 in Housing under the recovery section will be included. Stephanie will provide language to Karen for that section. Elizabeth suggested that consultation with tribes be added to technical assistance needs. Kristie suggested adding "recovery to the first line on #4 on page 91 to read, "peer recovery support services". She also added that she wanted to know if the Technical Advisory #11 Recovery Housing actually exists. MDCH staff will check on this or take it out on page 18 under Housing #1.

The group discussed some additional ways to solicit public comment. Karen asked if the BHAC would provide a letter of support for the application even if it is no longer required. Sally moved and Jeff Patton seconded to have the BHAC's executive committee provide the letter. The motion was unanimously approved.

Recovery Voices Update (June 11)

There have been two meetings and two new members since the last BHAC meeting. They are developing their advocacy agenda and looking at working on a legislative advocacy agenda. There will be a Legislative Day in September in Lansing at the same time as the peer conference. The group came up with their own physician's statement, and Chris read the 6 statements to the Council. The group meets the second Tuesday of every month. They would like to have meetings in the Upper Peninsula and are promoting their Facebook page to help expand membership. Chris will send a written summary of the group's activities to Karen to provide to the BHAC.

Recovery Council Update (May 17)

This group has had three main focuses: 1) Reviewing the policy issues surrounding quality of life and life expectancy, 2) Veterans issues - especially getting veterans who qualify for services connected to those services, and 3) Medicaid Expansion – maintaining advocacy efforts.

The group also had noticed that more support should be given to consumers who are being asked for their input on things like the duals plan on the front end. Norm indicated that he is currently working on a grant project that can provide just this kind of support, but it is a brand new project specifically for the duals project. Marlene requested more flexible funding for all kinds of projects. Elmer asked Marlene if she had any information on the feedback that consumers had received from legislators on Medicaid Expansion. So far they are all over the map.

Recovery-Oriented System of Care (ROSC) Steering Committee Update (June 20)

Felix gave an update on the new timelines for incorporating CAs into CMHs/PIHPs. ROSC is strong in some regions of the state and very weak in others. The group is looking at doing a survey of progress statewide. Lynda gave an update on the health care integration and BHDDA reorganization to include the elimination of BSAAS as an entity in favor of the office of ROSC.

Establish BHAC Priorities

Karen updated the Council on a webinar she attended sponsored by SAMHSA & NASMHPD that had some suggestions about what advisory councils can focus on in the implementation of the affordable care act. She provided a list of suggestions to the Council to start the discussion.

Elmer started the discussion with the status of Medicaid Expansion in Michigan. There is a hearing scheduled for July 3rd on Medicaid Expansion with time and location to be announced. It could be announced as early as tonight on www.michiganlegislature.org. Elmer suggested that BHAC members attend the hearing, and Grady also suggested people contact their legislators between now and July 3rd. This discussion was put on hold as Lynda arrived to provide an update to the Council.

Behavioral Health & Developmental Disabilities Administration Updates

Dual-eligibles: They are still looking at the 4 regions and will be releasing the RFP this summer. The feds do not have the capacity to split the money between the ICOs and the PIHPs, so the money will go first to the ICO, and there will have to be strong contractual language that will get money to the PIHPs for behavioral health and will ensure coordination, incentives, and outcomes. They cannot really provide detail on the RFP until it is released. The Memo of Understanding (MOU) from CMS & MDCH has not yet been finalized. There are opportunities for additional funding that may be available once the MOU is in place. Specific information on this can be found on the duals website: http://www.michigan.gov/mdch/0,4612,7-132-2939_2939_2939-259203--,00.html MDCH has made a commitment to keep to the standards as set forth in Medicare Part D; However, ICOs who have not had experience with both populations may have other ideas. MDCH will likely have to do education with ICOs to keep people on the same page. Lynda suggested that a presentation to the CMHs/CAs about Medicare Part D would be prudent. Lynda also discussed the opportunities for people to opt out of the duals project.

Internal Reorganization: On June 9th the BHDDA completed an internal reorganization. There are now two Bureaus: Bureau of Community Based Services & the Bureau of State Hospitals and Operations. There is still some clarifying going on so the reorganization continues to evolve. The purpose is full integration.

Mental Health and Wellness Commission & Diversion Council: These two commissions were created by executive order. The MH & Wellness Commission is time limited and will have recommendations by December 2013. The Diversion Council is an ongoing commission with appointees that include judges, sheriffs, MH professionals, etc. Lori will send the diversion priorities that came out of a pre-diversion council workgroup to Karen to send to the BHAC. Another difference between the two commissions is that the diversion council is about adults while the MH & Wellness commission is picking up children's and juvenile justice issues. The commission itself has six main members: a house republican and democrat, a senate republican and democrat, Director Haveman, and Lt. Governor Calley. Then there is a second tier of State Department representatives. They are looking at gaps and also revisiting previous MH Commission reports to see what has and has not been done. They have developed five workgroups to look at overcoming barriers to filling these caps and are still taking volunteers for the workgroups. There will also be three public hearings on the commission's activities coming up this fall.

Mental Health First Aid: There is a \$5 million one-time fund included in the state budget that is mostly targeted to children, but it also includes \$1.5 million in funding for mental health first aid training. The state will be rolling out this training in fiscal year 2014. This will enhance other mental health first aid initiatives already going on in the state. Mental health first aid has a formal definition that references a USA version of an Australia-based training for the general public.

Application for Proposals: This is on target, and they have gotten application from every region. Follow-up information was requested on each application that is due July 1st. Once those are in, there will be a site review to assure that PIHPs have appropriate information technology systems. Stakeholder input is also a very important focus. Marlene reiterated her point from earlier that in order to get stakeholder involvement there needs to be support on the front end. The BHAC members can help provide the Department with what is going well and what is not after January 1st.

Welcome and Remarks – Lt. Governor

Medicaid Expansion: Lt. Governor Calley spoke about the Governor's attempts to move the legislature forward to expand Medicaid eligibility in Michigan. The plan they came up with included good innovations. The top reason to do this is to support people that are working, but do not have access to affordable health care. He gave reasons why saying "yes" to Medicaid is important and noted that the federal budget deficit would actually be higher if they say "no" to Medicaid.

Mental Health & Wellness Commission: He discussed the composition and purpose of the group. This is an attempt to get needed change made by engaging policy makers at the front end. Creating champions within the system that makes the laws and the budgets. The commission wants their report complete by December so that recommendations can be made for the FY15 budget. Lt. Governor Calley commented on the July 3rd Senate Committee hearing on Medicaid Expansion that will be located on the 4th floor at the Capitol and some of the issues the expansion has been running into thus far. The public reason given by the Senate is that they are not going to allow a vote until 13/26 republicans will vote for it. This is not required by any law or regulation.

The Medicaid expansion will create \$205 million more in general fund room to get things done. You can contact the MH & Wellness Commission workgroup organizers to provide input at www.michigan.gov/mentalhealth.

He discussed the Diversion Council as well. This group was meeting informally, but the Council is the formalized group that is looking at improving options and outcomes for people with mental health concerns who are involved in the criminal justice system. The Lt. Governor then took questions from the council.

Jeff Wieferich asked the executive committee to work on identifying areas of focus for the BHAC before the next meeting.

Public Comment

Norm called the Council's attention to the flyer about the camp, "Her Power! Her Pride! Her Voice!" offered by the Michigan Disability Rights Coalition (MDRC). It is for women ages 15-19 to attend a 4-day camp to break through the beliefs that women have about their futures. There is still some room if there is someone you know that would be a good candidate. He also recommended a book published by O'Reilly media that he can send you a link to if you email him about it.

Stephanie informed the Council about a joint grant application between MDCH and MSHDA to provide funding to support the chronic homeless population in Detroit. They will find out if they will be receiving the funding in August. It is a 3-year grant just under \$2 million, and only 17 states could apply.

Brian announced that the JIMHO Annual Support Group Conference is on July 16th at LCC West.

Lauren announced another grant application that MDCH/MDE/MDHS collaboratively submitted for funding to support mental health access to services in schools in Saginaw, the Educational Achievement Authority, and Houghton Lake. It is \$2.2 million for 4 years.

Marcia wanted to point out that this is a great time to advocate for important changes that have been needed for years in the behavioral health arena. The group discussed some of the facets of these needed changes and how to assess the need and evaluate the effectiveness of our policies and practices.

Jeff Wieferich moved to adjourn and Norm seconded; the meeting was adjourned at 2:59 p.m.



Behavioral Health Advisory Council

Bylaws

ARTICLE I

Name

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

ARTICLE II

Function

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

ARTICLE III

Members

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



Behavioral Health Advisory Council

Bylaws

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

ARTICLE IV

Officers

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



Behavioral Health Advisory Council

Bylaws

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

ARTICLE V

Meetings

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



Behavioral Health Advisory Council

Bylaws

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

ARTICLE VI

Executive Committee

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

ARTICLE VII

Committees/Workgroups

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



Behavioral Health Advisory Council

Bylaws

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

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

ARTICLE VIII

Amendments

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

IV: Narrative Plan

Behavioral Health Advisory Council Members

Start Year:
 End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Amy Allen	State Employees	Department of Community Health - Medicaid	400 South Pine Street Lansing, MI 48933 PH: 517-241-8704	allena7@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
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
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
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	hmv_chris75@yahoo.com
Linda Burghardt	Others (Not State employees or providers)	NAMI - Michigan	921 N. Washington Avenue Lansing, MI 48906 PH: 517-485-4049	lburghardt@namimi.org
Elmer Cerano	Others (Not State employees or providers)	Michigan Protection and Advocacy Services	4095 Legacy Parkway, Suite 500 Lansing, MI 48911 PH: 517-487-1755	ecerano@mpas.org
Elizabeth Evans	Federally Recognized Tribe Representatives	Saginaw Indian Chippewa Tribe	2800 S. Shepherd Road Mt. Pleasant, MI 48858 PH: 989-775-4893	eevans@sagship.org
Michael Davis	State Employees	Department of Corrections	9036 East M-36 Whitmore Lake, MI 48189 PH: 734-449-3897	davism24@michigan.gov
Grady Wilkinson	Providers	Sacred Heart Rehabilitation Center, Inc.	400 Stoddard Road Memphis, MI 48041 PH: 810-392-2167	gwilkinson@sacredheartcenter.com
Jeffery Wieferich	State Employees	Department of Community Health - Substance Abuse	320 S. Walnut, 5th Floor Lansing, MI 48913 PH: 517-335-0499	wieferichj@michigan.gov
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
Julie Barron	Family Members of Individuals in Recovery (to include family members of adults with SMI)		812 E. Jolly Road, G-10 Lansing, MI 48910 PH: 517-346-9600	barron@ceicmh.org
Kevin McLaughlin	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		P.O. Box 105 Caledonia, MI 49316 PH: 616-262-8531	irenicoaching@gmail.com

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
Kristie Schmiege	Providers	Genesee County CMH	420 W. 5th Avenue Flint, MI 48503 PH: 810-496-5541	kschmiege@gencmh.org
Lauren Kazez	State Employees	Department of Education	608 W. Allegan Street, 2nd Floor Hannah Building Lansing, MI 48933 PH: 517-241-1500	kazeel@michigan.gov
Shareen McBride	Others (Not State employees or providers)	Association for Children's Mental Health	5938 W. Fourth Street Ludington, MI 49431 PH: 231-499-3333	shareenmm@yahoo.com
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
Lori Ryland	Providers	Venture Behavioral Health	100 Country Pine Lane Battle Creek, MI 49015 PH: 269-979-9132	lar@summitpointe.org
Marcia Probst	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		326 W. Kalamazoo Avenue #312 Kalamazoo, MI 49007 PH: 269-343-6725	mprobst@recoverymi.org
Marlene Lawrence	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		120 Grove Street Battle Creek, MI 49037 PH: 269-209-9748	marlenelawrence2000@yahoo.com
Jeff Patton	Providers	Kalamazoo CMH & Substance Abuse Services	3299 Gull Road, P.O. Box 63 Nazareth, MI 49074 PH: 269-553-8000	jpatton@kazooemh.org
Mary Chaliman	State Employees	Department of Human Services	Grand Tower, Suite 1514 Lansing, MI 48909 PH: 517-335-4151	chalimanm2@michigan.gov
Neicey Pennell	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		130 S. Clinton Street Charlotte, MI 48813 PH: 517-745-2531	jpennell00@yahoo.com
Norm DeLisle	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		780 West Lake Lansing Road, Suite 200 East Lansing, MI 48823 PH: 517-333-2477	ndelisle@mymdrc.org
Jamie Pennell	Parents of children with SED		211 Butler Leslie, MI 49251 PH: 517-589-9074	jpennell00@yahoo.com
Patricia Smith	State Employees	Department of Community Health - Public Health	P.O. Box 30195 Lansing, MI 48909 PH: 517-335-9703	smithp40@michigan.gov
Sonia Acosta	Providers	Centro Multicultural La Familia, Inc.	35 W. Huron, Suite 500 Pontiac, MI 48342 PH: 248-858-7800	sacosta@centromulticultural.org
Stephanie Oles	State Employees	Michigan State Housing Development Authority	735 E. Michigan Avenue, P.O. Box 30044 Lansing, MI 48912 PH: 517-241-8591	oles@michigan.gov

30233 Southfield

Mark Reinstein	Others (Not State employees or providers)	Mental Health Association in Michigan	Road, Suite 220 Southfield, MI 48076 PH: 248-647-1811	msrmha@aol.com
Ben Robinson	Others (Not State employees or providers)	Rose Hill Center	300 E. Michigan Avenue Holly, MI 48442 PH: 248-634-5530	brobinson@rosehillcenter.org
Sally Steiner	State Employees	Department of Community Health - Aging	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
Karen Cashen	State Employees	Department of Community Health - Mental Health	320 S. Walnut Street, 5th Floor Lansing, MI 48913 PH: 517-335-5934	cashenk@michigan.gov
Cynthia Wright	State Employees	Michigan Rehabilitation Services	201 N. Washington Square, P.O. Box 30010 Lansing, MI 48909 PH: 517-241-3957	wrightc1@michigan.gov

Footnotes:

IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	36	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	9	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED*	1	
Vacancies (Individuals and Family Members)	<input type="text" value="0"/>	
Others (Not State employees or providers)	8	
Total Individuals in Recovery, Family Members & Others	20	55.56%
State Employees	10	
Providers	5	
Federally Recognized Tribe Representatives	1	
Vacancies	<input type="text" value="0"/>	
Total State Employees & Providers	16	44.44%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="3"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="5"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	8	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="12"/>	

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

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

Michigan's Behavioral Health Advisory Council (BHAC) met on March 22, 2013, and June 28, 2013, to review the draft combined FY14-15 Block Grant Application. Several questions were asked regarding specific sections of the application, feedback was provided, and the BHAC voted to submit a letter of support (attached in Section W). Several BHAC members also submitted language for inclusion in varying sections of the application.

Footnotes:

IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) 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 BG 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 the Secretary of HHS.

Footnotes:

Y. Comment on the State BG Plan

MDCH will be offering several avenues for the citizens of Michigan to provide public comment on the Fiscal Year 2014-2015 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant Application including, but not limited to, the following:

- The application will be posted on the Department of Community Health's website with information on how to provide comments on the plan.
- All Prepaid Inpatient Health Plans, Community Mental Health Services Programs, and Substance Abuse Coordinating Agencies in the state will be given information on the availability of the plan and contact information for comments. A notice soliciting comments will be provided for them with the request that they post it in their lobbies. They will also be asked to provide the information to all of their subcontract agencies.
- A press release will also be issued by the MDCH's Communications Office for publication in newspapers. As a result of efforts in past years, numerous comments have been received from the public on the block grant program and on services in general.
- All meetings of the Behavioral Health Advisory Council (Planning Council) are open to the public with an opportunity for public comment listed on each agenda. The dates of the meetings are posted on the department's website.