Michigan

UNIFORM APPLICATION
FY 2009 - STATE PLAN

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 08/06/2008 - Expires 08/31/2011

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

Introduction:

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the 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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

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FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

__FY2009 __FY 2009-2010 _X_FY 2009-2011

STATE NAME: Michigan

DUNS #: 11-370-4139

I. AGENCY TO RECEIVE GRANT

AGENCY: Michigan Department of Community Health

ORGANIZATIONAL UNIT: Mental Health Administration

STREET ADDRESS: 320 South Walnut St.

CITY: Lansing STATE: MI ZIP: 48913

TELEPHONE: 517-335-5100 FAX: 517-241-7283

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: Irene Kazieczko TITLE: Director, Bureau of Community Mental Health

AGENCY: Michigan Department of Community Health

ORGANIZATIONAL UNIT: Mental Health Administration

STREET ADDRESS: 320 South Walnut St.

CITY: Lansing STATE: MI ZIP CODE: 48913

TELEPHONE: (517) 335-5100 FAX: (517) 241-7283

III. STATE FISCAL YEAR

FROM: 10/01/2008 TO: 09/30/2009

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Patricia Degnan TITLE: Service Innovation and Consultation Section Manager

AGENCY: Michigan Department of Community Health

ORGANIZATIONAL UNIT: Bureau of Community Mental Health Services

STREET ADDRESS: 320 South Walnut St.

CITY: Lansing STATE: MI ZIP: 48913

TELEPHONE: 517-373-2845 FAX: 517-335-6775 EMAIL: degnanp@michigan.gov

Michigan

Executive Summary

Please respond by writing an Executive Summary of your current year's application.

The Michigan Department of Community Mental Health (MDCH) is pleased to apply for the Community Mental Health Block Grant from the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. This grant has allowed Michigan to develop and improve, in innovative ways, its community-based system of care. This is a three-year application, for the period of October 1, 2009 to September 30, 2011. We are applying for the annual amount of $13,088,713, which is the current Michigan FY 2008 award amount.

Community Mental Health Block Grant funds have been, and will continue to be, important in Michigan's transformation of its system of care. Services developed over the past several years with block grant start-up funding have been instrumental in developing a system focused on the recovery of adults with serious mental illness and the resilience of children with serious emotional disturbance. Block grant funds are allocated at approximately two-thirds for adult community-based services and approximately one-third for children's community-based services.

In Michigan, state funds for mental health and developmental disability services are contracted by MDCH with 46 regional Community Mental Health Services Programs (CMHSPs). Medicaid funds, which are paid on a per Medicaid eligible capitated basis, are contracted with Prepaid Inpatient Health Plans (PIHPs) which are CMHSPs, or affiliations of CMHSPs. Each region is required to have an extensive array of services which 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 planning process and family-centered care for children.

MDCH issued a Request for Proposals (RFP) on March 4, 2008, which made approximately $3.5 million in block grant funds available to PIHPs and CMHSPs for adult services. A portion of the funding is dedicated to implementation and development of evidence-based practices selected by the Practice Improvement Steering Committee: Family Psychoeducation, Co-occurring Disorders: Integrated Dual Disorder Treatment, and Supported Employment. Block grant funds are also available, on a competitive basis, for programming in the areas of Anti-Stigma, Assertive Community Treatment, Clinical Skills Development, Clubhouse Programs, Consumer-Run Services, Co-occurring Disorders Enhancement, Crisis Residential Services, Cultural Competence, Family Psychoeducation Enhancement, Homeless/Supported Housing, Integrating Mental Health/Substance Abuse & Physical Health, Intensive Crisis Stabilization Programs, Jail Diversion, Older Adults, Certified Peer Support Specialists Staff Development, Recovery Systems Change, Special Populations, Trauma, and other proposed innovative services. New service projects are for two or three years and will begin October 1, 2008. Some projects awarded a year ago for a two-year period will begin their second year on that date.

A Children's System of Care Planning Document Request for Proposals (RFP) was sent out seeking proposals for FY09 to be funded through Mental Health Block Grant funds. This RFP was very broad in nature and requested Community Mental Health Services Programs (CMHSPs) to begin (or continue) comprehensive planning with community stakeholders including child welfare, juvenile justice, the schools, families, and youth. Approximately $3 million dollars in block grant funds will be awarded to support system of care development. The children's projects that were awarded block grant funds fall into four broad categories and

include juvenile justice/mental health screening and diversion, wraparound and family centered practice, early intervention services and community planning, and evidence based practices. Prior RFPs were focused on specific areas of the system of care, while this RFP allowed for greater flexibility based on the needs and priorities of the local communities. Some projects awarded a year ago in response to a system of care RFP will begin second year projects in FY 2009.

MDCH continues to meet the Maintenance of Effort and Children's Set-Aside requirements of the block grant and is not applying for waivers.

Governor Jennifer Granholm has authorized the MDCH director, Janet Olszewski, to act as her designee for all activities related to the Community Mental Health Services Block Grant. Director Olszewski has designated Irene Kazieczko, Director of the Bureau of Community Mental Health, to act on her behalf for all activities related to the Community Mental Health Block Grant.

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2009

I hereby certify that Michigan agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[1] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms adults with a serious mental illness and children with a severe emotional disturbance and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2008, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

21. The term State shall hereafter be understood to include Territories.

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a service area)
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.
(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

08-08-08

XXXXXXX
Jennifer M. Granholm, Governor

Date

OMB Approval No. 0920-0428

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, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees 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 workplace 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 workplace 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 (e) 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
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

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

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.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

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, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
Janet Olszewski AED	Director
APPLICANT ORGANIZATION	DATE SUBMITTED
MI Department of Community Health	8/7/2008

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DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. **Type of Federal Action:**	2. **Status of Federal Action**	3. **Report Type:**
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report _____

4. **Name and Address of Reporting Entity:**	5. **If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:**
Prime Subawardee Tier _____ , *if known:* **Congressional District**, *if known:*	**Congressional District,** *if known:*
6. Federal Department/Agency:	7. **Federal Program Name/Description:** **CFDA Number**, *if applicable:* _____
8. **Federal Action Number,** *if known:*	9. **Award Amount,** *if known:* **$**
10. a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*	**b. Individuals Performing Services** *(including address if different from No. 10a.)* *(last name, first name, MI):*
11. **Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.**	**Signature:** _____ **Print Name:** _____ **Title:** _____ **Telephone No.:** _____ **Date:** _____

Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity 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 a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

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, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

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

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 an mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
Janet Olszewski AED	Director
APPLICANT ORGANIZATION	DATE SUBMITTED
MI Department of Community Health	8/7/2008

Michigan

Public Comments on State Plan

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.

The draft and final versions of Michigan's Community Mental Health Block Grant Application, the state plan, are posted on the Department of Community Health's website with information about how to provide comment on the plan.

All Prepaid Inpatient Health Plans and Community Mental Health Service Programs in the state were given information on the availability of the plan and contact information for comments. A notice soliciting comments was provided for them with the request that they post the notice in their lobbies and to provide the information to all of their subcontract agencies. As was done last year, a press release will be issued by the department's Communications Office for publication in newspapers. As the result of this effort last year, numerous comments were received from the public on the block grant program and on mental health services in general. Approximately six hard copies of the plan were mailed to people who requested them.

All meetings of the planning council are open with a public comment opportunity. The dates of the meetings are posted on the department's website.

II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances(SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY __X__ **Federal FY _____**

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2007	Estimate/Actual FY 2008
$3,509,106	$3,569,196	$3,509,106

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. MAINTENANCE OF EFFORT(MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY __X__ **Federal FY _____**

State Expenditures for Mental Health Services

Actual FY 2006	Actual FY 2007	Actual/Estimate FY 2008
$403,607,721	$422,267,254	$426,650,531

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

TABLE 1. List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Alexander, Charnita	Family Members of Children with SED	ACMH Family Impact	1731 Georgetown Blvd. Lansing,MI 48911 PH:517-373-3654 FAX:	cforme2no@aol.com
Allen, Regina	Family Members of adults with SMI	Social Security Administration	2163 University Park Drive Suite 100 Okemos,MI 48864 PH:517-347-4125 FAX:517-347-4213	regina.allen@ssa.gov
Berman, Joel	Consumers/Survivors/Ex-patients(C/S/X)	Detroit Central City	624 Charlotte, #305 Detroit,MI 48201 PH:313-443-7939 FAX:	berman_joeli@yahoo.com
Boatwright, Jasmine	Consumers/Survivors/Ex-patients(C/S/X)		11789 Farley Redford, MI,MI 48239 PH:313-658-5145 FAX:	jboatwright@swsol.org
Cerano, Elmer	Others(not state employees or providers)	Michigan Protection and Advocacy	4095 Legacy Parkway Suite. 500 Lansing,MI 48911 PH:517-487-1755 FAX:517-487-0827	ecerano@mpas.org
Degnan, Patricia	State Employees	Mental Health	320 S. Walnut Lansing,MI 48913 PH:517-373-2845 FAX:517-335-6775	degnanp@michigan.gov

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Harrison, Sally	State Employees	Housing	735 East Michigan Lansing,MI 48912 PH:517-241-1157 FAX:517-241-6672	harrisonsa@michigan.gov
Hart, Dennis	State Employees	Vocational Rehabilitation	11611 W. Pine Lake Rd. Plainwell,MI 49080 PH:269-664-9212 FAX:	hartd1@michigan.gov
Hutchins, Judith	Family Members of adults with SMI	National Alliance for the Mentally Ill (NAMI) of Michigan	7460 U.S. 23 South Ossineke,MI 49766 PH:989-471-5015 FAX:	judy.hutchins@yahoo.com
Jasper, Colleen	Consumers/Survivors/Ex-patients(C/S/X)	Office of Consumer Relations Department of Community Health	2529 Limerick Holt,MI 48842 PH:517-373-1255 FAX:517-335-6775	JASPER@michigan.gov
McBride-Wicklund, Shareen	Others(not state employees or providers)	Association for Children's Mental Health	5938 W. Fourth St. Ludington,MI 49431 PH:231-499-3333 FAX:231-843-2066	shareenmm@yahoo.com
Naganashe, Arlene	Family Members of adults with SMI	Inter-Tribal Council of Michigan	34 Bridge Street Petosky,MI 49770 PH:231-347-9093 FAX:231-487-4673	anaganashe@northernhealth.org

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Patton, Jeff	Providers	Kalamazoo CMH & Substance Abuse Services	3299 Gull Road P.O. Box 63 Nazareth,MI 49074 PH:269-553-8000 FAX:269-553-8012	jpatton@kazoocmh.org
Pennell, Jamie	Family Members of Children with SED		211 Butler Leslie,MI 49251 PH:517-589-9074 FAX:	bnj00@cablespeed.com
Reagan, Jane E.	State Employees	Education	2nd Floor Hannah Bldg. Office of Special Education and Early Intervention Lansing,MI 48933 PH:517-335-2250 FAX:517-373-7504	reaganj@michigan.gov
Reinstein, Mark	Others(not state employees or providers)	Mental Health Association in Michigan	30233 Southfield Road Suite 220 Southfield,MI 48076 PH:248-647-1711 FAX:248-647-1732	msrmha@aol.com
Robinson, Ben	Others(not state employees or providers)	Rose Hill Center	5130 Rose Hill Boulevard Holly,MI 48442 PH:248-634-5530 FAX:248-634-7754	BRobinson@rosehillcenter.com
Scanlon, Kerin	Consumers/Survivors/Ex-patients(C/S/X)		3877 S. Shepard Rd. Mt. Pleasant,MI 48858 PH:989-772-9630 FAX:989-774-3143	kscanlon@tm.net

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Steiner, Sally	Others(not state employees or providers)	Michigan Office of Services to the Aging	7109 W. Saginaw Lansing,MI 48909 PH:517-373-8810 FAX:517-373-4092	steiners@michigan.gov
Straseske, Clayton	State Employees	Criminal Justice	P.O. Box 30003 Lansing,MI 48909 PH:517-373-3318 FAX:517_335-8071	straseca@michigan.gov
Vanda, Jocelyn	State Employees	Social Services	Grand Tower Bldg. Suite 1514 Lansing,MI 48909 PH:517-373-7985 FAX:517-335-6101	VandaJ@michigan.gov
Wellwood, Brian	Consumers/Survivors/Ex-patients(C/S/X)	JIMHO and Project Doors	520 Cherry St. Lansing,MI 48933 PH:517-371-2221 FAX:517-371-5770	brwellwood@yahoo.com
Winans, Amy	Others(not state employees or providers)	Association for Children's Mental Health	100 W. Washtenaw St. Suite 4 Lansing,MI 48933 PH:517-372-4016 FAX:517-372-4032	ajwinans@aol.com

Patricia Degnan represents Medicaid as well as Mental Health. In Michigan, the Department of Community Health includes both Mental Health and Medicaid. Mental Health staff are responsible for the Medicaid policy and contract mechanisms for Medicaid funding for mental health services.

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	23	
Consumers/Survivors/Ex-patients(C/S/X)	5	
Family Members of Children with SED	2	
Family Members of adults with SMI	3	
Vacancies(C/S/X and Family Members)	0	
Others(not state employees or providers)	6	
TOTAL C/S/X, Family Members and Others	16	69.57**%**
State Employees	6	
Providers	1	
Vacancies	0	
TOTAL State Employees and Providers	7	30.43**%**

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.

Michigan

Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

reviewing plans and submitting to the State any recommendations for modification
serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems,
monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.
the role of the Planning Council in improving mental health services within the State.
<STRONG>In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III. </STRONG>

The bylaws of the Michigan Planning Council, the Advisory Council on Mental Illness, are included in this section. The bylaws address the council's roles and duties, member selection and terms, and the conduct of meetings. The council worked extensively to produce this detailed and specific set of bylaws and has found them useful since they were approved by the department director for adoption on January 1, 2007. Specific activities of the council during the last year are discussed after the bylaws.

ADVISORY COUNCIL ON MENTAL ILLNESS
Bylaws

ARTICLE I
Name

1. The name of this unincorporated association shall be the Advisory Council on Mental Illness.

ARTICLE II
Function

1. The purpose of the Advisory Council on Mental Illness shall be to advise the Michigan Department of Community Health (MDCH) concerning proposed and adopted plans affecting mental health services provided or coordinated by the State of Michigan and the implementation thereof.

2. The Council's responsibilities as defined in P.L. 102-321 include, but are not limited to:

    a. To assist the Department of Community Health in planning for community-based programs targeted to persons with serious mental illness or serious emotional disturbance.
    b. To advocate for improved services to persons with serious mental illness or serious emotional disturbance.
    c. To monitor and evaluate the implementation of the "State Comprehensive Mental Health Service Plan for Persons with Serious Mental Illness (P.L. 102-321)."
    d. To advise the Director of the Department of Community Health as to service system needs for persons with serious mental illness or serious emotional disturbance.

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 P.L. 102-321.

2. Council member composition shall follow the guidelines set forth in P.L. 102-321 and any subsequent regulations pertaining to council membership.

3. The Council shall have a minimum of 22 members.
    a. More than fifty per cent of the members shall be consumers/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 two-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. Three absences during one year shall trigger an evaluation of 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 to P.L. 102-321

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 department's best interests. If exercising this authority, the department director shall inform the removed member of the reason(s) supporting such action.

ARTICLE IV
Officers

1. The Council shall use the calendar year for appointments and terms of officers. Officers serve for one calendar year. The officers of the Council shall consist of chairperson, vice-chairperson, and recording secretary, who shall be elected by the council.

2. The chairperson shall be responsible for conducting the meetings. The chairperson shall be an ex-officio member of all committees formed by the Council. The chairperson shall serve for a one-year term with a maximum of two consecutive years.

3. The vice chairperson shall act in the absence of the chair. The vice chairperson shall serve for a one-year term with a maximum of two consecutive years.

4. The recording secretary shall be responsible for keeping minutes, recording attendance and working with the other officers. The recording secretary shall serve for a one-year term with a maximum of two consecutive years.

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.

ARTICLE V
Meetings

1. The regular meetings of the Council will occur no less than four (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 the dates, time, location and agenda of regular meetings shall be posted publicly at least three days prior to any meeting of the Council.

3. The Director of the Department of Community Health, Council chairperson or six (6) members may call a special meeting of the Council as necessary.

4. A quorum shall be more than one-half of the number of members serving on the Council at the time of the vote.

5. Council action is determined by a majority vote. A majority vote is defined as a majority of those members present.

6. 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/advocate, then a consumer/advocate member will be added to the executive committee.

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

1. The Council or its chairperson may create special committees for a specific period of time. The Council chairperson shall designate the members of a special committee and assure each committee has representation from at least one primary consumer, and at least one family member of an adult with serious mental illness, or one parent/caregiver of a minor with serious emotional disturbance. The nature of the committee shall dictate the type of consumer / 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 Advisory Council on Mental Illness at its regular meetings held on May 12, 2006 and November 9, 2006, and concurred by the Director on January 1, 2007.

During the past twelve months, the council has met five times. Six-hour meetings were held on November 9, 2007; February 2, 2008; April 11, 2008; June 13, 2008 and August 8, 2008.

Attendance and participation has been very good and the inclusion of a youth representative, and additional older adult representative, and a consumer in recovery with co-occurring mental health and substance use disorders has enriched the council.

The council has been kept involved in discussions of the Practice Improvement Steering Committee and its Subcommittees. A department specialist updated the council on the Dual Disorder: Co-occurring Disorder Treatment Subcommittee work and the Co-occurring Change Agent training that began this year, and the new Integrated Treatment Committee. The departmental specialist for employment discussed the new Supported Employment Subcommittee.

In November, the council voted for the chair to write a letter to the MDCH director requesting that the council be give representation on a newly formed MDOC/MDCH Mental Health Committee. MDOC received an appropriation to study the extent of mental illness in the prison population, how many need treatment, and how many are getting treatment. As the result of this, a member and alternate from the council were appointed to the committee. The committee's four work groups have recently submitted reports to the departments.

The council reviewed the FY 07 Block Grant Implementation Report, the FY09 Plan, and an amendment to the FY 08 Plan. The council was involved in decision making for the Children's System of Care Request for Proposals (RFP), the Adult System Transformation RFP, the Housing Resource Centers integrated, and was involved in discussion of the Integrated Treatment RFP issued by the Office of Drug Control Policy. Council representatives served on block grant proposal review panels for some of the program areas.

At the August 8 meeting the council members received an advance copy of the Concept Paper issued by the recently appointed Director of the Mental Health and Substance Abuse Administration. The Community Mental Health Services Bureau Director met with the council to discuss the paper.

Special Presentations to the council this year included:

- One of the few CMHSPs in the state that operates a stand-alone 24/7 walk-in emergency service presented on their services. People of all ages are served; many can be treated there and avoid the hospital emergency room

- DCH Staff responsible for inpatient facilities gave an update on state mental health hospitals and the forensic center. There is a concentrated effort to place all people with developmental disabilities in the community.

- CMHSP staff from a rural area of the state presented on their block grant supported Elderly Mental Health Accessibility Initiative. There was a frank discussion of the difficulties involved in engaging older adults in mental health services.

- Consumers provided a lively Stomp-Out-Stigma presentation in which they shared their own personal recovery stories.

- The Recovery Center of Excellence presented on their services and requests regular input from the council; the director will be attending council meetings regularly.

The council chairperson is working with NAMPAC to plan a Council Leadership technical assistance day in December.

Michigan

Adult - Overview of State's Mental Health System

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

State-level mental health program staff are located in the Mental Health and Substance Abuse Administration of the Department of Community Health. The Bureau of Community Mental Health Services is comprised of approximately 58 staff. The Division of Program Management, Consultation, and Contracts is responsible for specialty mental health standards, innovative service development, technical assistance, training, and contract management. The adult block grant coordinator who also is the Section Manager for Service Innovation and Consultation, as well as two staff supported by Mental Health Block Grant funds are in this division. Ten program specialists are responsible for specialty areas including Consumer Relations, Peer-Support Specialists, Recovery, Evidence-Based Practices, Integrated Service Development, Jail Diversion, Consumer-Run Programs, Older Adults, Adults with Dementia, Assertive Community Treatment, and Housing Services work in the bureau. These staff all have some responsibility for block grant planning and programming. They review proposals for block grant funding (as part of a team which includes consumers), make recommendations, and oversee the programs through quarterly report review and site visits as needed. One staff member is primarily responsible for the block grant contracts.

Other areas of the department that are involved in mental health services, including block grant processes, include the Bureau of Finance, Accounting Division and the Bureau of Budget and Audit, Office of Audit and Budget and Contracts Division. Administrative expenses for these services are charged to the block grant using a "Random Moments" process.

The state subcontracts for all of the community-based mental health services in the state. Community Mental Health Services Programs provide some direct services and the balance is contracted with an extensive network of community service providers.

Michigan

Adult - Summary of Areas Previously Identified by State as Needing Attention

Adult - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

Michigan identified the problem of meeting the service need with current funding as being problematic. Michigan's economy has not improved and it continues to have declining tax revenues and increasing unemployment. Michigan's unemployment rate, the highest in the country, was 8.5% in both June and July, 2008. In July of 2007, it was 7.1%. The projected $1.8 deficit for the current fiscal year was not resolved until after the beginning of the fiscal year, at which time a balanced budget was achieved. The state continues to operate with executive orders in place to decrease state administrative spending. The fiscal year 2009 budget for the department was recently approved.

Although the numbers of state level staff has decreased, funding appropriated for direct mental health services has not declined. The funding made available to the Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Service Providers (CMHSPs), for the most part, has been maintained at previous levels. Most of those who provide services directly to beneficiaries are employed by the PIHP or affiliate CMHSPs. Fortunately, their work force has remained relatively stable. MDCH continues its efforts to implement efficiencies and maximize federal reimbursement.

Michigan

Adult - New Developments and Issues

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

The structure of the mental health delivery system in the state has remained unchanged.

Mental health services for Medicaid recipients are contracted between MDCH and the 18 Prepaid Inpatient Health Plans in a carve-out managed care arrangement. A limited outpatient benefit for Medicaid recipients with mild or moderate mental health disorders is contained in the MDCH contract with the Medicaid Health Plans, which are responsible for primary health services.

MDCH's current renewal of its 1915(b) Medicaid Managed Specialty Supports and Services waiver program, which has been operating since 1998, runs until September 30, 2009.

State Children's Health Insurance Program funds are contracted by the Michigan Department of Community Health (MDCH) with the 46 Community Mental Health Services Programs for the MiChild Program and the Adult Benefit Waiver Program.

The state's Adult Benefit Waiver serves 64,000 adults at or below 35% of the federal poverty level.

Michigan

Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.

The Department of Community Health's fiscal year 2008 appropriate bill requires it to conduct a study of current policies and allocation methodologies to develop options that encourage administrative efficiencies for Community Mental Health Services Programs, local Public Health Departments, Substance Abuse Coordinating Agencies, and Area Agencies on Aging. This study was completed with the assistance of a state university, and in consultation with stakeholders from the four service areas. A report of the study was submitted to the state budget director and relevant legislative committees on August 1, 2008.

The department's fiscal year 2009 appropriation bill includes funding for mental health court pilot programs. The department will work with the State Court Administrative Office to develop guidelines for the operation and evaluation of pilot mental health courts. Local CMHSPs and trial courts will be invited to submit joint applications for funding of mental health court pilots.

Michigan

Adult - Description of Regional Resources

Adult - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

Michigan has a strong community-based system of mental health care. Its network of eighteen Prepaid Inpatient Health Plans (PIHPs) and forty-six Community Mental Health Services Programs (CMHSPs) (as described in the Overview of State's Mental Health System section) provide for a full array of services and supports. Consumers are at the center of the system. Each CMHSP region has at least one consumer-run program, many of which are consumer-run drop-in centers. Assertive Community Treatment (ACT) is available throughout the state. There are approximately eighty Co-occurring Disorder: Integrated Dual Disorder Treatment teams in operation, or development, in Michigan. Many of these are part of ACT treatment. Family Psychoeducation is another evidence-based practice that has been implemented over the past few years and is available throughout the state. Clubhouse programs and supported employment programs assist individuals in becoming more independent. Work is underway to increase the number of employment programs that are modeled on the evidence-based practice. Trained and certified Peer Support Specialists are working throughout the state in a variety of service settings.

The eighteen PIHPs are responsible for administration of all Medicaid funded mental health and substance abuse services for the region's Medicaid beneficiaries. They must comply with all Balanced Budget Act requirements. Medicaid payments are sent to PIHPs monthly with capitation based on the number and eligibility category of current Medicaid enrollees in the region.

The forty-six CMHSPs receive the state general funding for mental health services. These are county-based programs, some single county and others multiple counties. The CMHSPs have a local match requirement by contract.

Community Mental Health Block Grant funds for services are awarded to PIHPs and to CMHSPs. With the exception of an ongoing system transformation award to Detroit-Wayne County, service projects are awarded on a competitive basis in response to MDCH Requests for Proposals.

Michigan

Adult - Description of State Agency's Leadership

Adult - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

The organization of the children's system of care 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, 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 also 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 and the Michigan State Housing Development Authority.

The state level policy direction to the local public mental health and substance abuse service delivery system is provided by the Mental Health and Substance Abuse Administration and the Office of Drug Control Policy within the Michigan Department of Community Health through administrators and program specialists who provide technical assistance and participate in multiple interagency and collaborative groups at the state and local level to assist in implementing and monitoring promising practices and to further improve the system of care. One staff member is currently employed full time by MDCH to help with implementation of the Federal Mental Health Block Grant related to children's services.

Michigan

Child - Overview of State's Mental Health System

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

The organization of the children's system of care 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, 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 and the Michigan State Housing Development Authority.

The state level policy direction to the local public mental health and substance abuse service delivery system is provided by the Mental Health and Substance Abuse Administration and the Office of Drug Control Policy within the Michigan Department of Community Health. MDCH contracts with 18 Prepaid Inpatient Health Plans (PIHPs), which are made up 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. MDCH also contracts with the 46 CMHSPs for delivery of non-Medicaid funded services (including the federal mental health block grant). The public mental health service delivery system also contains a small outpatient mental health benefit (20 visits) within Medicaid Health Plans who are 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 a 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 "B3" services which are included in the MDCH contract include: Community Inclusion and Integration Services, Crisis Response Extended Observation Beds, Family Support and Training including Parent-to-Parent Support, Respite Care, Housing Assistance, Peer Delivered or Operated Support Services, Prevention and Consultation Services, and Wraparound Services.

There has been increased interagency collaboration in the state, especially in recent years, which has led to a more comprehensive system of care for children in a number of communities. In responding to the FY 2009 system of care block grant Request for Proposals (RFP), CMHSPs were asked to take the lead with their community stakeholders including the other agencies (child welfare, juvenile justice, education) and family members to plan the system of care for children and base their RFP proposals on identified gaps. This is the third year that MDCH has required that RFP submissions for block grant funds be based on system of care planning. However, many barriers remain in the development of a statewide comprehensive system of care 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-centered practice, to maximize the use of funds. Community Collaboratives continue to focus on improving the system of care and collaboration.

Historically, 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 is supported with block grant funding. The development and implementation of intensive community-based services have been crucial to moving children into the least restrictive environment without compromising treatment effectiveness. Consistent with Goal 2 of the President's New Freedom Commission Report, a major part of Michigan's transformation plan has been the incorporation of family-centered practice, which has led to increased consumer choice and treatment interventions that are designed as the child and family desires. With the support of the Mental Health Block Grant, training in family-centered practice, evidence-based, and promising practices has been occurring to assist in the implementation of Michigan's transformation plan. A continuing focus will be placed on client level outcomes and data collection in FY2009-FY2011, especially for children's block grant funded projects.

The Michigan Department of Community Health 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 system of care 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 system of care, increase parent leadership development, and increase and maintain youth involvement on interagency committees.

In addition Michigan has two ongoing SAMHSA System of Care grants which were awarded in September 2006, one in Ingham County and one in Kalamazoo County. These two systems of care grants, along with a former grant site in Southwest Detroit provide leadership in collaborative efforts to develop systems of care in their communities and impact the state level policy efforts. Four additional system of care proposals were approved for block grant funding in FY2009 to initiate or continue system of care activities in local communities. 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, Michigan Department of Human Services (MDHS), substance abuse agencies), family court judges, prosecutors, families and sometimes a youth, private agencies and community representatives.

The system change initiative Michigan adopted requires systems to develop integrated treatment capacity at every level of care for both adults and in many instances children. Individuals with co-occurring disorders face issues that are complex in nature. These complexities cut across various health and human service agencies. The initial system change approach Michigan adopted is to develop a comprehensive model that addresses the needs of every individual who seeks help. To that effect, PIHPs are encouraged to develop consensus documents along with other systems that delineate the expectations of the individuals who have co-occurring disorders including both adults and children. Most of the CMHSPs are at varying degrees in implementation.

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 MI and SA 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. These include Network180, Genesee, and LifeWays.

Michigan

Child - Summary of Areas Previously Identified by State as Needing Attention

Child - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

Three areas identified by the State in the FY08 Application as needing attention with regard to the system of care for children were: 1) Differences in accessing the array of services available at the local level; 2) Expansion of Current Innovative Projects; and 3) Services to Children in Foster Care.

MDCH has had some significant success in addressing these areas through a variety of approaches. First, MDCH utilized the Request for Proposal process for allocating the Mental Health Block Grant to focus on these areas of need. In the System of Care Request for Proposals for Children with Serious Emotional Disturbance for FY 2008, there was a specific emphasis placed upon Community Mental Health Services Programs (CMHSPs) planning with community partners to identify needs and then addressing those needs through the creation of service projects. This RFP was very broad in nature and requested CMHSPs to begin (or to continue) comprehensive system of care planning to meet the needs of children with serious emotional disturbance. Prior to FY 2007, RFPs were focused on specific areas of the system of care, while the FY2007, 2008 and 2009 RFPs allowed for greater flexibility based on the needs and priorities of the local communities in hopes of creating a local system that makes sense and is accessible to those that need it. CMHSPs were encouraged to specifically focus on how to better serve those youth with serious emotional disturbance that are involved in the child welfare or juvenile justice systems. Projects supported as a result of these RFPs include wraparound, infant mental health, screening of mental health needs for youth involved in juvenile justice and other evidence-based practices including Parent Management Training-Oregon Model, Multi-System Therapy, Therapeutic Foster Care and Functional Family Therapy.

To address the differences in access and service array, a partnership between MDCH and the PIHPs/CMHSPs was formed to develop various policy standards that would create more uniformity across the service system. The Standards Group is comprised of MDCH staff, representatives of the 18 PIHPs consumers and parents. The access eligibility workgroup of The Standards Group developed a standard policy guideline that addresses access processes and decision making. The guideline was put out for field review in May 2007 and, as of FY2009, it has now become an attachment to the MDCH contract with PIHPs and CMHSPs. In addition, MDCH Division of Mental Health Services to Children and Families convened a group of stakeholders including mental health clinicians and a parent to revise specific access criteria for children birth through 3 years, 4 through 6 years, and 7 through 17 years with serious emotional disturbance. The proposed revised criteria were developed and distributed in late FY 2007. The access/eligibility criteria were issued as a Technical Advisory for use by the field. It is anticipated that ultimately this criteria will also become part of the MDCH contract with PHIPs/CMHSPs in FY2010. Additionally, MDCH staff has been meeting regularly with the Michigan Department of Human Services staff (child welfare) to determine a way to better serve children in foster care that have a serious emotional disturbance. The Centers for Medicare and Medicaid Services (CMS)'s approval of Michigan's 1915(b) Medicaid Waiver included additional funding for children which will be available 10/01/2008. This additional funding is to be used to provide increased access and additional services to children with a serious emotional disturbance and children with developmental

disabilities with a specific focus on children in foster care who have been abused and/or neglected. Additional funding has also been added to the substance abuse Medicaid Waiver capitation for both children and adults for increased access to services. The FY 2009 contract between the MDCH and the 18 PIHPs contains specific performance targets for increased access for children.

Michigan

Child - New Developments and Issues

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

MDCH has been making strides in implementing evidence-based practices and outcomes management with CMHSPs. One example is Parent Management Training – Oregon Model (PMTO). MDCH has been supporting CMHSPs to receive training in PMTO, which is an evidence-based practice for working with children and families developed by Gerald Patterson in the 1960s. PMTO is tailored to work for serious behavior problems for youth from preschool through adolescence. PMTO is a family intervention designed to empower parents, identify and build on the strengths of the family, and provide skills training in effective parenting practices for parents. The skills training focuses on skill encouragement, limit setting, monitoring /supervision, family problem solving, and positive involvement. MDCH is currently training staff across the state in PMTO and established regional training sites within PIHPs in 2008 with the help of block grant funding. In addition, other evidence-based practices supported with block grant funds include Multi-systemic Therapy, Therapeutic Foster Care, and Functional Family Therapy.

The Michigan Level of Functioning Project (MLOF) has led to Michigan being a national leader in outcomes management for youth with serious emotional disturbance. MLOF uses the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 2000) to assess children with serious emotional disturbance upon entry into services though CMHSPs and then requires quarterly assessments of children. CMHSPs are provided with reports that can help to monitor progress for individual children and their families and this information can be used with families in making decisions about treatment through family-centered practice. The data collected has led to improved outcomes management for children with serious emotional disturbance and their families and the identification of areas that could be improved in the system of care. Michigan continues to look for ways to transform the system of care using data- based decision making.

Wraparound is a planning process that is used for children and families that are in multiple systems and are determined by the community team to be eligible for wraparound services. Michigan has been a leader in the development and implementation of the wraparound process. Wraparound is available statewide and is a Medicaid covered service under the 1915b/c mental health managed care waiver. Wraparound training is provided in partnership with the Department of Human Services (DHS) which includes youth and parent trainers. DHS has also contributed substantial funds to implement wraparound. Michigan is developing a fidelity evaluation system and provides ongoing training to help ensure fidelity to the wraparound process. Supporting the wraparound process is part of Michigan's transformation strategy to develop an individualized plan of care for children with a serious emotional disturbance. In addition, Michigan applied for and received a 1915(c) home and community based waiver for youth with a serious emotional disturbance (SEDW) and began enrolling children in FY07. This waiver has helped Michigan transform its system and expand wraparound services across the state. Wraparound provides a practical way for clinicians to provide individualized family-centered services.

Family-centered practice is the framework in which services are planned and delivered in Michigan in the public mental health system and by other child-serving systems. MDCH

developed a technical advisory on Family-centered practice that was distributed to PIHPs/CMHSPs in April 2006. The technical assistance advisory was developed in partnership with the Association for Children's Mental Health (Michigan's Federation of Families Chapter). Continued focus on providing services that meet the needs of children and families has led to the development of a family-centered practice training model that can be used for cross-systems training.

Family-centered practice is a planning and service delivery process that:

A. recognizes that parents play a unique and essential role in the lives of their minor children and have the greatest influence on the child's health, growth and development;
B. recognizes that enhancing parenting competence and confidence is the best avenue to achieving better outcomes for children;
C. is family specific, individualized by the culture, strengths, concerns, and resources of each family;
D. seeks to build self-empowerment within parents, children and youth; and
E. promotes resiliency by developing interventions that build competence and skills in children, youth and families, reduce risk and enhance protective factors.

The Centers for Medicare and Medicaid Services (CMS)'s approval of Michigan's 1915(b) Medicaid Waiver included additional funding for children which will be available 10/01/2008. This additional funding is to be used to provide increased access and additional services to children with a serious emotional disturbance and children with developmental disabilities with a specific focus on children in foster care who have been abused and/or neglected. Additional funding has also been added to the substance abuse Medicaid Waiver capitation for both children and adults for increased access to services. The FY 2009 contract between the MDCH and the 18 PIHPs contains specific performance targets for increased access for children. In addition, a new service was included in the 1915(b)(c) Waiver renewal as a (b)(3) additional service. This is parent-to-parent support, which will provide a trained parent support partner who has or had a child with special mental health needs to provide education, training and support to another parent whose child is receiving services in the public mental health system. MDCH, through a contract with the Association for Children's Mental Health, has developed a training curriculum for parent support partners which will be implemented in FY2009.

Michigan

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

The Michigan Mental Health Commission was created by Governor Granholm in 2004 with the executive directive to look at issues related to mental health and to provide recommendations. MDCH is working and reporting on these recommendations on a regular basis.

The Michigan Legislature's Appropriations Act for MDCH requires that an annual survey of consumer satisfaction be conducted. For the past 12 years, MDCH has targeted a statewide probability sample of adult Medicaid beneficiaries who received mental health, developmental disabilities, or substance abuse treatment. The sample of consumers received a mailed copy of SAMHSA's Mental Health Statistical Improvement Program (MHSIP) consumer survey. Beginning in 2007, each PIHP began to use the MHSIP to survey adults with mental illness and children with serious emotional disturbance receiving certain covered services during the month of May.

The Appropriations Act also requires MDCH to look at cost allocation, access and eligibility issues and the standardization of certain activities across the state. MDCH along with its PIHPs created The Standards Group (TSG) which is a joint effort of the MDCH, PIHPs and the Michigan Association of Community Mental Health Boards. The TSG is charged with developing uniform and consistent standards for statewide use on serving persons with mental illness, developmental disabilities and substance use disorders. In follow-up to the Mental Health Commission recommendations, it was determined that consumers of public mental health services in Michigan would benefit from a more uniform approach to eligibility and access to services and supports across the state. To begin to design a more equitable, accessible and uniform service delivery system, the PIHP and CMHSP systems came together to create a capacity to standardize clinical and administrative practices that affect how services and supports are organized and delivered. TSG developed an Access and Eligibility Guideline to be used uniformly across all PIHPs. This guideline is an attachment to the MDCH/PIHP/CMSP FY2009 contracts.

Michigan

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Child - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

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Michigan

Child - Description of State Agency's Leadership

Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

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Michigan

Adult - Service System's Strengths and Weaknesses

Adult - A discussion of the strengths and weaknesses of the service system.

Michigan has a strong community-based system of care. Person-centered planning has been required for all people served by the mental health system for more than a decade. The process, with emphasizes people's strengths and respects their own personal goals and choices, is a strong foundation to infuse recovery throughout the system. There is a wide array of services available in the state as the result of Michigan's 1915(b) Medicaid waiver, which allows for many alternative services provided under the authority of 1915(b)(3) in addition to state plan services. MDCH serves as both the mental health authority and the state Medicaid agency, so mental health program staff determines policies and procedures for most publicly-funded mental health in the state. There is a limited outpatient mental health benefit in the Medicaid health plans.

Consumers have become central to the system and have an ever-increasingly power to influence policy at both the regional and state levels. Consumers serve on every CMHSP board, every PIHP Improving Practices Leadership team and many statewide groups, including the Practice Improvement Steering Committee, the Integrated Treatment Committee, and the Supported Employment Subcommittee. The Recovery Council, which is largely comprised of consumers, continues to meet quarterly and is integral to system development and change.

Peer Support Specialist training is a major state initiative. There are currently 398 Certified Peer Support Specialists. The state planning council, which also has had strong consumer representation, has recently added representation in the form of a young adult who received public mental health services and an adult consumer with co-occurring mental health and substance use disorders who is also a Certified Peer Support Specialist.

The concentrated implementation and support of selected evidence-based practices over the past two years is also strength. All PIHPs will have Family Psychoeducation and Co-occurring Disorders: Integrated Dual Disorders Treatment (COD-IDDT) services evidence-based practices available by fiscal year 09/10. There is a trained team of peer assessors in the state to measure fidelity to the COD-IDDT model that operates in conjunction with a state university. In addition to specific program development, the state has required and supported system change using the CCISC model so that integrated screening, assessment, and treatment become available with both the mental health and substance abuse services for people with various levels of care needs. A recently formed Integrated Treatment Committee has representation from Medicaid health plans, Medical Services Administration, Mental Health and Substance Abuse and is working to make the entire system co-occurring capable. Supported Employment is the third practice selected by the Practices Improvement Steering Committee for implementation with block grant support, and several programs are in development. The Supported Employment Subcommittee has been meeting since June, 2008. The implementation of evidence-based practices is increasing research-based treatment options as choices for consumers.

The public mental health system is weaker when it comes to serving people in need that do not have Medicaid coverage. Medicaid rates increase as required by the Managed Care Regulations for actuarial soundness. State general fund allocations have not increased in the last ten years, resulting in less funding to serve individuals who are not Medicaid beneficiaries. General funds are used according to the Michigan Mental Health Code requirement that priority be given to those with the most serious mental illness. Persons with mild or moderate conditions or less urgent needs can expect to be placed for some period of time on waiting lists for services or be

referred to private non-profit mental health providers for service. To some members of the public it appears that individuals have to be in crisis in order to access the mental health system. For FY 09, MDCH will require all CMHSPs to keep waiting lists of people they are unable to serve.

Another weakness in the state funded system is the variability between regions. This variability may be due to combinations of availability of funding by region, regional population and need, admission criteria, service array, and response. Access standards for the state network have been established and will be included in FY 09 contracts with PIHPs and CMHSPs. This will reduce variability between regions.

As discussed previously, the weakness of the state economy is problematic on several levels. There are increasing numbers of people with lower incomes, and an increasing percentage of people in the state are receiving public financial assistance and Medicaid. The state's unemployment rate is the highest in the nation, and the housing foreclosure rate is very high. Finding meaningful, well paying work is difficult for many in the state, including many of those with disabilities. Funding for community mental health services has had the support of the governor and the legislature and has not been cut, although it has not kept up with inflation. Administrative efficiencies and the delivery of more evidence-based and promising practices are both being pursued to allow for the best services possible to support people to have meaningful lives in the community.

Michigan

Adult - Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

The work of transforming the system to one that emphasizes strengths and abilities and is firmly rooted in the belief in recovery is ongoing. It takes time for new beliefs and understandings to permeate a system, and as evidenced by some language and behaviors and from input from consumers, additional progress is needed.

There are opportunities to improve the service array available through continued implementation of evidence-based practices and promising practices. There is also a need to implement policies and practices to assure sustainability of evidence-based practices that maintain model fidelity over time.

There are not enough integrated services to meet the needs of individuals with both mental health and substance use disorders. Individuals with co-occurring disorders still face hurdles when accessing care, which at time involved the mental health system, the substance abuse system, and the Medicaid health plan system.

There is a need for increased meaningful work for consumers and for the supports needed for success in work. The demographic data and encounter data indicate there has not been significant growth in employment for consumers in several years.

Michigan

Adult - Plans to Address Unmet Needs

Adult - A statement of the State's priorities and plans to address unmet needs.

The Community Mental Health Block Grant funding in Michigan is being used to support mental health system transformation. Block grant funding, although a small percentage of overall mental health funding, has made a large and very important impact in transformation. All funded block grant projects much indicate how the project will assist consumers in recovery, and have consumer involvement. Based on recommendations of the Recovery Council, the department will require all CMHSPs in fiscal year 2009 to use the Recovery Enhancing Environment (REE) tool to assess where its region stands in relation to Recovery. Based on its results, each CMHSP will develop a plan to move the system forward.

The work of implementing evidence-based practices to improve the service array available as choices to consumers continues with the direction of the Practice Improvement Steering Committee. The committee has selected Supported Employment as the third new evidence-based practice for concentrated implementation in the state. Block grant funds have been made available to assist PIHPs implement the practice. PIHPs have been advised that effective in fiscal year 2010 they will be required to have Family Psychoeducation and Co-occurring Disorders: Integrated Dual Disorder Treatment (COD:IDDT) available for consumers in their region. Specific training requirements are in place for clinicians to deliver Family Psychoeducation in the state. Trained peer reviewers in the state do fidelity reviews of COD:IDDT teams. Minimum state criteria have been set for COD:IDDT teams before services can be reported as such.

Assertive Community Treatment is already required as part of the service array. Model fidelity of ACT is being assisted by the use of a recently developed ACT Field Guide, which includes both state Medicaid requirements and evidence-based fidelity items. State Medicaid standards are currently being revised to incorporate some of the components of the resource guide, included increased physician time dedicated to the teams. MDCH is working with universities in the state to assure sustainability of fidelity.

Much progress has been made in the state on implementation of integrated services. Development of programs based on the evidence-based COD:IDDT model is one part of this. Training and external peer fidelity reviews will continue to be supported by the state. The state is also supporting the larger system level change needed throughout the mental heath and substance abuse systems. An internal work group is charged with addressing the multiplicity of issues involved and communicating with a consistent voice. Statewide and regional consultations and supports continue. The COD:IDDT Subcommittee of MDCH's Practice Improvement Steering Committee continues to meet and to sponsor Learn and Share opportunities for regions to learn from one another. In July of 2008 a new Integrated Treatment Committee of 21 invited stakeholders first met. The group is being charged with service development direction for persons at all level of mental health need, whether they are primarily served in the mental health, the substance abuse, or the Medicaid health plan. The group includes consumers, a Medicaid health plan psychiatrist, state Medicaid, mental health, and substance abuse staff, and community mental health and substance abuse administrators and providers.

The need for meaningful work opportunities for consumers and for the supports needed for success in work is being addressed by targeted implementation of the evidence-based practice of

Supported Employment in the state. The Supported Employment Subcommittee of the Practice Improvement Steering Committee began meeting in June 2008. The department is engaged in frequent meetings with Michigan Rehabilitation Services to take an in-depth look at our agencies missions, goals, and how we can work together to better serve our customers.

Michigan

Adult - Recent Significant Achievements

Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

Mental Health System Transformation

The Community Mental Health Block Grant funding in Michigan is being used to support mental health system transformation. This funding, although a small percentage of overall mental health funding, has made a large and very important impact in transformation. PIHPs have been required to have consumer input into block grant proposals submitted for the last few years. Proposed projects must address how they support consumers in recovery. Consumers are expected to be part of the proposal development and part of the project implementation. Every proposal is reviewed by a team that includes at least one primary consumer.

Evidence-Based Practices and Improving Practices:

The Practice Improvement Steering Committee, which consists of mental health consumers, representatives from the PIHPs, major state universities, MHCH staff, and mental health advocacy organizations, continues to oversee the adoption of evidence-based practices in Michigan's public mental health system. The committee determined that PIHPs would be required to implement either Family Psychoeducation (FPE) or Integrated Dual Diagnosis Treatment for Co-Occurring Disorders (IDDT) in FY 06 and FY 07 using the federal Substance Abuse and Mental Health Services Administration (SAMHSA) recognized models. Federal Mental Health Block Grant funds were provided to each PIHP to initiate their evidence-based practice (EBP) projects and to assist with community organizing and staff training. For FY 08, federal Mental Health Community Block Grant funds are being used to assist PIHPs to implement one of the two practices not yet implemented in FY 05-07 or, if they are implementing both FPE and IDDT, to implement supported employment. It is intended that all PIHPs have both FPE and IDDT available for consumers who choose them by October 1, 2009. Universities are assisting with fidelity measurement coordination and evaluation of the implemented projects. The Practice Improvement Steering Committee has selected Supported Employment as the third evidence-based practice for adults for concentrated implementation in the state. For FY 09-10, block grant funding has been made available for Supported Employment implementation to PIHPs. A new Supported Employment Subcommittee began meeting in June 2008. The department is working with Michigan Rehabilitation Services to address how our systems can work together most beneficially for consumers. A three-year initiative to develop, train and provide ongoing consultation for 16 new and existing Dialectical Behavior Treatment teams is ongoing.

System Change for Integrated Co-occurring Services

Seventeen of the 18 PIHPs have selected a group of committed individuals to lead the system change work needed to meet the needs of individuals with co-occurring mental health and substance use disorders. The department is using the Comprehensive, Continuous Integrated System of Care model developed by Drs. Ken Minkoff and Christie Cline. Since January of 2008 these Change Agent Teams have been coming together in daylong sessions with Drs. Minkoff and Cline. Each time there is a day for the southern half of the state and a day for the northern half of the state.

The state convened an invited group of stakeholders to address the system needs of people with co-occurring disorders who seek care in the public mental health, substance abuse, and Medicaid health plan systems. This Integrated Treatment Group began meeting in July 2008. The charges to the group are:

- Incorporate all the stakeholders to develop a Comprehensive, Continuous, Integrated System of Care for all the individuals served by the public mental health and substance abuse system
- Develop consensus in addressing co-occurring disorder services for people at all levels of severity (all four quadrants)
- Work with the local change agent groups to address areas where system change is necessary to ease implementation
- Identify and address barriers
- Address performance improvement, quality improvement, and outcome monitoring

The Integrated Treatment Group will be providing reports and recommendations to the department's Internal Integrated Treatment Group. This latter group meets on a bi-weekly basis and it dedicated to removing system barriers for people with co-occurring disorders. The group has constructed and communicated a method for collecting date on integrated services in the state (both the evidence-based practice and other integrated services) to both the mental health and substance abuse systems. It recently put together a joint Request for Proposal that will fund integrated treatment initiatives for people primarily in the substance abuse system whose mental health needs are cannot be met without the involvement of mental health professions.

Peer Support Specialists

One of the foundations for system transformation efforts in Michigan includes the initiative of hiring Peer Support Specialists. MDCH has offered an RFP process for several years to encourage the PIHPs/CMHSPs to hire consumers in peer support positions. In partnership with the Appalachian Group of Georgia, MDCH has committed to working with Larry Fricks and Ike Powell in developing the Peer Specialists Curriculum that serves as the basis for the upcoming SAMHSA toolkit on peer supports.

Peer Support Specialists in Michigan are a covered service through the 1915 (b) Waiver for Specialty Services. Encounter data on the number of contacts per each county is collected as part of the process for examining the availability of peer supports.

Since 2005, Michigan has provided training and testing with 398 peers receiving certification as of May 2008. MDCH continues to provide at least four trainings a year and has developed a partnership with the Copeland Center for WRAP facilitation. Over 40 Certified Peer Support Specialists are WRAP Facilitators.

Continuing education activities for Peer Support Specialists are part of the RFP process with several counties utilizing this opportunity to train peers at the local, state and national level. MDCH receives frequent inquiries for information from other states interested in establishing peer supports as a covered service.

Michigan

Adult - State's Vision for the Future

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

On August 12, 2008 the Director of the Mental Health and Substance Abuse Administration issued a Concept Paper on "Focusing a Partnership for Renewal and Recommitment to Quality and Community in the Michigan Public Mental Health System." The concept paper sets the stage for collaborative work at the state, regional, and local levels to continually improve services and promotes partnerships between agencies.

MDCH is developing an Application for Renewal and Recommitment that will identify areas of importance for PIHPs to meet their responsibilities to the people they serve, the state and federal government, and the public. This application will build on what was communicated during the Application for Participation process in 2002 and incorporate the transformation work that has occurred since then. MDCH will also be developing new Policy Planning Guidelines for the CMHSPs for FY 09.

MDCH will continue to work with stakeholders to build on person-centered and recovery principles to shape a system of public mental health care that supports consumers to live satisfying and hopeful lives in the community.

The service and support array available will include more services that have shown to be effective for the target population. These services will be offered as a choice for consumers; consumers will be provided with information regarding the available services in order to make an informed decision. Fidelity to evidence-based models will be ensured and supports provided to clinicians and administration to maintain quality services.

A quality improvement approach will be used throughout the system of care, with the involvement of people in all types of positions in the system. Uniformity in access, eligibility, and quality will be increased across all regions of the state. Administrative efficiencies will be sought while assuring that services are not harmed.

Mental health administrators and providers will work with other departments and agencies that also serve our customers to assure meaningful systems of care, and to provide integrated care wherever possible. Integration of mental health and substance abuse services will continue, and aligning them with physical heath care will be increased.

Michigan

Child - Service System's Strengths and Weaknesses

Child - A discussion of the strengths and weaknesses of the service system.

Managing and developing the system of care
Michigan is transforming its system by reducing fragmentation and supporting developing systems of care. Michigan has had Community Collaboratives established for over twenty years covering every county in the state. The Community Collaborative is an inclusive planning and implementation body of stakeholders at the county or multi-county level. The Community Collaboratives articulate a shared vision and mission to improve outcomes for children and families through sharing risk, making decisions concerning use of funds, facilitating cross-systems arrangements, and making joint programming and policy decisions. The Community Collaboratives are involved with supporting and implementing a number of collaborative initiatives described below, such as Wraparound and the Mental Health Juvenile Justice Screening, Assessment, and Diversion Project.

Wraparound
Wraparound is a planning process that is used for children and families that are in multiple systems and are determined by the community team to be eligible for wraparound services. Michigan has been a leader in the development and implementation of the wraparound process. Wraparound is available statewide and is a Medicaid covered service under the 1915b/c mental health managed care waiver. Wraparound training is provided in partnership with DHS which includes youth and parent trainers. DHS has also contributed substantial funds to implement wraparound. MDCH continues to provide skill set training for wraparound and technical assistance as well. In addition, two quality improvement tools are part of the contract requirement for wraparound funding. In FY2008, MDCH worked on the development of an enhanced evaluation process which may include the Wraparound Fidelity Index (WFI), which is a nationally recognized tool, in addition to other tools to measure fidelity as well as overall outcomes for wraparound in Michigan. Supporting the wraparound process is part of Michigan's transformation strategy to develop an individualized plan of care for children with a serious emotional disturbance. In addition, Michigan applied for and received a 1915(c) home and community based waiver for youth with a serious emotional disturbance (SEDW). This waiver will help Michigan transform its system and expand wraparound services across the state. Wraparound provides a practical way for clinicians to provide individualized family-centered services. Wraparound is consistent with Goal 2 in the President's New Freedom Commission Report

Family-Centered Practice
Person-Centered Planning/Family-Centered Practice is the framework in which services are planned and delivered in Michigan in the public mental health system and by other child-serving systems. Person-Centered Planning was incorporated in the Michigan Mental Health Code in 1996. In the policy guidance on Person-Centered Planning MDCH states that "in the case of minors, the child/family is the focus of services planning, and family members are integral to the planning process and its success." Based on this guidance MDCH developed a technical advisory on Family Centered practice that was distributed to PIHPs, CMHSPs in April 2006. The technical assistance advisory was developed in partnership with the Association for Children's Mental Health (Michigan's Federation of Families Chapter). Continued focus on providing services that

meet the needs of children and families has led to the development of a Family-Centered Practice training model that can be used for cross-systems training.

Family-centered practice is a planning and service delivery process that:

A. Recognizes that parents play a unique and essential role in the lives of their minor children and have the greatest influence on the child's health, growth and development;
B. Recognizes that enhancing parenting competence and confidence is the best avenue to achieving better outcomes for children;
C. Is family specific, individualized by the culture, strengths, concerns, and resources of each family;
D. Seeks to build a self-empowerment within parents, children and youth.
E. Promotes resiliency by developing interventions that build competence and skills in children, youth and families, reduce risk and enhance protective factors.

Evidence-Based Practices
As part of its transformation plan and consistent with Goal 5 of the President's New Freedom Commission Report, Michigan is also implementing evidence based practices within the framework of an individualized family centered planning process. Three primary models of practice are being supported with block grant funding, these include: Trauma Informed Cognitive Behavior Therapy, Parent Management Training-Oregon Model (PMTO), and Multi-Systemic Therapy (MST). Outcome data from The Michigan Level of Functioning Project has led to decisions about which EBP models to develop and implement, while efforts such as Wraparound and Family-Centered Practice have been directed at improving the process and family/youth voice and choice in which practices are delivered.

Michigan is planning to implement Parent Management Training – Oregon Model (PMTO) statewide. PMTO is designed to work with children who have a serious emotional disturbance and behavior disorder. PMTO is a manualized treatment that focuses on positive skill encouragement, limit setting, monitoring/supervision, family problem-solving, and positive youth involvement. Eleven PIHPs are currently implementing PMTO. Multi-Systemic Therapy is designed for children with conduct disorders and who are involved with the juvenile justice system. There are currently 5 communities where the court and CMHSP are coordinating (sharing funding and training staff) to implement MST.

Michigan Level of Functioning Project
The Michigan Level of Functioning Project uses the Child and Adolescent Functional Assessment Scale (CAFAS) to gather data about children receiving services from the children's public mental health system and then utilizes this data in three primary areas. These include the identifying evidenced-based practices to be implemented, improving access to services and improving the quality of existing services in the system, such as home based services. Outcome data was utilized to help determine which evidence-based practice can be most helpful to Michigan in improving services to children and families.

The data has also been used to develop guidelines for access to services provided by the PIHPs/CMHSPs in order to develop more uniform decision making across the mental health system. In addition, this data has been used to identify promising practices within the CMHSP programs who are using data to monitor themselves to improve existing services.

Great Start Initiative (Early Childhood Comprehensive System [ECCS] Project)
The ECCS Project is an initiative that will better coordinate the services the State of Michigan provides for its very young children. Consistent with Goal 4 of the President's New Freedom Commission Report, the initiative includes immediate steps to strengthen Michigan's early childhood efforts and to build an early childhood system of care, for children birth through five and their families, through local Great Start Collaboratives convened by the Intermediate School Districts.

Governor Jennifer Granholm launched Project Great Start in her 2004 State of the State address. The governor described this new initiative as a movement that challenges us all to recognize that education begins at birth, not when a child enters school. The Early Childhood Investment Corporation was established by Governor Granholm to allow the state to more effectively focus early childhood efforts and leverage public and private dollars to expand the availability of services and supports in seven component areas: Physical health, social-emotional health, family supports, parenting education basic needs, economic stability and safety, and early education and child care.

Improving Family Voice and Choice in Policy development, Planning, Training, and RFP Reviews
Michigan is constantly looking for new and creative ways to involve families in policy development, planning, training, and in the block grant. Family members are involved in reviewing RFP's and making recommendations for which PIHP/CMHSP will receive funding. Youth and families are involved in wraparound steering committee, training and technical assistance workgroups, many early childhood projects and numerous other committees that have been formed related to children's mental health services. The chair person for the Advisory Council on Mental Illness is currently the parent of a child with a serious emotional disturbance. We are also working on strengthening our youth voice and have initiated a workgroup to develop a young adult peer to peer model and plan to continue to involve youth in other opportunities and training.

Weaknesses of the children's service system
Three areas identified by the State in the FY08 Application as needing attention with regard to the system of care for children were: 1) Differences in accessing the array of services available at the local level; 2) Expansion of current innovative projects; and 3) Services to children in foster care.

MDCH has had some significant success in addressing these areas through a variety of approaches. First, MDCH utilized the Request for Proposal process for allocating the Mental Health Block Grant to focus on these areas of need. In the System of Care Request for Proposals for Children with Serious Emotional Disturbance for FY 2008,

there was a specific emphasis placed upon Community Mental Health Services Programs (CMHSPs) planning with community partners to identify needs and then addressing those needs through the creation of service projects. This RFP was very broad in nature and requested CMHSPs to begin (or to continue) comprehensive system of care planning to meet the needs of children with serious emotional disturbance. Prior to FY 2007, RFPs were focused on specific areas of the system of care, while the FY2007, 2008 and 2009 RFPs allowed for greater flexibility based on the needs and priorities of the local communities in hopes of creating a local system that makes sense and is accessible to those that need it. CMHSPs were encouraged to specifically focus on how to better serve those youth with serious emotional disturbance that are involved in the child welfare or juvenile justice systems. Projects supported as a result of these RFPs include wraparound, infant mental health, screening of mental health needs for youth involved in juvenile justice and other evidence-based practices including Parent Management Training-Oregon Model, Multi-System Therapy, Therapeutic Foster Care and Functional Family Therapy.

To address the differences in access and service array, a partnership between MDCH and the PIHPs/CMHSPs was formed to develop various policy standards that would create more uniformity across the service system. The Standards Group is comprised of MDCH staff, representatives of the 18 PIHPs consumers and parents. The access eligibility workgroup of The Standards Group developed a standard policy guideline that addresses access processes and decision making. The guideline was put out for field review in May 2007 and, as of FY2009, it has now become an attachment to the MDCH contract with PIHPs and CMHSPs. In addition, MDCH Division of Mental Health Services to Children and Families convened a group of stakeholders including mental health clinicians and a parent to revise specific access criteria for children birth through 3 years, 4 through 6 years, and 7 through 17 years with serious emotional disturbance. The proposed revised criteria were developed and distributed in late FY 2007. The access/eligibility criteria were issued as a Technical Advisory for use by the field. It is anticipated that ultimately this criteria will also become part of the MDCH contract with PHIPs/CMHSPs in FY2010. Additionally, MDCH staff has been meeting regularly with the Michigan Department of Human Services staff (child welfare) to determine a way to better serve children in foster care that have a serious emotional disturbance. The Centers for Medicare and Medicaid Services (CMS)'s approval of Michigan's 1915(b) Medicaid Waiver included additional funding for children which will be available 10/01/2008. This additional funding is to be used to provide increased access and additional services to children with a serious emotional disturbance and children with developmental disabilities with a specific focus on children in foster care who have been abused and/or neglected. Additional funding has also been added to the substance abuse Medicaid Waiver capitation for both children and adults for increased access to services. The FY 2009 contract between the MDCH and the 18 PIHPs contains specific performance targets for increased access for children.

Michigan

Child - Unmet Service Needs

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

The Mental Health Commission established by Governor Jennifer Granholm made recommendations based on their analysis of MDCH service data and expenditures and testimony from consumers and families. One of the key recommendations was that access to services state-wide among PIHPs/CMHSPs should be consistent. Another recommendation was to increase access to appropriate mental health services to children in the child welfare system. Thirdly, MDCH, consistent with transformation of the mental health system, has identified certain evidence-based practices that need to be implemented state-wide.

Data from the Level of Function project as well the MDCH data system was used to first identify some of the differences in who was getting into services as well as what services they were receiving. Data from the child welfare and mental health systems was used to identify youth who were served in both systems and a small percentage of the youth involved with the child welfare system were also being served in the public mental health system. Additional data from the Level of Functioning Project was used to determine which CMHSPs were achieving successful treatment outcomes and identifying which evidence based practices they were using to achieve that end so these practices can be utilized by other CMHSPs.

Michigan

Child - Plans to Address Unmet Needs

Child - A statement of the State's priorities and plans to address unmet needs.

Collaborative groups at the state level continue to work with communities to expand their local system of care and ameliorate differences in services available to children and families. Consistent with Goal 3 in the President's New Freedom Commission Report, MDCH has developed a uniform eligibility guideline to improve access to quality services across the state. In addition, communities that have not received block grant funding in the past will receive top priority for funding in FY2009. Finally MDCH continues to target block grant funding to serve children involved with child welfare and juvenile justice.

Decrease differences in array of services available at the local level
MDCH has developed 1) access system standards that will be an attachment to the FY2009 MDCH/PIHP and CMHSP contracts; and 2) access criteria for children with severe emotional disturbance issued as a Technical Advisory for use by the PIHPs/CMHSPs in FY 2008 and 2009. It is anticipated that it will become part of the FY2010 PIHP/CMHSP contracts. These guidelines will assist in making access criteria and access process uniform across the state. The access criteria will also serve as clear guidelines for other systems about the children who are eligible for services from the public mental health system.

Expansion of Current Innovative Projects
At present time, evidence-based practice training and innovative projects such as the Mental Health Juvenile Justice Screening, Assessment, and Diversion Projects and the Michigan Level of Functioning Project are slowly being expanded statewide using block grant funding. Michigan is increasing collaboration with state and local partners to expand wraparound through the use of a 1915(c) waiver for children with a serious emotional disturbance. This project also started small but plan to enroll additional children in FY08 and FY09. This is a collaborative effort that involves funding from the courts as well as DHS and the CMHSPs.

Services to Children in Foster and Adopted Care
Children in foster care are excluded from the Medicaid Health Plan benefit, which includes an outpatient mental health benefit. The Medicaid capitated Mental Health Specialty Services provided through PIHPs/CMHSPs serves children with serious emotional disturbance including children in foster care who meet specialty services criteria. Access to mental health services for children in foster care is a problem that has been identified as a special focus by MDCH and Department of Human Services. The Department of Human Services (DHS) purchases services for children in foster care from the private mental health system and a small percentage children in foster care receive services through the CMHSP. The Michigan Department of Community Health is working with the Department of Human Services to help children in foster and adoptive care receive services that are appropriate to their needs.

Shared Funding
There are four primary methods to blend and braid funding to provide intensive community based services to fill gaps for children in Michigan. They include the following: 1) combining Community Mental Health Service Programs (CMHSP) local

general funds with the Child Care Fund (CCF); 2) combining local CMHSP, CCF and the 1915(c) waiver for children with a serious emotional disturbance (SEDW); 3) combining CMHSP general funds as well as Medicaid funds with CCF, and other local funds such as substance abuse funding, or United Way funding, to provide wraparound services; 4) using adoption medical subsidy funding to provide intensive community based services for children who have been adopted. Michigan plans to continue to support jointly funding services across systems. This helps build collaboration and supports cost sharing versus cost shifting.

Michigan

Child - Recent Significant Achievements

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

Children in foster care are excluded from the Medicaid Health Plan benefit, which includes an outpatient mental health benefit. The Medicaid capitated Mental Health Specialty Services provided through PIHPs/CMHSPs serves children with serious emotional disturbance including children in foster care who meet specialty services criteria. Access to mental health services for children in foster care is a problem that has been identified as a special focus by the Michigan Department of Community Health (MDCH) and Department of Human Services (DHS). DHS purchases services for children in foster care from the private mental health system and a small percentage of children in foster care receive services through the PIHP/CMHSP. MDCH is working with DHS to help children in foster and adoptive care receive services that are appropriate to their needs. In FY2008, $13.2 million in funding was added to the capitation for children under the Medicaid 1915(b)/(c) waiver for mental health specialty services and supports. Performance expectations in FY2009 MDCH contracts with PIHPs/CMHSPs continue to target an increase in services to children in the child welfare system that have been abused/neglected or placed in foster care.

MDCH and its system partners in child welfare and the juvenile justice systems continue to meet on a regular basis and continue to work on improving services across systems. MDCH continues to introduce and support evidence-based and promising practices to improve quality of service as well. MDCH has shown a dedication to continuing PMTO training across the state, supporting Wraparound training and fidelity projects, expanding Juvenile Justice Diversion programs, and encouraging the development of family and youth advocacy/involvement programs in local communities. The development of local systems of care and improving services and collaboration will continue to be a focus in FY 2009, 2010, and 2011. MDCH has also initiated training for CMHSP clinicians on Trauma Informed Cognitive Behavioral Therapy in order to better serve abused and neglected children in DHS foster care.

Michigan

Child - State's Vision for the Future

Child - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

Michigan plans to continue to transform its mental health system by using block grant funding to support the development of the system of care at a state and local level. Within in the mental health system, the focus will be on providing evidence-based and promising practices that are family-centered, intensive, community-based services, and serve as an alternative to out of home care.

The Michigan Department of Community Health 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 system of care 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 system of care, increase parent leadership development, and increase and maintain youth involvement on interagency committees.

In FY2009, there will be a continued focus on serving children in the child welfare and juvenile justice systems. The Block Grant RFP for FY2009 targets these populations and asked communities to increase interagency collaboration to develop systems of care that serve youth with serious emotional disturbance more effectively. The majority of projects funded in FY09 are multi-year projects (either in their 2nd or 3rd year of funding or starting a new cycle of multi-year funding that could be for up to 5 years.) and/or ongoing training or outcomes evaluation projects. The plan is to fund these types of projects in the next two fiscal years.

Michigan

Adult - Establishment of System of Care

Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

MDCH believes that a managed system of supports and services operated through the public mental health and substance abuse systems must be based on values that reflect person-centered planning. This system must support individuals to be:

- empowered to exercise choice and control over all aspects of their lives;
- involved in meaningful relationships with family and friends;
- supported to live with family while children, and independently as adults;
- engaged in daily activities that are meaningful, such as school, work, social recreation and volunteering; and
- fully included in community life and activities.

MDCH contracts public funds for mental health, substance abuse, and developmental disability services. Medicaid funds, which are paid on a per Medicaid-eligible capitated basis, are contracted with Prepaid Inpatient Health Plans (PIHPs), which are individual Community Mental Health Services Programs (CMHSP) or affiliations of CMHSPs. Each region is required to have an extensive 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 planning process and family-centered care for children. MDCH is actively promoting values of recovery and resiliency. Limited outpatient mental health services are available through Medicaid Health Plans (MHPs).

MDCH along with its partners are promoting and supporting system transformation to one based on the principle of person centered, recovery oriented system of care. The Michigan Recovery Council was created in 2005 to address this throughout the system. The majority of the members of this council are primary consumers. The council is charged with reviewing all MDCH policies that support or hinder recovery and proposing proactive changes that will further the goals of recovery. MDCH is continuously promoting anti-stigma activities through out the state through the Recovery Council, state sponsored conferences, trainings, contract requirements, site reviews, etc. The state also sponsors two consumer conferences every year, which are attended by more than 600 consumers. The Michigan surgeon general is actively working with several different stakeholders and developing statewide strategies that address suicide prevention.

The Michigan Mental Health Code dictates that every individual who receives care must have an individualized plan of care developed through the person-centered planning process. MDCH believes that persons who have received services have a valuable perspective on how to help others. To date, MDCH has trained 398 certified peer support specialists. Recruiting and trainings are ongoing and include continuing education for those who are already certified. MDCH works with the Michigan Association of Community Mental Health Boards to create a training plan that improves access and provides quality care that is culturally competent. Several PIHPs are developing electronic medical records for their system. Improving Primary Care Physician coordination is also part of overall improvement for the system. The department initiated an Improving Practices/Evidence Based Practice Steering Committee in 2004. The purpose of this initiative is to improve the practices within the public mental health system and provide consumers choices and access for evidence-based, state of the art practices. The steering committee committed to a quality improvement process for the 88 Assertive Community Treatment teams and several Supported Employment activities. The steering committee has selected Co-occurring Disorders: Integrated Dual Disorder Treatment, Family Psychoeducation, and Support Employment evidence based practices throughout the mental health system.

Intensive work is underway to make the public mental health and substance abuse systems co-occurring capable. Change Agent Teams from across the state have met four times since January 2008 with Dr. Ken Minkoff and Dr. Chris Cline and have accepted the responsibility to assure adoption of the Comprehensive, Continuous, Integrated System of Care model in their region. In addition to a subcommittee which continues to meet regularly around the implementation of the evidence-based practice, a new Integrated Treatment Committee is addressing the needs of all people with co-occurring disorders served by mental health, substance abuse, and Medicaid health plans for mental health outpatient needs. The department's Internal Integrated Treatment Group has approved new reporting mechanisms to allow for the uniform collection of integrated services and has recently developed a Request for Proposals using both mental health and substance abuse block grant funds. Proposals must show a partnership between a Substance Abuse Coordinating Agency and a CMHSP and provide for the integration of the mental health needs of individuals in the substance abuse system whose mental health needs are currently unmet. Another subcommittee of the Practice Improvement Steering Committee, the Measurement Group, is addressing ways to measure system performance.

Michigan

Adult - Available Services

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing
services;
Educational services;
Substance
abuse services;
Medical and dental services;
Support services;
Services provided by local school
systems under the Individuals with Disabilities Education Act;
Case management services;
Services
for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities
leading to reduction of hospitalization.

Health, Mental Health, and Rehabilitation Services

The comprehensive system of care for adults in Michigan includes the following services:

Mental Health Services:

Assertive Community Treatment
Assessments
Behavioral Management Review
Clubhouse Psychosocial Rehabilitation
Crisis Interventions
Crisis Residential Services
Individual and Group Therapy
Intensive Crisis Stabilization
Medication Administration
Medication Review
Nursing Facility Mental Health Monitoring
Targeted Case Management
Telemedicine
Transportation
Treatment Planning
Crisis Observation Care
Housing Assistance
Peer-Delivered or Peer-Operated Support Services
Respite Care Services
Support and Service Coordination
Supported/Integrated Employment Services
Fiscal Intermediary Services

Employment Services:

As part of the systems transformation processes, the Practice Improvement Steering Committee voted to support the implementation of Supported Employment in addition to Co-occurring Disorders: Integrated Dual Disorder Treatment and Family Psychoeducation beginning in FY07. For FY09, Community Mental Health Block Grant funds were made available to all PIHPs on a non-competitive base for implementation of the Supported Employment evidence-based practice.

MDCH convened a statewide evidence-based supported employment committee to support the implementation of the practice in June, 2008. This group consists of employment service and supports coordinators, administrators, peer support specialists, and employment specialists.

MDCH is committed to improve Supported Employment as an evidence-based practice by providing a series of trainings for consumers, families, employment specialists, administrators, and vocational rehabilitation service agencies. The trainings place an emphasis on information, resources, tools, and consultation focused on understanding supported employment principles and successful implementation processes.

Medicaid Infrastructure Grant:

Activities supported by Michigan's Medicaid Infrastructure Grant (MIG) include increasing Freedom to Work/Medicaid Buy-In enrollments, increasing the employment rate of people with disabilities, providing Work Incentives Planning and Assistance benefits planning and increasing the use of Social Security work incentives. The state MIG project coordinates a Recharging Competitive Supportive Employment workgroup consisting of CMHSP agencies. The work of this workgroup is being coordinated with the Supported Employment Subcommittee.

The community-based vision of this work includes: all individuals with disabilities recognizing the inherent values of work and are able to do so at the level they desire; system disincentives such as Medicaid spend-down requirements would be removed; all individuals choosing to work would working in integrated, not segregated, settings; and a Michigan specific website proving accurate information encouraging informed choice about an individual's benefits would be available.

Clubhouse/Psychosocial Rehabilitation Programs:

Michigan continues to support Clubhouse Programs throughout the state. Funding is provided to support members including improving employment outcomes and assisting with housing supports. MDCH offers training across the state to assist programs in increasing community involvement and integrating clubhouse members into community groups, developing and maintaining an array of employment opportunities, implementing tools of the recovery model, transportation, staffing, and job development in a rural community, developing self-help groups, and integration of Peer Support Specialists in the clubhouse.

The Clubhouse Assessment Tool was developed through a committee of clubhouse members and staff who volunteered to participate in a four-step iterative process. This Clubhouse Assessment Tool will be tested in the field in FY09. The feasibility of using the measure from the reviewers and the clubhouses' perspectives, the need to train outside reviewers in the process, members and staff input, and establishing reliability of ratings will be part of the pilot testing process. Any modifications to the protocol and tool itself will be reflected in the final version of the Clubhouse Assessment Tool and Protocol.

Housing Services:

The Supportive Housing Program and Ending Homelessness Partnership is in its ninth year and continues to produce more than 100 units per year in nine counties. This program is supported by a set-aside of low-income housing tax credits for people with special needs.

Every community across the state has developed a 10-Year Plan to End Homelessness. To assist in implementation of their plans, the Michigan State Housing Development Authority (MSHDA) has made $14,500,000 available to create supportive housing for homeless families with children, homeless youth, chronically homeless, and homeless survivors of domestic violence.

In addition, supportive housing developments in Detroit, Grand Rapids, and Battle Creek are being proposed targeted to homeless veterans. This initiative will create approximately 275 units of supportive housing for homeless veterans and has been effective in bringing new partners, both private and public, to the table.

MDCH Homeless Programs consist of Housing Opportunities for People Living with AIDS, PATH, Shelter Plus Care, and Supportive Housing Program grant programs in addition to a program of training and technical assistance made available to sub-grantees. Recent innovations include using PATH dollars to create a Housing Resource Center in Detroit and 10 other counties in the state. All of these programs provide outreach to people who are homeless with linkages to support to find and sustain housing.

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

Several Community Mental Health Block Grant Initiatives address homelessness (each of these projects is required to have a linkage to a local 10-year plan to end homelessness). On January 9, 2008, a separate Community Mental Health Block Grant Request for Proposals was issued to PIHPs and CMHSPs specifically for the development of Housing Resource Centers in communities without them. The centers outreach to people with mental illness who are homeless and assist them in obtaining and maintaining independent living. Several new projects were funded as the result of this process and funds for this purpose were again offered for new projects for FY09.

Educational Services, Services Provided by Local School Systems under the Individuals with Disabilities Education Act (IDEA):

The Michigan Department of Education (MDE), under the direction of the Superintendent of Public Instruction, carries out the policies of the State Board of Education. Within the MDE, the Office of Special Education and Early Intervention Service (OSE-EIS) is responsible for education and early intervention programs and services for young children and students with disabilities. Many young adults with mental illness continue in the public school system as Michigan provides public education for students with disabilities through age 25.

IDEAIDEA, enacted by Congress in 1975 to assure children with disabilities had the opportunity to receive a free and appropriate public education, authorized Special Education Services. The most recent revision, called IDEIA, attempts to align with the No Child Left Behind Act of 2001. It requires that children are really in general education first with assessment and accommodations in individual educational plans. There is increased responsibility for general and special education collaboration. The Michigan Special Education Mandate of 1971 created the birth through age 25 system of programs and services. MDE receives IDEA funding (on average about 19% of states' costs) under an approved State Performance Plan. Intermediate School Districts are responsible for special education, which is funded by a variety of sources including property taxes. Michigan has a Medicaid School Based Services program, which brings in federal funds to the state.

Transition services for students moving from school to post-school activities, including post-secondary education, vocational training, integrated employment including supported employment, continuing and adult education, adult services, independent living, or community participation, are provided. The primary responsibility for transition services is with the local education agency, as long as the student is eligible for public education. Other agencies including the Michigan Department of Labor and Economic Growth, Michigan Rehabilitation Services, and CMHSPs have planning and coordination responsibilities to assure that the transition from school to post-school activities is seamless. Once a student with a disability leaves school, the primary responsibility for transition services shifts to the state rehabilitation agency and other community agencies, as appropriate. MDCH participates in a Transition Network Team, which also includes Michigan Rehabilitation Services, Special Education, Department of Human Services, intermediate school districts, and local transition coordinators.

PIHPs are contractually required to work with local school systems, and local Michigan Rehabilitation Services, to address the needs of consumers eligible for services from both systems. The Person-Centered Planning process required in Michigan addresses life domains, including school, work, and health, for each individual in the development of the Individual Plan of Service.

Substance Abuse Services:

Substance Abuse Services that may be paid for out of Medicaid substance abuse capitation include subacute detoxification, residential services, outpatient services, and pharmacological supports. State General Funds may be used to pay for these services for Medicaid recipients as well as non-Medicaid recipients. CMHSPs are required by contract to provide or arrange for assessment and treatment services for individuals with co-occurring mental health and substance use disorders. MDCH contracts federal Substance Abuse Prevention and Treatment Block Grant funds and state general funds through 16 regional Substance Abuse Coordinating Agencies (CAs). Medicaid funds for substance abuse services flow through the PIHPs that manage the mental health (and development disabilities) benefits. Some PIHPs are also CAs; others subcontract with one or more CA.

Integrated Treatment for People with Co-occurring Mental Health and Substance Use Disorders:

It is the policy of MDCH that individuals with both mental health and substance use disorders receive services and supports in an integrated manner. MDCH has been working with all the PIHPs and the CAs for several years and this is a major treatment initiative. In June 2008, MDCH created an Integrated Treatment Committee (ITC) with 21 invited stakeholders to address barriers and develop strategies for individuals with co-occurring mental health and substance abuse disorders, whether they be primarily served in the public mental health, public substance abuse, or Medicaid primary care system.

MDCH is promoting co-occurring disorder system change at the state level and local levels through a group of individuals that includes administrators, supervisors, consumers and front line clinicians called change agents. MDCH brought approximately 350 change agents together four times this year and is planning to bring them one more time in October 2008. The expectation for these change agents that came together at the state level is that they go to their regional systems and work with their PIHPs and CAs to identify and address system barriers.

To further promote integrated treatment, the Mental Health and Substance Abuse Administration and the Office of Drug Control Policy issued a joint Request for Proposals in June 2008 for CAs to partner with one or more CMHSP to develop services and supports for individuals with co-occurring disorders who are being treated primarily in the public substance abuse system. MDCH received twelve proposals and selected six for funding for two years beginning in FY09.

MDCH is working with Wayne State University and a group of fifteen trained fidelity reviewers from different PIHPs to monitor the fidelity of the SAMHSA endorsed Evidence-Based Practice, COD:IDDT. At present, approximately 80 teams are in different stages of implementation of the IDDT model. Readiness assessments have been completed for approximately 50 teams to date. Initial fidelity assessments have been completed for approximately 30 teams. The fidelity assessment team is also providing technical assistance (TA) to the teams that request it. MDCH provided approximately 60 days of different trainings and TA through national and local experts related to integrated treatment at the state level and local level. These trainings and TA are targeted toward system change, program development and consumer advocacy, and self-help.

As part of its improving practice initiative, MDCH is currently working with a MINT certified trainer to train a group of clinicians to become the trainers for the system. The first group of 16 trainers will get a Michigan specified limited certificate. It is expected that those who get the certification will train others in the system on Motivational Interviewing. The vision of integrated treatment is to have the entire system capable of addressing co-occurring mental health and substance use disorders in a welcoming, emphatic, and hopeful way. This includes having access systems that provide a "no wrong door" policy and staff in these agencies welcoming individuals regardless of their symptoms or diagnosis.

Medical and Dental Services:

The Medical Services Administration within MDCH is responsible for the Medicaid Program in Michigan. Medicaid is the largest single item in the state's budget. One of every seven Michigan residents is eligible for Medicaid. As of August 2008, there are 1,464,674 people enrolled in Medicaid. Of these, 565,768 are age 20 or older, and 898,906 are age 0 through 19.

The majority of Medicaid beneficiaries receiving services through a PIHP are enrolled in a Medicaid Health Plan (MHP) for their health care services. In addition to primary health care, MHPs in Michigan are responsible for providing non-specialty level mental health services to their enrollees. If their mental health needs meet medical necessity criteria in the Health Plan (provision of 20 or fewer outpatient mental health sessions per year), the beneficiary is entitled to services through the Health Plan. PIHPs must have written, functioning coordination agreements with all MHPs that serve any part of the PIHP's service area.

In Michigan, Medicaid health services for adults also include:

- Inpatient and outpatient hospital services
- Prenatal care
- Physicians' services and medical and surgical services furnished by a dentist
- Family planning services and supplies
- Laboratory and x-ray services and supplies
- Rural Health Clinic and Federally Qualified Health Care services
- Nurse midwife services
- Medical transportation
- Home health care for persons eligible for skilled nursing services
- Nursing facility services
- Diagnostic services
- Clinic services furnished by or under the direction of a physician
- Prescribed drugs, medical supplies, prosthetics and durable medical equipment
- Hearing, speech, and vision services including eyeglasses
- Rehabilitation and physical therapy services
- Hospice care
- Case management services
- Respiratory services
- Personal care services for people not in a hospital, nursing facility or institution
- Home and community based care for certain persons with chronic impairments
- Private duty nursing services
- Substance abuse services

Dental services that may be provided to all Medicaid beneficiaries include emergency, diagnostic, preventive, and therapeutic services for dental disease which, if left untreated, would become acute dental problems or cause irreversible damage to teeth or supportive structures.

MDCH has received a grant from Eli Lily Corporation to implement a pharmacy quality improvement project. Comprehensive NeuroScience is analyzing pharmacy claims for Medicaid beneficiaries who use psychotropic medications to review prescribing practices of physicians and patient adherence to prescriptions. The outcomes of the project are to improve continuity of care, eliminate redundant treatments, coordinate care among providers, and decrease risks associated with inappropriate use. Prescribing physicians will have access to peer psychiatrists for consultation about improved practices.

Michigan's Adult Benefit Waiver (ABW) provides health care benefits for childless adults aged 18 through 64 with incomes at or below 35% of the federal poverty level that are otherwise uninsured. The ABW replaced the State Medical Assistance Program in January 2004. There are an estimated 62,000 persons enrolled in the ABW.

The ABW program provides the following coverage:

- Inpatient hospital medical/surgical
- Outpatient hospital
- Lab and x-ray
- Nurse practitioner (co-pay)
- Family planning
- Physician (co-pay)
- Ambulance
- Prescribed drugs (co-pay)
- Medical supplied (limited coverage)
- Diagnostic
- Hospital Emergency Department services (co-pay if not admitted)
- Mental Health (covered through CMHSPs)
- Substance Abuse (covered through the CMHSPs/CAs)
- Access Assessment and Referral Services
- Outpatient Treatment
- Intensive Outpatient Treatment
- Office of Pharmacological and Alternative Therapies/Center for Substance Abuse Treatment (OPAT/CSAT) approved Pharmacological Supports

To assure access to needed medical services for persons with serious mental illness, MDCH's contracts with PIHPs require coordination with the MHPs responsible for primary care for Medicaid recipients. CMHSPs must have documented policies and procedures to assure that coordination regarding mutual consumers is occurring between the CMHSP and/or its contracted service providers, and providers of primary health care. This policy must minimally address all consumers of CMHSP services for whom services or supports are expected to be provided for extended periods of time and those receiving psychotropic medications.

Case Management Services and Support Services:

Targeted Case Management is a mental health service that assists people to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist individuals in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services and natural supports developed through the person-centered planning process. Targeted case management is provided in a responsive, coordinated, effective, and efficient manner focusing on process and outcomes.

Targeted Case Management Services must be available for all Medicaid recipients with serious mental illness and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services. Individuals must be provided choice of available, qualified case management staff upon initial assignment and on an ongoing basis.

Support and Service Coordination is also a mental health service in Michigan. The service is defined as functions performed by a supports coordinator, coordinator assistant, supports and services broker, or otherwise designated representative of the PIHP that include assessing the need for support and service coordination, and assurance of the following: planning and/or facilitating planning using person-centered principles; developing an individual plan of service using the person-centered planning process; linking to, coordinating with, follow-up of, advocacy with, and/or monitoring of specialty services and supports and other community services/supports; brokering of providers of services/supports; assistance with access to entitlements, and/or legal representation; and coordination with the MHP, Medicaid fee-for-service, or other health care providers. Whenever independent supports and service brokers provide any of the supports coordination functions, it is expected that the consumer will also have a supports coordinator or case manager or their assistants employed by the PIHP or its provider network that assures that the other functions above are in place.

Supports strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. Supports coordinators will work closely with the consumer to assure his/her ongoing satisfaction with the process and outcomes of the supports, services, and available resources.

Supports coordination is reported only as a face-to-face contact with the consumer, however the function includes not only the face-to-face contact but also related activities that assure:

- The desires and needs of the beneficiary are determined
- The supports and services desired and needed by the beneficiary are identified and implemented
- Housing and employment issues are addressed
- Social networks are developed
- Appointments and meetings are scheduled
- Person-centered planning is provided, and independent facilitation of person-centered planning is made available
- Natural and community supports are used
- The quality of the supports and services, as well as the health and safety of the beneficiary, are monitored
- Income/benefits are maximized
- Activities are documented
- Plans of supports/services are reviewed at such intervals as are indicated during planning

While supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other services, and/or short-term provision of supports, it may not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the Individual Plan of Service.

Other Activities Leading to Reduction of Hospitalization:

The entire public system of community mental health care is in place to assist people to lead hopeful lives in the community whenever possible. Information is provided below on services, at least partially supported by Community Mental Health Services Block Grant funds, all of which are vital to system transformation in Michigan.

Assertive Community Treatment (ACT):

ACT is a very intensive community-based approach to comprehensive assertive team treatment and support for adults with serious mental illness. ACT services are chosen by the most vulnerable adults in the public mental health system. Many of the consumers receiving ACT services are those with difficulty managing medications without ongoing support; with psychotic/affective symptoms despite medication adherence; with serious mental illness with a co-occurring substance use disorders; with serious mental illness who exhibit socially disruptive behavior that puts them at high risk for arrest and inappropriate incarceration or those exiting a county jail or prison; who are frequent users of inpatient psychiatric hospital services, crisis services, crisis residential, or homeless shelters; or older adults with serious mental illness who have complex medical/medication conditions. Many mental health consumers experience physical health issues because they are more likely to smoke, exercise little, and have a long history of psychotropic medication use. Medical and psychiatric symptoms and issues tend to blur, especially in older consumers, medication usage requires different dosing, and medication interactions are a constant concern. Team based services, which include a full time registered nurse, help address some of these issues.

Consumers receiving ACT services as well as consumers working as peers were (and are) supported by block grant funding as programs and processes are continually integrated into the public mental health system. 5,935 consumers in Michigan received ACT services from 90+ teams based upon the full year FY07 Encounter Data.

Block grant funding for ACT service improvements(s) that enhance recovery included projects such as New Center's expansion of the ACT team to include a consumer advocate, who was hired from the current consumer base, to provide services to ACT consumers who have been identified as having co-occurring substance abuse and serious mental illness. Community Care Services used block grant funding to enhance ACT services by hiring two peers with expertise and experience in vocational services. Both grants have faced and are working through the challenges of hiring and keeping qualified peer staff.

ACT teams continue to address the individual mental health needs of consumers by working together on person-centered plans while instilling the concepts of hope and recovery. ACT uses proactive engagement and provides continuous, rapid, flexible, and mobile team based care, 24/7. The ACT team is the fixed point of responsibility for the development of the consumer's person-centered plan and for supporting consumers in all aspects of community living. ACT assists consumers to live in the most independent setting possible. ACT is an evidence-based practice that has a positive effect in using fewer hospital services, increasing housing stability and service satisfaction. ACT services are available to the consumer for as long as needed; the expectation is that many consumers will improve to the point of using a less intensive service.

Several years ago, MDCH began to address ACT program drift in Michigan contractually, with Medicaid revisions and with required ACT staff training. ACT staffs across the State have made progress, but continue to require training, support, and encouragement to develop a recovery expectation mindset that helps consumers believe in and move toward recovery. New Medicaid requirements include one training annually for all ACT staff in addition to required ACT 101 for new staff. Block grant funding supports a contract with the Assertive Community Treatment Association (ACTA) for training sessions. Working cooperatively, the MDCH ACT specialist and the ACTA Executive Director assess Michigan ACT staff training needs, then plan and implement training in various locations throughout the state. ACT staff also have enjoyed the opportunity to learn more about ACT and IDDT; ACT Physicians-Improving Our Practice; Motivational Interviewing and Cognitive Behavioral Interventions that Promote Recovery; How Medications Work: An Overview of Psychotropic Medications for Non-Psychiatrists; Hearing Voices That Are Distressing: ACT Team Development; Everyday Ethics in ACT; How to Be Hope Givers and Hope Receivers; and Take Charge of Your Life. All training sessions incorporate principles of recovery and hope and they receive very high approval and evaluation ratings.

For several years, MDCH has had private foundation funding to evaluate ACT services in Michigan. The ACT Field Guide; a self assessment/quality improvement tool is in the final stages of development and beginning early implementation. The Field Guide to ACT in Michigan will be used to assess current programs and to plan for technical assistance in areas of need. Well trained and stable teams tend to support more stable consumers.

Recovery Transformation:

Recovery transformation involves transforming both systems and also individuals who provide services and consumers receiving services. Recovery has basic principles that need to be ingrained in the system of care. These principles include hope, responsibility, choice, trauma awareness, empowerment, and self-determination, to name a few.

Recovery is the belief that consumers can and do lead productive live in spite of having a mental illness. Mental illness in a recovery environment is not the great definitive barrier to a quality of life, of years past. Recovery portrays the effectiveness of hope in healing from a mental illness. Recovery is not only the defining principle of modern mental health systems but also the guiding aspect of each consumer's life. The uniqueness of each consumer's journey of recovery cannot be understated. Having hope for each consumer coming into an agency is essentially the main aspect of staff's role as healers.

Recovery needs to be conveyed in all aspects and all levels of the mental health system. The belief in the power of recovery as the essential healing ingredient in consumer's lives cannot be understated. Recovery as the foundation of the mental health in the system of care is vital to not only consumers but to a caring staff that desires to excel in the healing process.

MDCH is working with the Michigan Recovery Center of Excellence and Advocates for Human Potential to implement the Recovery Enhancing Environment measure. The 18 PIHPs and 46 CMHSPs will survey a variety of areas including psychosocial rehabilitation, ACT, supported employment, group homes, targeted case management, and medication clinics. The data collected from the surveys will be used as a quality improvement process.

Peer Support Specialists:

Michigan is a national leader in developing and supporting employment of Peer Support Specialists. In partnership with the Appalachian Consulting Group, over 400 persons with a serious mental illness have received a full week of training, a follow-up day of Michigan-specific information related to the Mental Health Code and contract requirements, a study session, and a four-hour examination for certification. Thus far, 398 Peer Support Specialists have received certification. In FY09, Lansing Community College will be offering three elective credit hours for completion of certification. In addition to the requirements for certification, a variety of continuing education opportunities have been provided including Pathways to Recovery, Wellness Recovery Action Planning, trauma informed care, leadership, and health and wellness.

Michigan is part of a three state research study with Massachusetts and Georgia to measure the relaxation response for health and wellness. The study is being conducted in partnership with the Benson-Henry Institute and Massachusetts General. The study is a direct response to the NASMHPD report that persons with mental illness are dying 25 years earlier than the general population. A health and wellness training pilot was conducted in Battle Creek, Michigan, leading to the development of a curriculum that will be provided to Certified Peer Support Specialists who will work on developing groups in each local and regional area.

The employment of Peer Support Specialists has strengthened efforts in systems transformation infusing the concepts of recovery as a foundation for services and supports. Certified Peer Support Specialists work in a variety of service areas including supported employment, housing, homeless outreach, case management, ACT, psychosocial rehabilitation, consumer-run programs, and other settings.

Family Psychoeducation (FPE):

FPE is a specific method of working in partnership with consumers and families in a long-term treatment model to help them develop increasingly sophisticated coping skills for handling problems posed by mental illness. The goal is that the practitioner, consumer, and family work together to support recovery. Common issues include participation in outpatient programs, understanding prescribed medication, alcohol or other drug abuse, and symptoms that affect the consumer.

During FY09, four PIHPs will begin their second and final year of block grant funding to provide FPE services through multifamily groups based on the model developed by Dr. William McFarlane and supported by SAMHSA. The PIHPs will continue to expand the FPE services that were started in FY08 and focus on sustaining the services after block grant funding ends.

Two other PIHPs will also provide FPE services in FY09. One PIHP received approval for an FPE enhancement project that will focus on advanced staff training for staff who want to be qualified FPE trainers. Another PIHP received approval for a one-year project to expand FPE services throughout its three-county service area by replicating FPE services that were started by one of the PIHP's community mental health agencies.

Consumer-Run, Operated and Directed Programs:

Consumer-run initiatives continue to support the enhancement of drop-in centers, consumer resource development, outreach efforts, and the integration of Peer Support Specialists into the mental health system as a conduit for recovery services and community supports. Drop-in centers provide an opportunity for consumers to convene and network, develop anti-stigma strategies, and provide peer one-on-one assistance for healthy living in the community. As participation in drop-in centers grows, the need for assistance in facility maintenance, day-to-day operational supplies and materials, transportation supports, and community inclusion activities continue to be crucial to the survival of this type of service delivery program.

Self-help support groups are a growing intervention which, when delivered at a community site such as a drop-in center, are developing as a viable resource for peer support and as options for Peer Support Specialists to lead. Groups such as Alcoholics Anonymous, Narcotics Anonymous, Dual Recovery Anonymous, Wellness Recovery Action Planning, and Emotions Anonymous groups are being formulated and promoted throughout the state. MDCH funds a peer led consultation and technical assistance project which covers the state to assist in the development of these support groups, drop-in centers, and the promotion of utilizing Peer Support Specialists as first line respondents to consumer needs. MDCH will continue to identify ways to assist and support consumer involvement and peer led efforts at all levels of the mental health system.

Jail Diversion:

Jail Diversion programs and services continue to be viewed as an important element of a community based service array. With MDCH's Jail Diversion Practice Policy Guidelines and the Gains Center Criminal Justice/Mental Health Consensus Report as a resource base, each local CMHSP is examining their jail diversion system for ways to better deliver services to individuals who have a mental disability and have contact with the criminal justice system. There are efforts to address gaps in current system delivery jail diversion programs, provide better customer friendly services via the use of Peer Support Specialists as jail diversion workers and community liaisons for consumers when they are released from jail.

The use of Mental Health Courts to address the special needs of this population is taking root in our jail diversion system. Several CMHSPs and criminal justice systems are collaborating to develop and implement Mental Health Courts that cater to a special population with special needs. The legislative budget for FY09 has earmarked financial resources to support the development of Mental Health Courts modeled after currently operating drug courts. Block grant resources are being used to fund two Mental Health Courts with data collection and evaluations of this effort regarding how they will impact recidivism and community re-integration for consumers returning to the community from county jails.

It is anticipated that the upcoming three year period will see an increase in training for jail diversion staff of both mental health and criminal justice systems, along with the development of usable resources for hands-on use by law enforcement, which will improve their recognition and how they handle individuals they encounter who may have a mental health issue and co-occurring disability.

Wraparound Services for Persons with Dementia:

In alliance with MDCH's systems transformation process and vision of recovery, the Wraparound Initiative promotes person-centered planning, strength-based problem-solving, meaningful relationships with family and friends, engagement in daily activities that are meaningful, and inclusion in community life and activities. A Wraparound Model that is currently successfully used for children and families is being modified to provide a distinct strategy to help adults with dementia that exhibit acute behavioral symptoms of distress to remain in the community and prevent premature institutionalization. This subset of individuals and their families is perhaps one of the most vulnerable groups to whom the Olmstead decision applies. Wraparound is a term that describes an approach to building constructive relationships and networks of support with individuals and families whose needs fall outside the scope of traditional service systems and require integrated coordination among organizations and the individual's natural supports. Wraparound is a planning process, not a service, which places individuals and families at the center in identifying the person's strengths and coordinates mental health and other community-based resources to enable the person to continue living safely in the community.

Trauma Informed Services:

The latest research shows that 97% of mental health consumers have a history of trauma. This is not to say that trauma is a causation of mental illness, but rather a compounding factor. Trauma is a foundation of care that acknowledges trauma as the key to understanding mental illness and, in doing so, heals the core of most consumers' pathology. Acknowledgement of the effects and signs of trauma is critical in the healing process for all trauma-informed environments. Recovery for consumers is intertwined with healing from trauma. Without acknowledging and healing from trauma, recovery from mental illness for consumers cannot truly evolve. The need to become a trauma-informed system of care is essential for all CMHSPs. The question then becomes not "what's wrong with you?" but rather "what happened to you?" The change in perspective is important in not only treating specific trauma situations, but also critical in creating trauma-informed environments in all CMHSPs. MDCH's goal is to educate consumers, administrators, and staff to create a clear understanding of the signs of trauma, the healing effectiveness of treatments and the support needed to enable consumers to live quality lives in spite of trauma.

Block grant funds are being use to support trauma initiatives that may include education about trauma, both in the system and community; specialized training with consumers; support groups; organizational changes required to be trauma-informed; awareness of the interactive aspects of mental illness and trauma; and other strategies.

Anti-Stigma:

Stigma is a barrier for individuals with mental health problems in getting help. Some people suffer needlessly rather than access mental health services. Without addressing stigma and its compounding effects, a mental health agency cannot reach the individuals who truly need assistance. Understanding the dynamic of stigma in the access areas of CMHSPs is important to provide a welcoming and friendly environment for all. Consumers who come forth for help and assistance need to be treated with respect and dignity, which eliminates the compounding negativism of stigma. Stigma not only hinders individuals from asking for help but also affects consumers who are in the system in their journey of recovery. Providing support for consumers and their families is essential in addressing the pre-existing stigma from the system and the community at large. Also realizing that self-stigma is also a barrier in recovery and needs to be addressed cannot be overlooked.

The format of combating stigma can be unique and creative but needs to involve consumers in all aspects. Consumers' input brings a realistic perspective and provides healing not only for the consumers who are participating in the anti-stigma efforts but also brings a quality of connectedness to the anti-stigma work. Block grant funds will continue to be used for creating anti-sigma campaigns through the creation of DVDs, billboards, radio and television advertisements, and trainings.

Integrating Physical Health and Mental Health:

Mental health recovery requires overall wellness and is critical to overall health. MDCH's vision is that the public mental health system addresses every consumer's health needs through a person-centered planning process that focuses on the individual needs and not that of the agency. In a recovery-oriented mental health system, physical health care is as central to an individual's goals as housing, employment, or education. Individuals with serious mental illness often have co-morbid medical conditions, take several medications, and see multiple health care providers. The provision of services to individuals whose needs span multiple service systems has long been recognized by the public mental health system as a huge challenge. Individuals with multiple medical and social needs have had to navigate through a complex and fragmented system of care. Failure to tackle these problems and deliver these services more effectively results in poor outcomes for the consumers and increased expenditures for the system. The President's New Freedom Commission on Mental Health stressed the importance of a recovery-oriented public mental health system with services based on a single, comprehensive plan that focuses on all of a consumer's service needs. This initiative is to develop a "one person – one plan – one team" for these individuals. MDCH is working with the PIHPs/CMHSPs to address these issues and provide services that are effective and person-centered.

In FY09, block grant funds will support eleven projects to coordinate and provide care in an integrated fashion and include: working on co-locating mental health staff at the primary care setting; primary care doctors working at the community mental health centers; integrating health care information; developing a learning collaborative; and working with primary care doctors in the area much more closely. Projects will share their results with all projects working in this program area. MDCH is planning to bring the various project staff together during the beginning and end of next fiscal year to talk about the project outcomes.

Intensive Crisis Stabilization:

MDCH, for FY09, is planning to work with the PIHPs to make Intensive Crisis Stabilization Programs a mobile, recovery-oriented crisis team that works collaboratively in the community with the law enforcement, Department of Human Services, primary care, hospitals and emergency rooms to coordinate care and alleviate the crisis. The team must be available 24/7 and able to screen, assess, diagnose, and develop short-term goals through a person-centered planning approach. A multi-disciplinary team that includes Peer Support Specialists develops strategies focusing on wellness and recovery and the program incorporates the belief that consumers of mental health services determine what is important in their life, even in time of crisis. Intensive Crisis Stabilization Services are explicitly intended to be a short-term alternative to inpatient psychiatric services. Members of this team provide mobile outreach crisis services, including screening and assessment, counseling/therapy, and therapeutic support services.

Block grant funds have been awarded for FY09 to support two projects that will employ Peer Support Specialists and provide outreach and mobile crisis intervention services. MDCH is also planning to bring together all the Intensive Crisis Stabilization Programs in the state for a day of training that will be recovery based.

Crisis Residential:

Crisis Residential Services (CRS) are designed as an alternative to hospitalization for individuals who are presenting with psychiatric disorders and/or co-occurring substance use disorders. CRS provide supports and services in the least restrictive environment possible, leading to reduction in inpatient psychiatric unit admissions. The goal of CRS is to facilitate reduction in the intensity of those factors that lead to admission to this level of care based on a recovery-centered approach.

Individuals who are admitted to CRS are able to explore and learn more about crisis, substance abuse, identity, values, choices and choice making, recovery and recovery planning. Recovery and recovery planning includes every area of life including relationships, where to live, employment training, daily activities, and physical well-being. In FY09, MDCH will work with the PIHPs and CMHSPs to transform CRS to a recovery-oriented, culturally competent, co-occurring capable system. Block grant funds will be used to fund three projects that will focus on developing a recovery-based, community-based CRS program that addresses co-occurring disorders, using a recovery model of service and the availability of Peer Support Specialists.

Clinical Skills Development:

For a recovery-oriented system of care, staff and clinicians must be able to address every aspect of a person's care. Clinical skills include various therapy and brief intervention approaches that are effective and/or proven to be effective. MDCH is working with PIHPs and CMHSPs to identify the clinical gaps identified and address them so that consumers can be best supported to achieve recovery at the fullest.

Block grant funds are assisting in clinical skills training on Dialectical Behavior Therapy, Motivational Interviewing trainings, Cognitive Behavioral Therapy, and Integrated Treatment for individuals with co-occurring substance use and mental health disorders.

Cultural Competence:

MDCH is working with the CMHSPs on a continuous basis to make the system culturally competent. Its general objectives are to provide quality services for culturally diverse populations, including culturally appropriate outreach, location of services, engagement, assessment, and interventions. Culture is critical in determining what people bring to the clinical setting, the language they use, how they express and report their concerns, how they seek help, the development of coping styles and social supports, and the degree to which they attach stigma to mental health and substance abuse problems.

Block grant funds are currently being utilized to develop a stakeholders group that will include racial and ethnic representatives as well as cultural and linguistic minorities to develop a statewide plan for the public mental health system to address the gaps. The plan for next fiscal year is to develop a training curriculum that address clinical issues, cultural issues, issues related to person-centered planning, self-determination, and recovery, which are central to cultural competence.

Michigan

Adult - Estimate of Prevalence

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

According to the estimate provided by the National Research Institute, Michigan's population of adults age 18 and older who have a serious mental illness is about 411,491 (or between 281,948 and 541,035). The average estimate is 5.4% of Michigan's 2007 adult population of 7,620,209. The lower limit of the estimate is 3.7% of that population and the upper limit is 7.1%.

State estimates of the number of adults with serious mental illness in each of Michigan's CMHSP regions in 2000 used a methodology developed by a group of technical experts working under the auspices of CMHS. In order to produce CMHSP-level estimates of the prevalence of adults with serious mental illness, two data sources were employed. First, county-level 2000 Census counts were supplied by Ken Darga, State Demographer, Michigan Information Center, Michigan Department of Management and Budget. These counts of adults 18 years and older were stratified by gender, age groups, and county urbanicity, factors predictive of the number of adults with serious mental illness. Second, adult SMI prevalence rates were supplied by the National Comorbidity Survey completed by Kessler and others in 1994, and reported for each cell of a county-level cross-classification table based on the predictive factors listed previously – gender, age group, and urbanicity.

Michigan

Adult - Quantitative Targets

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

Based upon the estimated prevalence of adults with serious mental illness, demand for services in the public sector vs. the private sector, and service capacity, the following are the estimated numbers of people with serious mental illness to be serviced during the next three years:

74,200 are targeted to be served in fiscal year 2009;
74,300 are targeted to be served in fiscal year 2010; and
74,400 are targeted to be served in fiscal year 2011.

Michigan

Adult - Outreach to Homeless

Adult - Describe State's outreach to and services for individuals who are homeless

The Supportive Housing Program and Ending Homelessness Partnership is in its ninth year and continues to produce more than 100 units per year in 9 counties. This program is supported by a set-aside of low-income housing tax credits for people with special needs.

Every community across the state has developed a 10-Year Plan to End Homelessness. To assist in implementation of their plans, the Michigan State Housing Development Authority (MSHDA) has made $14,500,000 available to create supportive housing for homeless families with children, homeless youth, chronically homeless, and homeless survivors of domestic violence. In addition, supportive housing developments in Detroit, Grand Rapids, and Battle Creek are being proposed targeted to homeless veterans. This initiative will create approximately 275 units of supportive housing for homeless veterans and has been effective in bringing new partners, both private and public, to the table.

The MDCH Homeless Programs consist of Housing Opportunities for People Living with AIDS, PATH, Shelter Plus Care, and Supportive Housing Program grant programs in addition to a program of training and technical assistance made available to sub-grantees. Recent innovations include using PATH dollars to create a Housing Resource Center in Detroit and 10 other counties in the state. All of these programs provide outreach to people who are homeless with linkages to support to find and sustain housing.

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

Several Community Mental Health Block Grant Initiatives address homelessness (each of these projects is required to have a linkage to a local 10 year plan to end homelessness). On January 9, 2008, a separate Community Mental Health Block Grant Request for Proposal was issued to PIHPs and CMHSPs specifically for the development of Housing Resource Centers in communities without them. The centers outreach to people with mental illness who are homeless and assist them in obtaining and maintaining independent living. This is a system transformation effort to assist people achieve recovery. Several new projects were funded as the result of this process and funds for this purpose were again offered for new projects for FY 09.

Currently funded housing/homelessness block grant projects include:

- Ionia County CMHSP is funded to create a supported housing position to identify available housing opportunities in Ionia County, teach landlords and consumers how to work with each other, and have an intervention process with the landlord to prevent evictions.
- Detroit Wayne CMHSP is funded to transition people from adult foster care to independent living.
- Detroit Wayne CMHSP is also funded for a systems transformation grant that has housing as a component.
- Macomb County CMHSP is funded to develop an outreach team for chronically homes adults with serious mental illness.

- Macomb County CMHSP is also funded to train peers, family members and agency staff so they can help people with mental illness obtain and sustain independent living arrangements.
- Macomb County CMHSP is also funded to provide a Housing Resource Center that will provide professional and peer support services for those seeking or working to maintain independent housing.
- Northern Lakes CMHSP is funded to provide peer support specialists and support for obtaining affordable and safe housing for adults with severe mental illness.
- Oakland County CMHSP is funded to work with young adults to learn independent living skills and help them access community resources to prevent homelessness.
- Oakland County CMHSP is also funded to create a comprehensive guide for adults with serious mental illness and their families transitioning from congregate living settings to independent supported housing.
- Saginaw County CMHSP is funded to assist adults with serious mental illness in finding and maintaining housing.
- St. Clair CMHSP is funded to develop a local website that organizes and provides access to local, state and national resources to obtain and maintain stable housing.
- Lapeer County, Central Michigan CMHSP, St. Clair County CMHSP Authority, Oakland County CMHSP, Kalamazoo CMHSP and Substance Abuse Services, Macomb County CMHSP Services, Berrien Mental Health Authority, Saginaw County CMHSP Authority and Network 180 are all funded to create Housing Resource Centers.

Michigan

Adult - Rural Area Services

Adult - Describes how community-based services will be provided to individuals in rural areas

MDCH recognizes that the prevalence and incidence of serious mental illness occur at similar rates in both rural and urban populations, but that the suicide rate is higher in rural areas, that teen suicide is higher, and that white rural men over the age of 85 have the highest suicide rate of all (Kessler et al., 1994, "One Healthy People 2010," National Center for Health Statistics 2001). The majority of Michigan's population lives in the seven counties that are urban. The remaining 76 counties are classified as rural. Due to loss of population, four counties that were classified as urban until recently are now considered rural.

Mental health disorders are the fourth highest ranked rural health concern (Journal of Rural Health 18(1) 9-14, 2002). Rural populations tend to either not recognize mental illness or not perceive the need for care until later than urban populations and tend to be more concerned about costs and stigma involved with a mental illness. 56.8 % of adults over age 65 do not perceive the need for mental health treatment and therefore did not receive it; 1.3% perceived a need and did not receive mental health treatment. In people aged 50-64, 34.2% did not perceive the need for mental health treatment or receive it; 7.9 % of this group perceived a need for treatment and did not receive it (National Survey on Drug Use and Health, June 26, 2008). People living in rural areas tend to have lower paying jobs than those living in urban areas and they are less likely to have health insurance with mental health coverage. Michigan continues to have the highest unemployment rate in the United States and a recently has had a high rate of home foreclosures. People living in rural areas tend to have a higher poverty level than those in urban areas. Issues of access, including transportation, become more pronounced. Some adults in rural areas receive ACT services; these consumers do not need to travel for those services as ACT workers see consumers in their homes and other locations outside of the office.

Michigan has assured the availability of mental health services to all residents by requiring the full array of services in each PIHP, but there remains variability within and between regions related to funding, population served, need and admission criteria. Access standards related to timeliness and geographic availability are required by contract. For office or site-based mental health services, the consumer's primary service providers must be within 30 miles or 30 minutes of the consumer's residence in urban areas, and within 60 miles or 60 minutes in rural areas.

Recognizing that recovery involves a more holistic approach than previously used, the recently issued RFP for block grant funding offered opportunities for program innovations for integrated physical health and mental health. Many mental health consumers experience physical health issues because they are more likely to smoke, exercise little, and have a long history of psychotropic medication use. Medical and psychiatric symptoms and issues tend to blur, especially in older consumers, medication usage requires different dosing, and medication interactions are a constant concern. People with serious mental illness tend to die earlier than others, and emerging research indicates that often even standard care is not provided (Dr. Steven Bartels, lecture, Mental Health and Aging Conference, May 2008). Recognizing the high incidence of co-occurring mental health and substance use disorders, MDCH is in the fourth year of implementing the evidence-based practice of Co-occurring Disorders: Integrated Dual Disorder Treatment of Dual Disorders in rural as well as urban areas throughout the public mental health system. The evidence-based practice must be provided in a broader co-occurring capable system.

Clinician training is provided on an ongoing basis. Training topics have included Integrated Treatment, Family Psychoeducation, Supported Employment, Motivational Interviewing, Dialectical Behavior Therapy, Assertive Community Treatment, and Cognitive Behavioral Therapy.

Despite high unemployment rates, a very poor economy, an aging population and other factors that enhance the use of public services, Michigan continues to move forward in providing evidence-based treatment provided by professional and certified peer staff in all areas of the state, including rural.

Michigan

Adult - Older Adults

Adult - Describes how community-based services are provided to older adults

People, aged 65 and older, with a serious mental illness include the following subsets of hard to reach and underserved populations: those with severe and persistent mental illness developed earlier in life, those at risk of suicide, those who develop depression or another mental illness as a direct result of co-occurring medical conditions or chronic diseases requiring active monitoring and multiple types of medications; those with a co-occurring mental illness (depressed mood, behavioral disturbances or delusions) and substance use disorder, and family care givers of isolated older adults with mental illness or progressive, disabling medical conditions.

Older adults use fewer public mental health services than younger adults; the reasons include stigma, denial, inadequate outreach services, lack of education about the services and mental illness, lack of staff trained in geriatrics and newer research that indicates older adults may not perceive themselves as needing mental health services. Specialty services used by older adults are tracked quarterly. The most appropriate penetration rate has yet to be determined, but attention to the elderly needing and receiving services continues and efforts such as the Gatekeeper model are being used to assist with identification.

In Michigan, it remains a priority to improve identification of older adults in all settings who exhibit significant changes and disturbances in mood, cognition, or behavior that may pose a danger to themselves or others. Outreach strategies include traditional and innovative techniques to establish trust, rapport, acceptance, and increased use of mental health services by older adults at-risk. Access must continue to be simplified and facilitate appropriate clinical interventions and services to assess, treat, and manage emergent or persistent mental illness and co-occurring medical conditions. Often it is someone other than the mentally ill older adult who requests services on their behalf.

Disparities continue to exist in mental health services: "specific outreach efforts are needed to reach older adults, persons with dementia, and their caregivers". Demographics indicate the number of older adults will continue to increase dramatically, and by the time people reach 85 years of age, there is a 50% chance of dementia. All psychiatric service needs become more complicated when consumers are over 65 and Medicare becomes primary. Older adults with mental illness incur added challenges to recovery with aging stigma and isolation caused by retirement, non -enrollment in schools, family and friends having died or moved away, stoppage of driving, and higher percentage living in rural communities.

Recovery concepts, where people are able to live fulfilling and meaningful lives, and continue to participate fully in their communities are continually presented by Department older adult specialists at the annual OBRA New Worker Orientation, Mental Health & Aging Conference workshops, (the last two include presentations by older adult peer), CMH regional meetings, Michigan Dementia Educators Network, Michigan Direct Care Workers Initiative, Primary Care Dementia Network, Geriatric Education Center-Michigan at Michigan State University, and the Long Term Care Supports & Services Commission and its workgroups. Department staff is part of numerous innovative grant proposal planning committees where recovery concepts are a priority.

A two-year block grant, the Elderly Mental Health Accessibility initiative, has done 'everything right' according to traditional to outreach wisdom. Highly qualified staff, both professional and peer, an excellent work plan, etc., the project has had poor results in

identifying older adults with psychiatric needs and assisting them to obtain mental health services. Project staff presented at a meeting of the Advisory Council on Mental Illness, the state planning council. The year one results lead one to ponder if perhaps outreach efforts to older adults should be different.

Preparations in the public system are needed, especially to support methods that assist people to remain at home with supports as long as possible and avoid further burden on public money. A system challenge and gap occurs when adults over the age of 65 endure limbo status with duo-eligibility of Medicare and Medicaid, and when CMHSPs reduce their priority; yet Medicare and private pay ability do not cover needed services. This subset of individuals, and especially those and their caregivers suffering from dementing illnesses is perhaps one of the most vulnerable groups to whom the Olmstead decision applies. The MDCH has addressed this growing need through one of the Alzheimer's Disease Demonstration Grant to States Wraparound Initiatives. Wraparound pilot projects are being conducted by two current block grants and two additional pilots from the Alzheimer's Disease Demonstration Grants to States. Addressing Goal #2 of the President's New Freedom Commission report, Wraparound is an individualized, needs-driven, strengths-based process for individuals and families with special needs, currently used for children at risk for institutionalization. A model is currently under development for persons with dementia with acute behavioral symptoms of distress living in the community at risk for placement in nursing homes. Family Teams are formed for each enrolled family to build on strengths of the individual, their caregivers, other family members and friends, and the community, and blend use of natural, informal supports with formal supports. The Strengths/Culture Discovery lists values, preferences, traditions, rituals, skills, abilities, interests, and attributes of the person and those who can support the interests of the individual. Goals are prioritized for the individual, the primary caregiver, and those who support them. The Family Team develops strategies and a plan to reach their identified goals. Families have expressed great satisfaction and preliminary results seem to indicate longer community tenure.

An expectation of recovery and the provision of recovery-based services for older adults will continue to be integral to services and supports for older adults. Evidence-based practices have been introduced and expanded upon at the Mental Health and Aging Conference, Regional provider meetings as well as through the Prepaid Inpatient Health Plans. Older adult providers in the public system are currently learning the evidence-based practice of Cognitive Behavioral Therapy, modified for older adults. Many initiatives and activities have occurred and are occurring to benefit older adults through the block grant in Michigan. Assistance and encouragement to remain a part of one's own community has become a recognized and often achievable goal.

Michigan

Adult - Resources for Providers

Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

Medicaid has grown rapidly as a percentage of overall state funding for public mental health services and now represents 77% of funding. Along with Medicaid, state general funds, local funds, and federal Mental Health Block Grant funds are being utilized. MDCH also contracts with limited amounts from other federal grants and private foundation grants for specific projects.

Prepaid Inpatient Hospital Plans (PIHPs) and Community Mental Health Service Programs (CMHSPs) have been able to maintain staffing levels. Staff development is ongoing with statewide training, particularly for implementation of evidence-based practices and recovery transformation. Consumers and family members are given the opportunity to participate in all the training activities. Recent trainings and technical assistance activities have included Change Agent training for Integrated Treatment, Supported Employment, Family Psycho-education, Motivational Interviewing, DBT, ACT, Trauma, and Advance Directives. Training is provided by MDCH staff, university staff, and expert consultants. There is provider-to-provider training through learning collaboratives and learn and share sessions. All trainings sponsored by MDCH offer primary consumer the opportunity to participate at no charge. Consumer participation has had an impact on these programs.

Michigan

Adult - Emergency Service Provider Training

Adult - Provides for training of providers of emergency health services regarding mental health;

Police officers and other emergency services personnel receive both formal and informal training through CMHSP staff. Some have formal agreements with their local emergency agencies. CMHSPs are required to have collaborative agreements with primary care providers in their communities. Wraparound training has included paramedics. In addition, each CMHSP has at least one jail diversion program and recognizes the necessity for staff cross training in developing and maintaining an integrated jail diversion service delivery system. The department sponsored Jail Diversion training in June for teams of mental health and law enforcement staff for CMHSP regions, using a curriculum developed by a CMHSP.

Regional examples include Oakland County, where the CMHSP uses a Crisis Intervention Team within in pre-booking jail diversion process. The team is made up of law enforcement, emergency medical personnel and mental health staff to respond to situations involving individuals who have been identified as needing mental health intervention as apposed to arrest and jail incarceration. These teams receive training in both emergency and non-emergency interventions around law enforcement and mental health procedures and how to identify and handle situations where persons with a mental health need can be diverted to an appropriate mental health service in lieu of jail.

The Southwest Michigan Urban and Rural Consortium (CMHSP of St. Joseph County) has received federal block grant funding to enhance its jail diversion efforts, which include education and training of emergency service staff regarding pre-booking diversion. The CMHSP jail diversion specialist provides this education and training with collaboration from laws enforcement staff in the area.

Michigan

Adult - Grant Expenditure Manner

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

During FY09, adult block grant allocations are planned as identified in the following chart:

	Draft Spending Plan for FY09	Revised
	Adult Mental Health Block Grant	8/25/08
PCA	**Contract Title**	**Amount**
27900	Admin Salaries (Estimated)	$202,800
27903	ACMI	$6,000
27901	Adult Staff Travel	$7,500
27905	Consumer Travel	$15,000
20413	Equipment & DIT	$6,900
27902	CSS&M	$2,500
	Random Moments (Estimated)	$111,900
	Indirect (Estimated)	$12,000
20294	Assertive Community Treatment Association (ACTA) (Ongoing)	$110,900
27911	Detroit-Wayne - Comprehensive (Ongoing)	$4,500,000
27914	Inter-Tribal Council of MI (Ongoing)	$14,056
20532	JIMHO - Director's Meetings / Self-Help Groups (Ongoing)	$79,100
20295	Michigan State University - Su Min Oh (Ongoing)	$97,063
20814	Berrien - Homeless System Transformation Grant (2nd Year)	$50,000
20815	Central MI - Homelessness/Systems Transformation (2nd Yr)	$46,852
20728	Central MI - Jail Diversion / Peer Support Initiative (2nd Year)	$50,000
20731	Detroit - ACT Co-occurring Services (2nd Year)	$22,260
20650	Detroit - Employment Options (2nd Year)	$49,885
20651	Detroit - Access Center for Psychological Trauma (2nd Year)	$50,000
20652	Detroit - Recovery - Peer Support Specialists - LBS (2nd Year)	$35,789
20654	Detroit - Peer Support Employees Program (2nd Year)	$41,804
20655	Detroit - System Trans: Recovery Peer Support Specialist (2nd Yr)	$50,000
20658	Detroit - Peer Support Spec. Criminal Justice Intervention (2nd Yr)	$22,010
20659	Detroit - Home Care (2nd Year)	$13,968
20660	Detroit - Assertive Community Treatment (2nd Year)	$40,206
20663	Detroit - Case Management Hospital Outreach Specialist (2nd Yr)	$49,125
20664	Detroit - ACT Peer Support Specialists - CCS (2nd Year)	$48,875
20734	Kalamazoo - Healing from Trauma (2nd Year)	$15,000
20816	Kalamazoo - Homelessness/Systems Transformation (2nd Yr)	$40,638
20738	Lapeer - Clubhouse TEP and Long-Term Housing Assist. (2nd Yr)	$28,420
20739	Lapeer - Consumer Leadership Institute (2nd Year)	$12,750
20817	Lapeer - Homeless Services for Persons with COD (2nd Year)	$33,123
20740	LifeWays - Enhanced Adult Jail Diversion (2nd Year)	$30,700
20743	Macomb - Implementation of a Housing Resource Center (2nd Yr)	$50,000
20746	Macomb - Development of a Consumer Cooperative (2nd Year)	$30,950
20818	Macomb - Macomb Housing Resource Center Project II (2nd Year)	$78,923

PCA	Contract Title	Amount
20749	Muskegon - Recovery Cooperative of Muskegon (2nd Year)	$48,000
20807	Muskegon - Speakers' Bureau (2nd Year)	$3,000
20756	Muskegon - Health and Wellness Education Program (2nd Year)	$5,000
20857	MSU-Creating a Quality Improvement Tool for Clubhouses (2nd Yr)	$62,229
20760	network180 - Community Collaboration: The Asian Center (2nd Yr)	$10,000
20763	Northern Lakes - Supported Housing (2nd Year)	$41,580
20819	Oakland - Coordinated Homeless Housing Resource Ctr (2nd Yr)	$74,881
20766	Oakland - Crisis Recovery Services - Living Room (2nd Year)	$50,000
20770	Oakland - Recovery and Evaluation (2nd Year)	$17,140
20773	Pines - Trauma Recovery Program (2nd Year)	$13,500
20775	Pines - Alzheimer's Respite Program (2nd Year)	$30,362
20776	Pines - Healthy Ideas: Identifying Depression for Seniors (2nd Yr)	$40,700
20820	Saginaw - Housing Resource Center (2nd Year)	$50,945
20780	Saginaw - Supported Housing (2nd Year)	$25,000
20785	St. Clair - Clubhouse Supported Employment Kiosk (2nd Year)	$25,211
20821	St. Clair - Housing Resource Center (2nd Year)	$36,578
20786	St. Joseph - Jail Diversion Program (2nd Year)	$46,086
20788	Summit Pointe - Peer Supports for Homeless (2nd Year)	$50,000
20824	Barry - Lighthouse on the Lake Drop-in Center Enhancement (New)	$14,992
20825	Bay-Arenac - Chores R Us Drop-in Enhancement (New)	$9,000
20826	Bay-Arenac - Integrating MH/SA and Physical Health (New)	$100,000
20827	Bay-Arenac - Drop-in Center Program Enhancement (New)	$29,000
20828	Berrien - Recovery-focused Community Integration Program (New)	$7,250
20829	Central MI - Anti-Stigma (New)	$100,000
20830	Central MI - Awareness of MH and CMHSP Services (New)	$100,000
20912	Central MI - Crisis Mobilization & Intervention Team (New)	$100,000
20913	Central MI - Integrating MH/SA & Physical Health (New)	$98,656
20831	Central MI - Supported Employment Initiative (New)	$70,000
20832	Central MI - Trauma-Informed Recovery Initiative (New)	$19,600
20833	Copper Country - Directions Unlimited Drop-in Equipment (New)	$10,500
20834	Copper Country - Wraparound (New)	$93,449
20835	Detroit - New Center MH/SA & PH Co-location (New)	$100,000
20836	Detroit – Cert. Peer Support Specialists Staff Development (New)	$75,000
20837	Detroit - Peer Support Case Management Program (New)	$89,330
20838	Genesee - Genesee County CMH Jail Diversion (New)	$82,240
20839	Genesee - Improving Member Employment Outcomes (New)	$55,027
20840	Genesee - Integrating MH/SA & Physical Health (New)	$95,662
20841	Huron - Flashpoint Center Drop-in Enhancement (New)	$14,500
20842	Ionia - Forget-Me-Not (New)	$100,000
20843	Kalamazoo - Clubhouse Member Leadership/Empowerment (New)	$74,258
20844	Kalamazoo - Consumer Driven Recovery Management (New)	$69,417
20845	Kalamazoo - Kalamazoo Mental Health Court (New)	$100,000

PCA	Contract Title	Amount
20735	Kalamazoo - Michigan Clubhouse Training Initiative (New)	$75,000
20846	Kalamazoo - Supported Employment (New)	$69,420
20847	Kalamazoo - The Living Room Project (New)	$100,000
20848	Lapeer - Clubhouse - Improving Health Outcomes (New)	$26,500
20849	Lapeer - Integrating MH/SA and Physical Health (New)	$75,880
20850	Lapeer - Older Adult Services (New)	$30,920
20851	Lifeways - MindChangers, MH Awareness Committee (New)	$42,050
20852	Macomb - Developing Crisis Residential COD Services (New)	$60,250
20853	Macomb - Integrating PH & MH Services for Adults with SMI (New)	$50,000
20854	Manistee-Benzie - Benzie Drop-in Center Enhancement (New)	$6,050
20855	Manistee-Benzie - Friendship Drop-in Center Enhancement (New)	$6,750
20856	Manistee-Benzie - Integrated Health and Wellness (New)	$100,000
20858	Monroe - New Directions Drop-in Center Development (New)	$48,996
20859	Monroe - Supported Employment Community Collaboration (New)	$100,897
20860	Muskegon - Clubhouse Relocation (New)	$50,760
20861	Muskegon - Multi-Media Approach to Eliminating Stigma (New)	$56,888
20862	Muskegon - Planning for Integrated Care Initiative (New)	$20,000
20863	network180 - Consumer Run Drop-in Center Enhancement (New)	$19,500
20864	network180 - Integrating Primary & Behavioral Health Care (New)	$66,525
20865	network180 - Motivational Interviewing Skills Development (New)	$38,800
20866	network180 - Site-Based Housing Enhancement (New)	$99,390
20867	network180 - Suicide Prevention (New)	$20,000
20868	Newaygo - Empowerment Network (New)	$9,378
20869	North Country - Enhancement of Beacon Center (New)	$10,123
20870	Northern Lakes - Anti-Stigma (New)	$59,860
20871	Northern Lakes - Interventions Cognitive Impairment (New)	$40,000
20872	Northern Lakes - Gathering Place Drop-in Enhancement (New)	$1,250
20873	Northern Lakes - Drop-in Program Enhancement (New)	$7,550
20914	Northern Lakes - Recovery System Change (New)	$100,000
20874	Northern Lakes - Traverse House Clubhouse Start-up (New)	$27,117
20875	Oakland - Anti-Stigma Community Inclusion Project (New)	$62,720
20876	Oakland - Comfort Zone Drop-in Center (New)	$3,650
20878	Oakland - FAIR Drop-in Center (New)	$7,891
20879	Oakland - South Oakland Drop-in Center	$9,480
20880	Pathways - Brantley Drop-in Center (New)	$31,965
20881	Pathways - Delta County Drop-in Co-occurring Anonymous (New)	$6,760
20882	Pathways - Supported Employment (New)	$45,546
20883	Pathways - Third Annual UP Consumer Conference (New)	$18,400
20884	Pathways - Wraparound Program (New)	$100,000
20885	Pines - Friendship Center Drop-in Enhancements (New)	$9,936
20886	Saginaw - CBT Training (New)	$15,000
20888	Saginaw - Clubhouse Enhancements (New)	$13,666

PCA	Contract Title	Amount
20889	Saginaw - Crisis Residential Treatment Program - PSS (New)	$29,958
20890	Saginaw - Dementia-How You Can Help (New)	$8,827
20892	Saginaw - Jail Diversion Peer Support Specialist (New)	$34,556
20893	Saginaw - Suicide Prevention Activities (New)	$17,000
20894	Saginaw - EBP Supported Employment Enhancement (New)	$70,000
20895	Saginaw - Technical Supports for Anti-Stigma Productions (New)	$3,100
20896	Sanilac - Drop-in Enhancement (New)	$9,299
20897	St. Clair - CPSS as Psychiatric Hospital Settings Liasons (New)	$25,627
20898	St. Clair - Keeping Recovery Skills Alive (KRSA) Training (New)	$6,260
20899	St. Clair - Port of Hopes Drop-in Center Enhancements (New)	$2,500
20916	St. Clair - Project Stay Enhancements (New)	$3,000
20900	Summit Pointe - Breaking Through to a Recovery Culture (New)	$79,000
20901	Summit Pointe - Integrating MH/SA & Physical Health (New)	$100,000
20902	Summit Pointe - Tools for Recovery Mentoring (New)	$75,000
20903	Tuscola - Anti-Stigma (New)	$37,100
20904	Tuscola - CPSS Staff Development (New)	$15,400
20905	Washtenaw - Addressing Trauma within the CMH Population (New)	$52,335
20906	Washtenaw - Believe in Me! An Anti-Stigma Training Project (New)	$62,980
20907	Washtenaw - Expanding Integrated Health Services (New)	$21,628
20908	Washtenaw - Mental Health for Older Adults (New)	$25,700
20910	Washtenaw - Intensive Crisis Stabilization (New)	$100,000
	MACMHB Training Contract:	
83960	Development of a Recovery-Based System of Care	$18,000
20751	Implementation of Supported Employment	$10,000
20752	Improving Practices Leadership Teams	$5,000
20753	Consumer Participation in Systems Transformation	$10,000
20754	System Improvements Project Coordinator	$75,000
20720	Co-occurring Disorders / IDDT Fidelity & Readiness	$215,000
20636	Trauma	$15,000
20642	Advance Directives	$12,500
20645	Anti-Stigma	$12,500
20648	Jail Diversion	$10,000
20587	Motivational Interviewing	$75,000
20666	Cultural Competency	$40,000
20667	Dialectical Behavioral Therapy Training	$250,000
20808	Peer Support Specialist Training Program	$450,000
20417	Grant Writing Training	$15,000
20823	Recovery Enhancing Environment (REE) Implementation	$400,000
20917	Crisis Residential	$5,000
20918	Intensive Crisis Stabilization	$5,000
20919	Peer Support Specialist Staffing	$75,000

PCA	Contract Title	Amount
	Mental Health Practice Improvements:	
20792	Bay-Arenac dba Access Alliance-Family Psychoeducation (2nd Yr)	$57,655
20793	Bay-Arenac dba Access Alliance-IDDT Continuation Grant (2nd Yr)	$40,000
20794	CEI dba CMH Affil. of Mid-Michigan - Family Psychoed. (2nd Year)	$80,000
20813	Central MI PIHP - COD:IDDT (2nd Year)	$80,524
20795	Genesee - COD:IDDT (2nd Year)	$59,650
20796	Kalamazoo dba Southwest MI - COD Enhancement (2nd Year)	$49,192
20799	Macomb - Family Psychoeducation (2nd Year)	$70,000
20736	Muskegon dba Lakeshore - Supported Employment (2nd Year)	$15,913
20797	Muskegon dba Lakeshore - COD:IDDT (2nd Year)	$35,000
20800	network180 - Family Psychoeducation (2nd Year)	$61,913
20801	North Country dba Northern Affiliation - COD:IDDT (2nd Year)	$61,395
20803	Oakland - Evidence-Based Supported Employment (2nd Year)	$90,000
20804	Pathways dba NorthCare - COD:IDDT (2nd Year)	$64,565
20806	Summit Pointe dba Venture - COD:IDDT (2nd Year)	$70,000
20877	Oakland - Co-occurring System's Change (New)	$49,300
20891	Saginaw - Family Psychoeducation Enhancement (New)	$26,557
20915	St. Clair - Family Psychoeducation Training Plan (New)	$31,090
	Miscellaneous Projects:	
20501	NAMI Michigan - Executive Director (2nd Year)	$90,000
20669	Recovery Center of Excellence	$200,000
20520	Gerontology Network - CBT Training (2nd Year)	$36,000
20911	SEMHA Older Adult MH and Dementia Program Consultant	$16,126
	Subtotal	$13,802,108
	FY08 Award	$8,725,809
	FY08 Carryforward (Est.)	$8,375,808
	Total Remaining	$3,299,509

For FY09, the plan is to use the Community Mental Health Block Grant funds in the same manner as in FY08. All new FY09 service projects are for two or three years, and will continue through FY10 or FY11 as long as work is progressing as planned and reports are up-to-date. The Detroit comprehensive systems transformation project will continue. Training will continue, with specific needs determined during the summer.

Community Mental Health Block Grant funds will be used in the same manner as listed above for FY10 and FY11.

Table C. MHBG Funding for Transformation Activities
State: Michigan

	Column 1	Column 2	
	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the *actual* **or** *estimated* amount of MHBG funding that will be used to support this transformation goal in FY	
		Actual	**Estimated**
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	☒		1,204,160
GOAL 2: Mental Health Care is Consumer and Family Driven	☒		4,384,983
GOAL 3: Disparities in Mental Health Services are Eliminated	☒		1,090,486
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	☒		1,754,007
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	☒		9,686,041
GOAL 6: Technology Is Used to Access Mental Health Care and Information	☒		422,036
Total MHBG Funds	N/A	0	18,541,710.00

*Goal 5 of the Final Report of the President's New Freedom Commission on Mental Health states: Excellent Mental Health Care is Delivered and Research is Accelerated. However, Section XX of the MHBG statute provides that research … Therefore, States are asked to report expected MHBG expenditures related to program evaluation, rather than research.

Michigan

Table C - Description of Transformation Activities

For each mental health transformation goal provided in Table C, breifly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State''s transformation activities are described elsewhere in this application, you may simply refer to that section(s).

As discussed throughout this block grant application, block grant funds for adult services have been dedicated to system transformation for the past several years. A summary of how the activities relate to each of the goals in the President's New Freedom Commission (PNFC) Report on Mental Health follows.

Goal 1: MDCH continues to improve awareness of mental health and to change and alter people's views about mental illness via educational meetings, community participation forum, and videos. In addition, training opportunities for Trauma, Advance Directives, Cultural Competency, Anti-Stigma, and Suicide Prevention have been offered for consumers, providers, and advocates to understand that mental health is essential to overall health.

Goal 2: One of major efforts to strengthen our consumer-driven system of support, MDCH has provided statewide training and certification for peer support specialists. MH Block grant funds have been awarded to many consumer-driven initiatives and services including development and enhancement of drop-in centers, clubhouses, self-help groups and increasing consumer leadership in the mental health care system.

Goal 3: To address disparities in mental health, MDCH continues to work with under-served population such as inter-tribal council and Arab Caldean Council. Services and supports for older adults have been improved by Alzheimer's respite, wraparound for older adults, and Dementia care programs.

Goal 4: MH Block grant funds are targeted for development of new and improved early screening, assessment and referral to services. MDCH is also providing training opportunities for consumers and care providers including crisis mobilization and motivational interviewing.

Goal 5: With help of statewide practice improvement steering committee, several evidence-based practices haven been implemented in all regions. At the same time, quality improvement efforts of existing evidence-based practices have been supported.

Goal 6: Recovery Center of Excellence and other multi-media approaches have been used to increase access mental health care and information. The recovery center of excellence serves as a statewide communication platform to link consumers, providers, advocates, families and community stakeholders on recovery.

For children's services, Michigan's transformation plan is the development of a comprehensive system of care for children with a serious emotional disturbance (SED). This is consistent with the President's New Freedom Commission (PNFC) Report on Mental Health which calls for a reduction in fragmentation of services and gaps in care for children. State agencies, local communities, and parents are all partners in working to transform the service system to develop a system of care that supports children and their families with intensive community-based services.

Consistent with Goals 1 and 2 of the President's New Freedom Commission Report (PNFC), Michigan continues to focus on transforming its system of care by developing those services that are intense, family-centered, evidence-based and community-based alternatives to out-of-home restrictive care. Strength-based models that incorporate an individualized, family-centered practice concept continue to be supported and encouraged. These models include wraparound services, PMTO, home-based services, and respite care.

Consistent with Goal 2 of the PNFC, a major part of Michigan's transformation plan has been the incorporation of family-centered practice which has led to increased consumer choice and treatment interventions that are designed as the child and family desires. Federal Block Grant resources are used to assist the Association for Children's Mental Health (ACMH), the Statewide Organization for the Federation of Families for Children's Mental Health. ACMH provides information, referral, resources, advocacy and support for families of youth with serious emotional disturbance. ACMH Family Advocates help families secure essential services for their child and family and often serve as a mentor for parents.

Consistent with Goal 3 of the PNCF, Federal Block Grant resources are used to support Family Advocates who serve individual families from seven regions of the state; regions which are under-served or have a high need for advocacy and help inform the MDCH system about the needs and experiences of children with SED and their families. Families are very involved in all aspects of children's mental health service development, policy decisions, planning and training. Extensive work is being done to improve the quality of mental health services in rural and geographically remote areas by providing training in promising practices such as wraparound and family centered practice.

Consistent with Goal 4 of the PNFC Report, Michigan has been transforming its system since FY2000 when Federal Mental Health Block Grant funding was available to CMHSPs for the purpose of providing screening and assessment services for the juvenile justice population served by local DHS and Circuit Court-Family Division and to provide services to youth who are screened and assessed and determined to be in need of mental health services.

Consistent with Goal 5 of the PNFC, four evidence-based practices have been introduced using federal block grant funding in Michigan. These practices include: Trauma Informed Cognitive Behavior Therapy, Parent Management Training-Oregon Model, and Multi-Systemic Therapy, Functional Family Therapy, and Therapeutic Foster Care. Extensive work is being done to advance evidence based practices in rural and geographically remote areas. Training is being provided in PMTO and or MST to workers in the Upper Peninsula as well as many other rural areas of Michigan.

Consistent with Goal 6 of the PNFC, MDCH has been working with local CMHSPs and Hawthorn Center, the remaining children's state psychiatric hospital, to video conference in families of youth served while the child is in the hospital. In addition, CMHSPs and Hawthorn Center are encouraged to use video conferencing for case conferencing.

Historically, 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 is supported with block grant funding. The development and implementation of intensive community-based services have been crucial to moving children into the least restrictive environment without compromising treatment effectiveness. With the support of the Mental Health Block Grant, training in family-centered practice, evidence-based, and promising practices has been occurring to assist in implementation of Michigan's transformation plan. A continuing focus will be placed on client level outcomes and data collection in FY2009-FY2011, especially for children's block grant funded projects.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	135,352	138,505	138,640	138,775	138,990	139,110
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Maintain or increase access to services for adults with mental illness.

Target: Maintain services for adults with mental illness.

Population: Adults with mental illness

Criterion: 2:Mental Health System Data Epidemiology
3:Children"s Services

Indicator: The number of adults with mental illness served by CMHSPs.

Measure: Count of adults with mental illness served by CMHSPs.

Sources of Information: FY 2007 Section 404 Quality Improvement File

Special Issues:

Significance: Adults with mental illness who rely upon publicly-supported services need access to the array of community-based services to promote recovery.

Action Plan: As stated in the Michigan Mental Health Customer Services Sandards and Access Standards, public mental health agencies must assure a welcoming culture to facilitate information on service options. For persons not on Medicaid, effective October 1, 2008, CMHSPs must keep names of people not able to access care on waiting lists.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	13	11.65	12.70	12.50	12.20	11.90
Numerator	606	521	--	--	--	--
Denominator	4,663	4,472	--	--	--	--

Table Descriptors:

Goal: Increase reliance on community-based alternatives to inpatient care.

Target: To maintain or decrease the percent of adults with mental illness readmitted to inpatient psychiatric care within 30 days of discharge.

Population: Adults with Mental Illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: The number of adults with mental illness who are re-hospitalized within 30 days of discharge.

Measure: Numerator: The number of adults with mental illness discharged within a quarter and re-admitted to inpatient psychiatric care within 30 days of discharge.
Denominator: Total number of adults with mental illness who are discharged from inpatient psychiatric care within a quarter.

Sources of Information: Michigan Mission-Based Performance Indicator System Report for the period October 1, 2007 to December 31, 2007 (Indicator #12b).

Special Issues:

Significance: The use of high cost alternatives, such as inpatient care, directly impacts the availability of other appropriate community-based services. Rapid readmission may suggest premature discharge and/or untimely or insufficient follow-up. MDCH's standard is 15% or lower.

Action Plan: In June 2008, the Health Services Advisory Group (HSAG) completed their report from tracking the results of this indicator. This will be a performance improvement project for FY09 for those PIHPs/CMHSPs that did not meet the standard.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	21.25	19.93	19.90	19.65	19.30	19
Numerator	3,609	3,507	--	--	--	--
Denominator	16,982	17,593	--	--	--	--

Table Descriptors:

Goal: Increase reliance on community-based alternatives to inpatient care.

Target: Percent of adults with mental illness readmitted to inpatient psychiatric care within 180 days of discharge.

Population: Adults with mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: The number of adults with mental illness who are re-hospitalized within 180 days of discharge.

Measure: Numerator: The number of adults with mental illness who are re-hospitalized within 180 days of discharge.
Denominator: Total number of adults with mental illness who are discharged from inpatient psychiatric care.

Sources of Information: FY2007 Section 404 Quality Improvement File / Encounter Data for FY2007.

Special Issues: Currently, the PIHPs report hospital lengths of stay by indicating the number of days of stay. As individuals may have lengthy stays and hospital encounters are reported in varying time segments, the date of discharge is not always clear. Garnering this information is complicated and time-consuming and resources are limited.

Significance: For some adults with mental illness, the occasional use of inpatient psychiatric care is necessary. The percent of adults with mental illness readmitted to inpatient psychiatric care within 180 days of discharge is a significant indicator that helps to determine appropriate discharge and follow-up from restrictive inpatient care.

Action Plan: MDCH is implementing programming to improve the data and is also working with the PIHPs to implement reporting methods that will result in data that is more easily interpreted.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	1,110	1,120	1,150	1.20	1.32	1.40
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To provide supported independent housing to all eligible individuals who have it as a goal in their individual plan of service.

Target: To maintain the level of supported independent housing.

Population: Adults with mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: The number of adults with mental illness receiving supported independent housing.

Measure: Count of adults with mental illness receiving supported independent housing.

Sources of Information: FY2007 Section 404 Quality Improvement File / Encounter Data for FY2007

Special Issues: FY07 Actual = 1,660 (Updated Data)

Significance: Research evidence supports the development of supported independent housing to meet the needs of persons with mental illness.

Action Plan: MDCH will continue to apply for Shelter Plus Care and Supportive Housing Program resources for rental assistance and has awarded block grants for development of Housing Resource Centers.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	1,034	N/A	965	.69	.70	.71
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To provide supported employment for all eligible individuals who have it as a goal in their individual plan of service.

Target: To maintain the level of supported employment.

Population: Adults with mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: The number of persons receiving supported employment.

Measure: Count of adults with mental illness receiving supported employment (not evidence-based).

Sources of Information: FY2007 Section 404 Quality Improvement File / Encounter Data for FY2007

Special Issues: FY07 Actual = 958 (Updated Data)

Significance: Statewide interest in the implementation of evidence-based supported employment practices has been increased due to system transformation efforts, statewide training, and presentations.

Action Plan: The Practice Improvement Steering Committee elected Supported Employment as the third adult evidence-based practice for statewide implementation and a Supported Employment subcommittee has been convened.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	6,650	5,935	5,700	4.10	4.20	4.40
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To provide Assertive Community Treatment (ACT) to all eligible individuals who request it.

Target: To maintain the level of ACT service provision.

Population: Adults with mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: The number of adults with mental illness receiving ACT services.

Measure: Count of adults with mental illness receiving ACT services.

Sources of Information: FY2007 Section 404 Quality Improvement File / Encounter Data for FY2007.

Special Issues: FY07 Actual = 5,696 (Updated Data)

Significance: ACT is an evidence-based practice implemented in Michigan. Program fidelity is assessed prior to approval and monitored regularly.

Action Plan: MDCH obtained private funding to evaluate ACT services in the state and now has an ACT Field Guide; a self-assessment/quality improvement tool is in the final stages of development. The Field Guide to ACT in Michigan will be used to assess current programs and to plan for technical assistance in areas of need.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	783	N/A	650	.46	.48	.50
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To provide Family Psychoeducation services to all eligible individuals who have it as a goal in their individual plan of service.

Target: To maintain the level of Family Psychoeducation.

Population: Adults with mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: The number of adults with mental illness receiving Family Psychoeducation.

Measure: Count of adults with mental illness receiving Family Psychoeducation.

Sources of Information: FY2007 Section 404 Quality Improvement File / Encounter Data for FY2007.

Special Issues: FY07 Actual = 633 (Updated Data)

Significance: This evidence-based practice provides sophisticated coping skills for handling problems posed by mental illness through a partnership between consumers and their families.

Action Plan: All PIHPs have implemented Family Psychoeducation in their regions. In FY10, there will be a contract requirement that this service be available. MDCH will continue to offer technical assistance and statewide training to all PIHPs.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	0	100	125	150	180
Numerator	N/A	0	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To provide evidence-based co-occurring disorders:integrated dual disorder treatment to people in need of this level of services as programs are implemented in the state.

Target: To implement COD:IDDT team based services throughout the state. PIHPs will be required to have this service available in FY 2010. Fidelity assessments of the first teams are occurring this fiscal year. Reporting guidelines have been issued by MDCH and after program approval, these evidence-based services can be reported by use of an encounter code modifier.

Population: Adults with mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Adults with mental illness and a substance use disorder receiving co-occurring disorders treatment in COD:IDDT services.

Measure: Count of adults with mental illness and a substance use disorder receiving the evidence-based practice of COD:IDDT.

Sources of Information: FY2007 Section 404 Quality Improvement File / Encounter Data for FY2007.

Special Issues: The integration of mental health and substance abuse treatment for persons with co-occurring disorders has become a major treatment initiative in Michigan. Historically individuals receive sequential or parallel treatment for their co-occurring disorders. The system of care must be able to address individuals with COD at any level of care and able to address specifically those individuals who have multiple needs and treatment through the Evidence-Based Practice: Integrated Dual Disorders Treatment teams. Recent direction from the department has been issued to allow the reporting, for the first time, of integrated services. Separate counts will be kept of COD:IDDT services, and other integrated services meeting criteria established by the department. During FY 2007, 3,252 people were reported as receiving one or more integrated services meeting the department's criteria. Reporting of services approved by the department as the evidence-based model of Co-Occurring Disorders: Integrated Dual Disorder Treatment is beginning in FY 2008.

Significance: Integrated treatment combines substance abuse and mental health interventions to treat the whole person more effectively. Use of the evidence-based practice is expected to provide better outcomes for consumers with co-occurring disorders needing this intensive level of care.

Action Plan: The concentrated implementation of integrated services including the evidence-based

COD:IDDT service, began two years ago under the state's Practice Improvement Steering Committee direction. A COD:IDDT Subcommittee of that committee is actively involved in supporting the initiative. Extensive traing and technical assistance at the state and regional level is being providing. Several regions are working with COCE on identification of people with co-occurring disorders. Work is occurring at the system level, the provider level, and the clinician level. A team of peer fidelity assessors has been trained and is conducting pre-readiness, readiness, and initial fidelity reviews of COD:IDDT teams as they are developed. This initiative will continue into the coming years.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	61.30	87.64	88	89	90	90.50
Numerator	160	1,915	--	--	--	--
Denominator	261	2,185	--	--	--	--

Table Descriptors:

Goal: Assure the existence of a quality, comprehensive service array responsive to consumer needs through planning.

Target: To maintain consumer satisfaction with mental health services.

Population: Adults with mental illness.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Percentage of adults with mental illness who complete the Mental Health Statistics Improvement Programs' (MHSIP)consumer satisfaction survey who are satisfied with services.

Measure: Numerator: Number of adults with mental illness who complete the MHSIP consumer satisfaction survey who agree with the statements regarding outcomes resulting from ACT services received at PIHP facilities.
Denominator: Number of adults with mental illness who complete the MHSIP survey.

Sources of Information: Mental Health Statistics Improvement Program Consumer Survey General Satisfaction Subscale: Statewide Analysis by ACT Team

Special Issues:

Significance: In 2007, Michigan revised its approach to the collection of MHSIP consumer survey data. Rather than conducting a single statewide probability survey of adults with mental illness, MDCH decided to have the state’s 18 PIHPs collect satisfaction information at the program level in order to render the data more relevant for quality improvement purposes.

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	15.54	14.50	14.55	14.60	14.67	14.75
Numerator	21,027	20,088	--	--	--	--
Denominator	135,352	138,505	--	--	--	--

Table Descriptors:

Goal: Increase opportunities for persons with mental illness to become employed.

Target: To maintain the percentage of adults with mental illness who are employed.

Population: Adults with mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of adults with mental illness who are employed.

Measure: Numerator: Total number of adults with mental illness served by CMHSPs who are employed.
Denominator: Total number of adults with mental illness served by CMHSPs.

Sources of Information: FY2007 Section 404 Quality Improvement File / Encounter Data for FY2007.

Special Issues: Personal assistance services in the workplace has been approved.

Significance: Meaningful employment is an important component in the recovery of many people with mental illness.

Action Plan: MDCH has recently convened a Supported Employment Subcommittee, is working intensively with Michigan Rehabilitation Services, and is using the Medicaid Infrastructure Grant and Freedom to Work program to increase employment opportunities for people with disabilities.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	7.72	10.21	10.25	10.32	10.40	10.48
Numerator	10,444	14,145	--	--	--	--
Denominator	135,352	138,505	--	--	--	--

Table Descriptors:

Goal: Increase the number of people with mental illness who are diverted from jail into mental health treatment.

Target: To increase the percentage of people diverted from jail.

Population: Adults with mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: The percentage of adults with mental illness served through CMHSPs who are diverted from jail.

Measure: Numerator: The number of adults with mental illness who are diverted from jail through mental health interventions.
Denominator: The number of adults with mental illness served through the CMHSPs.

Sources of Information: FY2007 Section 404 Quality Improvement File/Encounter Data for FY2007/.

Special Issues: The department had a Jail Diversion Data Workgroup meet extensively over the past year to develop a reporting mechanism to report jail diversions electronically. Prior to this, accurate information could only be gleaned through special manual reports. This new system is just beginning to be used so baseline numbers need to be developed to establish meaningful targets. This system allows for the reporting of arrest data, but this data is not readily available to mental health clinicians and is not required to be reported by the CMHSPs.

Significance: Many times people with mental illness are arrested and jailed when a more appropriate response is to provide mental health services to support that person in the community. In Michigan, both pre-booking and post-booking jail diversion programs exist and work with law enforcement at the community level continues.

Action Plan: Each CMHSP has one or more jail diversion programs in place. The department is supported enhanced mental health/law enforcement partnerships at the local level through provision of a training model designed in one of the successful regions of the state. Training is provided by both mental health and law enforcement staff to teams consisting of mental health and law enforcement staff from communities around the state. The department will be working with CMHSP jail diversion staff on using the new statewide data reporting mechanism for jail divesion activities.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	3.01	3.08	3.05	3	2.93	2.87
Numerator	4,074	4,260	--	--	--	--
Denominator	135,352	138,505	--	--	--	--

Table Descriptors:

Goal: Decrease homeless status for adults with mental illness.

Target: To decrease the percentage of adults with mental illness living in either a homeless shelter or are homeless.

Population: Adults with mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: The percentage of adults with mental illness served through CMHSPs who are living in either a homeless shelter or are homeless.

Measure: Numerator: The number of adults with mental illness who are living in either a homeless shelter or are homeless.
Denominator: The number of adults with mental illness served through the CMHSPs.

Sources of Information: FY2007 Section 404 Quality Improvement File / Encounter Data for FY2007.

Special Issues: There is increased activitiy in Michigan surrounding outreach programs to the homeless population. However, there is an upsurge in homelessness during difficult economic times, so a decline in the percentage of people who are homeless will be difficult to achieve in Michigan.

Significance: An increase in stability in housing is a significant factor in a person’s recovery.

Action Plan: MDCH will continue to apply for Shelter Plus Care and Supportive Housing Program resources for rental assistance, coordinate with the Michigan State Housing Development Authority to carry out Michigan’s 10-year Plan to End Homelessness, and allocate resources to projects which will work to end homelessness.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: In 2007, Michigan revised its approach to the collection of MHSIP consumer survey data. Rather than conducting a single statewide probability survey of adults with mental illness, MDCH decided to have the state's 18 PIHPs collect satisfaction information at the program level in order to render the data more relevant for quality improvement purposes. In June and July 2007, all consumers receiving Assertive Community Treatment (ACT) services were asked to complete the 28-item version of the MHSIP consumer survey. Unfortunately, items measuring (a) functioning (29-32), (b) social connectedness (33-36), and (c) criminal justice involvement (37-41) were not included in the revised protocol. At the time, MDCH was unaware that these three additional scales were required as part of the set of National Outcome Measures (NOMs).

MDCH has the capacity to collect data for these newer, developmental measures. The department's Quality Improvement Council will soon discuss adding these items to the next iteration of data collection. It is anticipated that the 2008 MHSIP Consumer Survey will be administered next spring, probably in May, with data ready for reporting by October 2008.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services
4:Targeted Services to Rural and Homeless Populations

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: In 2007, Michigan revised its approach to the collection of MHSIP consumer survey data. Rather than conducting a single statewide probability survey of adults with mental illness, MDCH decided to have the state's 18 PIHPs collect satisfaction information at the program level in order to render the data more relevant for quality improvement purposes. In June and July 2007, all consumers receiving Assertive Community Treatment (ACT) services were asked to complete the 28-item version of the MHSIP consumer survey. Unfortunately, items measuring (a) functioning (29-32), (b) social connectedness (33-36), and (c) criminal justice involvement (37-41) were not included in the revised protocol. At the time, MDCH was unaware that these three additional scales were required as part of the set of National Outcome Measures (NOMs).

MDCH has the capacity to collect data for these newer, developmental measures. The department's Quality Improvement Council will soon discuss adding these items to the next iteration of data collection. It is anticipated that the 2008 MHSIP Consumer Survey will be administered next spring, probably in May, with data ready for reporting by October 2008.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Access - 7 day Follow-up

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	87	90.27	89.33	89.50	89.63	89.80
Numerator	3,161	2,857	--	--	--	--
Denominator	3,635	3,165	--	--	--	--

Table Descriptors:

Goal: Assure access to the comprehensive service array.

Target: To provide follow-up services within 7 days after discharge.

Population: Adults with mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of adults with mental illness discharged from a psychiatric inpatient unit who are seen for follow-up care within 7 days.

Measure: Numerator: Number of adults with mental illness seen for follow-up care by CMHSPs within 7 days.
Denominator: Number of adults with mental illness discharged from a psychiatric inpatient unit.

Sources of Information: Final Michigan Performance Indicator Report for the period October 1, 2007 to December 31, 2007 (Indicator #4a(2)).

Special Issues:

Significance: The continuity of care post discharge from a psychiatric inpatient unit is important to the recovery and stabilization processes for consumers. When responsibility for the care of an individual shifts from one organization to another, it is important that services remain continuous. If follow-up contact is not immediately made, there is more likelihood that an individual may not have all supports required to remain living in the community. Lack of community supports could result in additional/recurrent hospitalization. Thus, quality of care and consumer outcomes may suffer.

Action Plan: In June 2008, the Health Services Advisory Group (HSAG) completed their report from tracking the results of this indicator. This will be a performance improvement project for FY09 for those PIHPs/CMHSPs that did not meet the standard.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Access: Face-to-Face

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	99.10	97.90	98.69	98.80	98.93	99.10
Numerator	6,635	6,803	--	--	--	--
Denominator	6,696	6,949	--	--	--	--

Table Descriptors:

Goal: Assure access to the comprehensive service array.

Target: To provide a face-to-face meeting within 14 days of non-emergent request for services.

Population: Adults with mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of new adults with mental illness receiving a face-to-face assessment with a professional within 14 calendar days of non-emergent request for service.

Measure: Numerator: Number of new adults with mental illness receiving an initial assessment within 14 calendar days of first request.
Denominator: Number of new adults with mental illness receiving an initial non-emergent professional assessment following a first request.

Sources of Information: Final Michigan Performance Indicator Report for the period October 1, 2007 to December 31, 2007 (Indicator #2b).

Special Issues:

Significance: Quick, convenient entry into the mental health system is a critical aspect of accessibility of services. Delays can result in appropriate care or exacerbations of distress. The time from scheduling to face-to-face contact with a mental health professional and commencement of services is a critical component of appropriate care.

Action Plan: MDCH has set a contractual standard for this indicator. It is expected that these assessments will occur within 14 calendar days 95% of the time. Ongoing contractual monitoring will continue to assure compliance.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Rural Services Population

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	22.80	27.80	29.42	24.20	24.40	N/A
Numerator	28,913	35,309	--	--	--	--
Denominator	127,009	127,009	--	--	--	--

Table Descriptors:

Goal: Increase availablility of the service array in rural communities with funds from the Mental Health Block Grant.

Target: To assure that block grant funds are used to support mental health services for adults with serious mental illness in rural areas.

Population: Adults with serious mental illness

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Percentage of rural adults with serious mental illness who receive mental health services.

Measure: Numerator: Number of adults with serious mental illness receiving services in rural counties. Denominator: Total number of adults with serious mental illness in rural counties.

Sources of Information: FY2007 Section 404 Quality Improvement File; Draft Estimate of the 12-month Prevalence of Serious Mental Illness in Michigan in 2000.

Special Issues: Counties in Michigan with populations greater than 250,000 are considered urban. In 2006, eleven counties were considered urban; in 2007 only seven are. These seven counties are: Genesee, Ingham, Kent, Macomb, Oakland, Washtenaw, and Wayne. All other counties, even though they may be good-sized cities within, are considered rural based on county population and used as part of the measure.

Significance: This indicator is being used to determine whether people living in the state's rural areas are being served at a level representative of the state population. Michigan has a significant portion of the population living in rural areas where they are sparsely distributed and often older, making concentrated services challenging to develop.

Action Plan: MDCH continues to emphasize the importance of rural service initiatives in our annual block grant request for proposals to the PIHPs/CMHSPs.

Michigan

Child - Establishment of System of Care

Child - Provides for the establishment and implementation of
an organized community-based system of care for individuals with mental illness.

For children's services, Michigan's transformation plan is the development of a comprehensive system of care for children with a serious emotional disturbance (SED). This is consistent with the President's New Freedom Commission (PNFC) Report on Mental Health which calls for a reduction in fragmentation of services and gaps in care for children. State agencies, local communities, parents are all partners in working to transform service system to develop a system of care that supports children and their families with intensive community based services.

Historically, 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 is supported with 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. Consistent with Goal 2 of the President's New Freedom Commission Report, a major part of Michigan's transformation plan has been the incorporation of family-centered practice, which has led to increased consumer choice and treatment interventions that are designed as the child and family desires. With the support of the Mental Health Block Grant, training in family-centered practice, evidence-based, and promising practices has been occurring to assist in implementation of Michigan's transformation plan. A continuing focus will be placed on client level outcomes and data collection in FY2009-FY2011, especially for children's block grant funded projects.

The Michigan Department of Community Health 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 system of care has improved through the elimination of duplicative efforts and new projects being planned with joint efforts in development, implementation, and evaluation and services. More work is being planned to further improve the system of care, increase parent leadership development, and increase and maintain youth involvement on interagency committees.

In addition Michigan has two ongoing SAMHSA System of Care grants which were awarded in September 2006, one in Ingham County and one in Kalamazoo County. These two systems of care grants, along with a former grant site in Southwest Detroit, provide leadership in collaborative efforts to develop systems of care in their communities and impact the state level policy efforts. Four additional system of care proposals were approved for block grant funding in FY2009 to initiate or continue system of care activities in local communities. 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 local Community Collaborative which functions to oversee children's services planning and development. The local collaborative bodies are comprised of local public agency directors (public health, community mental health, Michigan Department of Human Services (MDHS),

substance abuse agencies), family court judges, prosecutors, families and sometimes a youth, private agencies and community representatives.

The system change initiative Michigan adopted requires systems to develop integrated treatment capacity at every level of care for both adults and in many instances children. Individuals with co-occurring disorders face issues that are complex in nature. These complexities cut across various health and human service agencies. The initial system change approach Michigan adopted is to develop a comprehensive model that addresses the needs of every individual who seeks help. To that effect, PIHPs are encouraged to develop consensus documents along with other systems that delineate the expectations of the individuals who have co-occurring disorders including both adults and children. Most of the CMHSPs are at varying degrees in implementation.

Some PIHPs have placed a specific focus on training on COD for children and these include Oakland and Central Michigan. Oakland County PIHP has also held training in Motivational Interviewing in order to increase engagement of families in PMTO, as well as addressing the MI and SA 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. These include Network180, Genesee, and LifeWays.

Michigan

Child - Available Services

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing
services;
Educational services;
Substance
abuse services;
Medical and dental services;
Support services;
Services provided by local school
systems under the Individuals with Disabilities Education Act;
Case management services;
Services
for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities
leading to reduction of hospitalization.

Consistent with Goals 1-6 of the President's New Freedom Commission Report (PNFC), Michigan continues to focus on transforming its system of care by developing those services that are intensive, family-centered, evidence-based and community-based alternatives to out-of-home restrictive care. Strength-based models that incorporate an individualized, family-centered practice concept continue to be supported and encouraged. These models include wraparound services, evidence-based practices, home-based services, and respite care. The wraparound and home-based service models utilize a multi-agency staffing approach assuring the involvement of representatives of the health, education, child welfare and juvenile justice service arenas. The evidence-based practices that Michigan has introduced are consistent with Goal 5 of the PNFC, and include: Trauma Informed Cognitive Behavior Therapy, Parent Management Training-Oregon Model (PMTO), and Multi-Systemic Therapy (MST).

MDCH continues its activities to assure a family-centered children's mental health services system. Consistent with Goal 2 of the PNFC Federal Block Grant resources are used to assist the Association for Children's Mental Health (ACMH), the Statewide Organization for the Federation of Families for Children's Mental Health. ACMH provides information, referral, resources, advocacy and support for families of youth with serious emotional disturbance. ACMH Family Advocates help families secure essential services for their child and family and often serve as a mentor for parents consistent with Goal 3 of the PNFC Block Grant resources are used to support Family Advocates who serve individual families from seven regions of the state; regions which are under-served or have a high need for advocacy and help inform the MDCH system about the needs and experiences of children with SED and their families. Families are very involved in all aspects of children's mental health service development, policy decisions, planning and training.

Highlights of the community-based services for children include the following:

Home-based Services
Michigan requires CMHSPs to provide home-based services. MDCH established intensive mental health home-based services as a primary service delivery method for children with serious emotional disturbance and their families. By providing Medicaid coverage for home-based services, access to this intensive, family-centered service was dramatically increased. By including home-based services as a required component of CMHSP service arrays, such access is continued and reduces the potential for reliance on unnecessary and more costly restrictive placements. Home-based services must be available for the age range of children birth through 17 years. For children birth through three, home based services staff must be trained in Infant Mental Health interventions. CMHSPs provide early intervention services consistent with PNFC goal 4.

Wraparound Services
A service approach that has continued to grow is wraparound. Wraparound was introduced in Michigan in 1993. MDCH has made Mental Health Block Grant funding available for this wraparound planning. In some communities, CMHSP led initiatives are supported by annual federal block grant awards. The Department of Human Services also is a major funder of wraparound and other funders include the courts, schools and

substance abuse services. There has continued to be focus on entrenchment of the wraparound model and improvement in service proficiency and capacity for wraparound services to children with SED and their families. All wraparound services in Michigan are provided as a collaborative effort targeted to preserve families and reduce reliance on inpatient and residential treatment. Wraparound services initiatives in Michigan must be structured to involve a community team, a wraparound facilitator, and a child and family team. The initiative must plan and facilitate services and supports based on the principles of strength-based discovery, life domains planning, the philosophy of unconditional care, and 10 other core wraparound values. These fundamental elements are published in an informational advisory and are included as requirements in all MDCH/CMHSP wraparound contracts. In addition, wraparound is now included in the Medicaid capitated 1915(b)(c) waiver for specialty services and supports as a 1915(b)(3) service for children and adolescents. Wraparound is also included in Michigan's Mental Health Code, section 330.1206(2), as a service that CMHSPs shall provide to children, when appropriate. Finally, wraparound is also included as a 1915(c) Home and Community Based Waiver that Michigan recently received. All of the above activities help Michigan achieve Goal 2.1 in the PNFC to develop individualized services for children with a serious emotional disturbance and their families. Michigan will continue to enhance and develop more assurance to wraparound model fidelity. Data will be used to refine training tools and support communities through training and technical assistance.

Respite Services

Respite services provide an interval of relief to the families of children, who have a serious emotional disturbance, utilizing short-term care to the child within or out of the family's home. Parents of children with serious emotional disturbance have identified respite as a critical support service to families to keep their child within the family home. The provision of respite services to families of children with serious emotional disturbance has been a primary element supporting the successful reduction of reliance on inpatient services and out-of-home placements by allowing the family a break for their child, often reducing frustration for both the parents and the child. This helps to improve the child's overall functioning. CMHSPs provide respite services as part of their array of services.

Case Management Services

By policy, those clients needing case management are those who have multiple service needs and who require access to the continuum of mental health services (i.e., those individuals needing or provided substantial services), and those who have a demonstrated inability to independently access and sustain involvement with needed services. The determination of the need for case management may occur at any time due to changing circumstances. The need for case management services must be documented in the clinical record.

Family-Centered Practice

By policy and under the Mental Health Code, Michigan requires CMHSPs to utilize the Person-Centered Planning (PCP) approach. MDCH has developed a curriculum that focuses on the implementation of family-centered practice (FCP) when the child is a

minor. The training curriculum for the Person-Centered Planning and family-centered practice became available to CMHSP staff and families in early FY1999. MDCH provides PCP/FCP training upon the request of CMHSPs and works with the CMHSPs to design training specific to the needs of that CMHSP. With continued emphasis on family-centered, community-based interventions and efforts to keep children out of more restrictive, more costly, and often less beneficial out-of-home placements, the CMHSPs continue to be encouraged to focus on providing appropriate care that families and children request and desire. In addition, the MDCH Site Review Team monitors family-centered practice in the development of plans of services for children and families as part of their protocols. CMHSPs are cited for this and are referred to MDCH for technical assistance and training. Staff from the children's division consult with the site review team monitors to constantly work at improving family-centered practice that is provided by the PIHPs/CMHSPs.

Family-centered practice is being furthered, both internally and across systems. The Division of Mental Health Services to Children and Families has established a family-centered practice team to develop and implement family-centered strategies for the mental health system. This Team has developed an Interpretive and Consultative Guidance paper to assist CMHSPs in applying Person-Centered Planning to families using family-centered practice. The TAG Team, an interagency group including Michigan Department of Education, Michigan Department of Community Health (mental health and public health), Department of Human Services, juvenile justice, and families have developed strategies for implementing family-centered practice across systems.

Child Care Expulsion Prevention (CCEP)
CCEP programs provide trained early childhood mental health professionals who consult with child care providers and parents of children under the age of six who are experiencing behavioral and emotional challenges in their child care setting. CCEP aims to reduce expulsions and increase the number of families and child care providers who successfully nurture the social and emotional development of children ages 0-5 in licensed child care programs. These projects are a collaborative effort funded through DHS and implemented by the MDCH through local CMHSPs and the Michigan Community Coordinated Child Care Association and the Michigan State University Cooperative Extension both of whom provide information to child care providers. This program supports Goal 4 of the PNFC Report by promoting mental health of young children.

Community Collaborative
At the community level, interagency administrative groups, counterparts to each of the aforementioned structures, 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 local Community Collaborative which functions to oversee children's services planning and development. The local collaborative bodies are comprised of local public agency directors (public health, community mental health, DHS, substance abuse agencies),

family court judges, prosecutors, and families and sometimes youth, private agencies and community representatives.

Juvenile Justice Diversion
In collaboration with the DHS, the State Court Administrators Office, parents of children with SED, CMHSPs, and the Circuit Court Family Division, MDCH has created a model for juvenile justice screening diversion to occur at the local level. The mental health system, in cooperation with the local juvenile justice system, has a role to play at each stage in the adjudication process. Youth with mental health needs may be identified for diversion from the juvenile justice system at any point, including pre-adjudication (before formal charges are brought) or during the disposition process. Pre-adjudication diversion occurs at the point of contact with law enforcement officers and relies heavily on effective interactions between police and community mental health services. During the disposition process, youth may be screened and evaluated for the presence of serious emotional disturbance. After the determination of serious emotional disturbance is made, diversion may include negotiations with prosecutors, defense attorneys, community-based mental health providers, the local DHS, and the courts to produce a community-based disposition in lieu of prosecution or as a condition of a reduction in charges. In the diversion process, youth and families would be linked to an array of community-based services.

Michigan has been transforming its system since FY2000, when Federal Mental Health Block Grant funding was made available to CMHSPs for the purpose of providing screening and assessment services for the juvenile justice population served by the local DHS and Circuit Court-Family Division and to provide services to youth who are screened and assessed and determined to be in need of mental health services. This supports Goal 4 of the PNFC to screen for mental disorders and connect these children to treatment supports.

MDCH, DHS and CMHSPs will partner with the local DHS and the juvenile justice system to continue to divert youth with serious emotional disturbance from the juvenile justice system. Family and youth input into the development and implementation of these services is required.

Health and Rehabilitation Services for Children
The majority of Medicaid beneficiaries receiving services through a PIHP are enrolled in a Medicaid Health Plan (MHP) for their health care services. In addition to primary health care, MHPs in Michigan are responsible for providing non-specialty level mental health services to their enrollees up to 20 outpatient visits. PIHPs/CMHSPs are, by contract, required to collaborate and coordinate with other health service providers at their local level. The following is a description of dental and health services for children with Medicaid.

Dental Benefits for Children
Dental benefits are available to beneficiaries under 21 years of age through Medicaid, which provides Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Upon

completion of a well-child visit (EPSDT), providers must refer beneficiaries to a dental provider for a thorough dental examination. It is recommended that a dental appointment be made every six months and that it include a complete dental examination, appropriate x-rays, and preventive care such as a prophylaxis and fluoride treatment. If additional treatment is needed, follow-up dental visits are to be scheduled at the end of the examination so dental treatment can be completed.

Services Covered By Medicaid Health Plans (MHPs)
The following services must be covered by MHPs:

- Blood lead services for individuals under age 21
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Childbirth and parenting classes
- Chiropractic services for individuals under age 21
- Ambulance and other emergency medical transportation
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment and medical supplies
- Emergency services
- End Stage Renal Disease (ESRD) services
- Family planning services
- Health education
- Hearing and speech services
- Hearing aids for individuals under age 21
- Home health services
- Hospice services (if requested by enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative nursing care (in or out of a facility)
- Maternal and Infant Support Services (MSS/ISS)
- Medically necessary transportation for enrollees without other transportation options
- Medically necessary weight reduction services
- Mental health care (up to 20 outpatient visits per contract year)
- Out-of-state services authorized by the MHP
- Outreach for included services, especially pregnancy-related and well-child care
- Pharmacy services
- Podiatry services for individuals under age 21
- Practitioner services (such as those provided by physicians, optometrists, or oral surgeons enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Therapies (speech, language, physical, occupational)
- Transplant services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for individuals under age 21

Additionally, PIHPs are required to provide health services. Health services are provided for purposes of improving the beneficiary's overall health and ability to care for health-related needs. This includes nursing services (on a per-visit basis, not on-going hourly care), dietary/nutritional services, maintenance of health and hygiene, teaching self-administration of medication, care of minor injuries or first aid, recognizing early symptoms of illness and teaching the beneficiary to seek assistance in case of emergencies. Health assessments are also covered. A registered nurse, nurse practitioner, or dietician must provide these services, according to their scope of practice. Health services must be carefully coordinated with the beneficiary's health care plan so that the PIHP does not provide services that are the responsibility of the MHP.

Regarding rehabilitation services, skill-building assistance, social skills training, daily and community-living skills, and vocational planning/rehabilitation are provided by or in collaboration with, other community partners, such as schools, courts, the Department of Labor and Economic Growth and the DHS (child welfare).

Substance Abuse Services for Children
Covered services under Medicaid for substance abuse include:

- Access Assessment and Referral Services
- Outpatient Treatment
- Intensive Outpatient Treatment
- Office of Pharmacological and Alternative Therapies/Center for Substance Abuse Treatment (OPAT/CSAT) approved Pharmacological Supports

Some Medicaid-covered services are available to substance abuse beneficiaries, but are provided outside of the PIHP Plan. The PIHPs are not responsible to pay for the following:

- Acute detoxification.
- Laboratory services related to substance abuse (with the exception of lab services required for Methadone and LAAM).
- Medications used in the treatment/management of addictive disorders.
- Emergency medical care.
- Emergency transportation.
- Substance abuse prevention and treatment that occurs routinely in the context of providing primary health care.
- Routine transportation to substance abuse treatment services which is the responsibility of the local DHS.

CMHSPs are required to work with the substance abuse coordinating agency in systems planning to identify ways that the respective systems, working together, can bring about appreciable improvements in services, management or both. They are further required to have a documented policy and set of procedures to assure that coordination regarding mutual consumers is occurring. Several PIHPs also are the responsible Coordinating Agency for Substance Abuse and provide integrated assessments and treatment for

mental health and substance abuse. In FY2004, CAFAS data indicated that participants in the Level of Functioning Project were treating youth with moderate or severe maladaptive substance use with great success, showing a significant improvement (a decrease of 20 points or more on the CAFAS) for 75.3% of youth.

Children's Services System

In Michigan, responsibility for coordination of children's services is delegated to state departments by service area as described below.

Michigan Department of Community Health (MDCH)

The MDCH is a decentralized state agency responsible for assuring mental health services to individuals in the state. Through its contracts with Community Mental Health Services Programs (CMHSPs), PIHPs for Medicaid Specialty Services, and regional substance abuse agencies, MDCH assures mental health and substance abuse services to children with serious emotional disturbance and their families. These contracts require services coordination and integration with key local children's human services providers. Local CMHSP Directors participate as representatives to community human services interagency coordination groups known as Community Collaboratives.

Michigan Department of Human Services (DHS)

The DHS is a centralized state agency responsible for providing child welfare, child protection, and delinquency services in the state. Services are provided through state offices at the county level. Service coordination policies are implemented through community interagency agreements and local office performance contracts. Local DHS directors participate as representatives to Community Collaboratives.

Michigan Family Court System

The Michigan Family Court System, a division of the Circuit Court, has been phased in to replace the former Probate Court system. Child abuse, neglect and delinquency cases fall under the jurisdiction of the Family Court. Family Court judges or court administrators participate as representatives to Community Collaboratives. The State Court Administrator Office, which oversees the Family Courts, has been a key partner in developing and training for the blended funding initiative.

Michigan Department of Education (MDE)

The MDE is a decentralized state agency responsible for assurance of education services in the state. This responsibility includes assurance of special education services as required by the Individuals with Disabilities Education Act. In conjunction with Intermediate School Districts (ISDs), local public school districts are responsible for regular and special education services coordination. Intermediate and local public school superintendents and/or special education directors participate as representatives to Community Collaboratives. Education representatives also serve as members of child and

family services planning teams, service level components of interagency individualized services initiatives.

At the state human services systems level, Michigan has incrementally intensified its focus on interdepartmental planning and program development. Under Governor Jennifer M. Granholm, the Children's Cabinet has been established to work collaboratively to better support and serve Michigan's children. The members of the Children's Cabinet are the Directors of the Departments of Community Health, Labor and Economic Growth, Human Services and the Superintendent of Public Instruction. The Children's Action Network (CAN) has been appointed by the Children's Cabinet to focus on universal prevention and early intervention services for children birth to age five. The CAN includes members of the Children's Cabinet, members of the child advocacy community, and other key state governmental staff. The CAN brings together the Department Directors in human services – to work across state department boundaries to uplift children. Two major initiatives of the Children's Cabinet and CAN are:

School-based Family Resources Centers
Governor Granholm has responded to the challenge of turning around Michigan schools that are not meeting their academic achievement goals with a two-track strategy. The first track emphasizes improved leadership and professional development and better alignment of curriculum to state content guidelines in the "high priority" schools. The second track calls for the creation of School Based Family Resource Centers that will use a collaborative approach to improve human service delivery to school-aged children and their families. These Centers will serve as a "one stop shop" for family services located within or near a neighborhood school. Recognizing that services like health care, nutrition, and family support activities can have significant impact on education achievement, the Centers will help schools achieve their long-term goals of improved reading and math scores be improving services to families. The Centers will also promote greater parental involvement in education by linking human service delivery to the school environment. The DHS is leading this effort.

Project Great Start (PGS)
PGS is the Governor's umbrella effort that seeks to coordinate the early childhood work of various public and private entities in Michigan to achieve common targets and measurable results. PGS will seek opportunities for synergy among the many early childhood programs and initiatives that exist in Michigan today and ways to eliminate needless duplication of services and competition for resources. Existing early childhood programs in Michigan that wish to identify themselves with Project Great Start are welcomed and asked to embrace cooperative action. PGS will work to see that more resources, public and private, are devoted to achieving an early childhood vision of "A Great Start for every child in Michigan: safe, healthy, and eager to succeed in school and in life." and, in particular, will use the Children's Action Network to maximize the impact to reaching this vision. The Early Childhood Comprehensive System Project, which is funded by a federal Maternal and Child Health grant, is developing a strategic plan to assure a coordinated system of community resources and supports to assure the

vision of a “Great Start” for every child. The Early Childhood Core Team, a group of state staff and local community representatives, and parents, is guiding the process.

In addition, several state interagency structures have been established to facilitate planning and coordination in the development and delivery of education, child welfare and children’s mental health services. These interagency administrative committees are steering cross-system activities in the implementation of Part C of IDEA, wraparound services for children and families, and the Blended Funding Workgroup.

Targeted Services to Homeless Populations

Population Description: Michigan commissioned a study called, "The State of Homelessness in Michigan" which is supported by the Michigan Interagency Committee on Homelessness, a federally mandated entity comprised of representatives from all state agencies that provide homeless assistance programs. The 17-month study was released in June of 1995. The study attempted to estimate the numbers of homeless persons and families, and to survey homeless individuals and families presently provided services in order to gather demographic information and descriptive information regarding services involvement, including mental health services, substance abuse history, school involvement (for children), etc., both to identify what services homeless individuals and families are receiving and to identify what services they feel they need. The study was commissioned to provide baseline information to the state for planning purposes. The study estimates that there are 77,000 to 136,000 incidents of homelessness among school age children each year.

Services Provided: The Michigan Department of Education (MDE) was awarded funding to maintain approximately 31 local Intermediate School District projects for outreach and support of homeless children to attend and be successful in school by providing tutorial services, transportation, and other related support services to families (case management).

Since FY95, annual appropriations, through the Department of Human Services has maintained Michigan's runaway programs and homeless youth programs. This past year, 27 runaway programs and 11 homeless youth programs have been established to meet the evolving needs of local communities. Since then, the State of Michigan and the Skillman Foundation have annually renewed their commitment to support the Michigan Network for Youth and Families (MNYF). The programs provide a variety of counseling services, case management, emergency shelter, support services, and 24-hour crisis intervention. Although, data is not available for specific diagnosis, it is assumed that a number of these children are SED and are being served within the MNYF programs on a short-term basis and referred for mental health services. Several MNYF agencies and CMHSPs have established relationships to facilitate services for mutual clients. In these instances, MNYF programs are able to provide emergency crisis intervention and referral for the CMHSP, emergency respite services, or foster care and parent support groups. The CMHSP is able to provide counseling and other services for MNYF clients with mental health needs. MDCH continues to encourage the development of these relationships. In late 1997, MDCH and DHS began to explore strategies to identify approaches to enhance access to mental health services for youth served by the MNYF Programs. Staff involved

in these discussions detailed a significant overlap of issues and service barriers presented by the needs of homeless and runaway youth and the focus of the transition services models. During FY98, DHS and MDCH children's as well as adult's services staff reviewed national youth in transition models and released requests for CMHSP mental health services transition proposals.

Policy Academy on Homeless Families and Children

Michigan completed a Policy Academy on Homeless Families and Children with the vision of "All Michigan children and Families live with dignity and thrive in safe, affordable, and sustainable homes in supportive communities." Goals of the Policy Academy on Homeless Families and Children are:

- Expanding the supply of and access to affordable and safe housing for homeless families, children, and youth.
- Strengthening and expanding efforts to prevent homelessness among families, children, and youth.
- Increasing awareness and utilization of "mainstream" services and community resources for homeless families, children, and youth.
- Increasing the quality of data and efficacy and impact of collaborative federal, state, and local planning for ending homelessness among families, children, and youth.
- Building a political agenda and public will to end homelessness for families, children, and youth.

The Goals of the Policy Academy on Homeless Families and Children are now incorporated in the Governor's 10-year Plan to End Homelessness. Every community across the state has developed a 10-Year Plan to End Homelessness. To assist in implementation of their plans, the Michigan State Housing Development Authority (MSHDA) has made $14,500,000 available to create supportive housing for homeless families with children, homeless youth, chronically homeless, and homeless survivors of domestic violence.

Michigan

Child - Estimate of Prevalence

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

Prevalence Estimation: The literature estimates that from 3 to 21 percent of the general population require mental health services. The *Surgeon General's Report on Mental Health* (1999) indicates that the Methodology for Epidemiology of Mental Disorders in Children and Adolescents (MECA) Study estimated that 21 percent of U.S. Children ages 9 to 17 had a diagnosable mental or addictive disorder. Additionally, if significant functional impairment was required, the percentage dropped to 11 percent. This is consistent with the *Prevalence of Serious Emotional Disturbance in Children and Adolescents* (1998).

Under the federal definition, the Department of Community Health estimates that most children provided public mental health services in Michigan qualify as being SED. All of the children identified as having an emotional illness in Michigan have a diagnosis exclusive of V codes, primary substance abuse, and developmental disorder, and have usually had this condition for six or more months. This would qualify them as having a serious emotional disorder under the federal definition. Based upon the broad federal definition of SED, Michigan has used a prevalence estimate for SED of 11%, which calculates to 285,534 children. In *Prevalence of Serious Emotional Disturbance in Children and Adolescents*, the Center for Mental Health Services cites two ranges of prevalence based on severity of impairment. It should be noted that when using the broader range and definition (10% - 12% with significant functional impairment), Michigan's current prevalence rate for SED, 11%, is slightly higher than the mean of the recommended rate. This figure takes into account recommended adjustments for differing levels of poverty. Michigan's rate is also less than three percentage points above the extreme functional impairment range cited by CMHS.

SED Definition: Michigan's Mental Health Code defines serious emotional disturbance in compliance with the federal definition as published in the May 20, 1993 Federal Register Notice, Vol. 58, No. 96. The MDCH contract with community mental health service programs (CMHSPs) also defines serious emotional disturbance using the parameters included in the federal definition. In recent years, MDCH has made a concerted effort to correct aberrations regarding reported numbers of children with serious emotional disturbance served by CMHSPs. The CMHSP reporting patterns over the last several years have improved and continued efforts have been made to ensure more consistency.

Targeted Population: The MDCH/CMHSP contract now requires that CMHSPs administer the Child and Adolescent Functional Assessment Scale (CAFAS) at intake (for non-emergent cases) and at closure or annually thereafter. During FY1998, the MDCH mandated the statewide use of the Child and Adolescent Functional Assessment Scale (CAFAS) by CMHSPs in order to more accurately describe the SED population served by CMHSPs and to begin to equate the functioning level of the population served with the level of service intensity required to meet the child and family's needs. The subscale scores of the CAFAS are required to be reported to MDCH as part of the data set reporting requirements.

The following chart illustrates the number of children per CMHSP catchment area in Michigan, the general population per catchment area in Michigan, the percentage of

children in the general population for CMHSP catchment areas, the estimated number of children with SED served by CMHSPs in FY07, the percentage of the child population that received services from the identified CMHSPs in FY07, and the calculation of 11% of children per CMHSP catchment area. This chart utilizes 2000 census data.

CMHSP	# OF CHILD 0-18	# GEN. POP	% OF GEN. POP 0-18	Number of Children Served	Number of SED Children Served 84% of # Served	% of 0-18 Pop. Served	11% OF CHILD 0-18
ALLEGAN	30,495	105,665	28.86%	252	211.68	.82%	3,354
AUSABLE VALLEY	13,409	58,402	22.96%	473	397.32	3.53%	1,475
BARRY	15,433	56,755	27.19%	282	236.88	1.83%	1,698
BAY-ARENAC	30,972	127,426	24.31%	745	625.80	2.41%	3,407
BERRIEN	42,302	162,453	26.04%	583	489.72	1.38%	4,653
CENTRAL MI	64,257	267,250	24.04%	858	720.72	1.34%	7,068
C.E.I.	110,643	447,728	24.71%	1,314	1103.76	1.18%	12,171
COPPER COUNTRY	11,969	54,881	21.81%	162	136.08	1.35%	1,317
DETROIT-WAYNE	577,680	2,061,162	28.03%	11,332	9518.88	1.96%	63,545
GENESEE	119,601	436,141	27.42%	1,505	1264.20	1.26%	13,156
GOGEBIC	3,548	17,370	20.43%	97	81.48	2.73%	390
GRATIOT	10,058	42,285	23.79%	312	262.08	3.10%	1,106
HIAWATHA	12,892	59,389	21.71%	207	173.88	1.61%	1,418
HURON	8,749	36,079	24.25%	149	125.16	1.70%	962
IONIA	16,554	61,518	26.91%	333	279.72	2.01%	1,821
KALAMAZOO	57,391	238,603	24.05%	1,349	1133.16	2.35%	6,313
KENT	162,259	574,335	28.25%	1,876	1575.84	1.16%	17,848
LAPEER	24,601	87,904	27.99%	141	118.44	0.57%	2,706
LENAWEE	25,658	98,890	25.95%	294	246.96	1.15%	2,822
LIFEWAYS	52,840	204,949	25.78%	1,199	1007.16	2.27%	5,812
LIVINGSTON	45,125	156,951	28.75%	220	184.80	0.49%	4,964
MACOMB	189,784	788,149	24.08%	1,268	1065.12	0.67%	20,876
MANISTEE-BENZIE	9,294	40,525	22.93%	314	263.76	3.38%	1,022

MONROE	39,993	145,945	27.40%	233	195.72	0.58%	4,399
MONTCALM	16,580	61,266	27.06%	236	198.24	1.42%	1,824
MUSKEGON	46,878	170,200	27.54%	571	479.64	1.22%	5,157
NEWAYGO	13,933	47,874	29.10%	279	234.36	2.00%	1,533
NORTHEAST	14,757	67,759	21.78%	363	304.92	2.46%	1,623
NORTHERN LAKES	45,569	183,477	24.84%	952	799.68	2.09%	5,013
NORTH COUNTRY	37,013	143,957	25.71%	961	807.24	2.60%	4,658
NORTHPOINTE	15,678	65,936	23.78%	310	260.40	1.98%	1,725
OAKLAND	300,760	1,194,156	25.19%	1,625	1365.00	0.54%	33,084
OTTAWA	68,396	238,314	28.70%	330	277.20	0.48%	7,524
PATHWAYS	26,519	120,040	22.09%	395	331.80	1.49%	2,917
PINES (BRANCH)	11,698	45,787	25.55%	438	367.92	3.74%	1,287
ST. CLAIR	43,971	164,235	26.77%	466	391.44	1.06%	4,837
ST. JOSEPH	17,180	62,422	27.52%	487	409.08	2.33%	1,890
SAGINAW	55,890	210,039	26.61%	710	596.40	1.27%	6,148
SANILAC	11,992	44,547	26.92%	128	107.52	1.07%	1,319
SHIAWASSEE	19,244	71,687	26.84%	196	164.64	1.02%	2,117
SUMMIT POINTE	35,854	137,985	25.98%	1,021	857.64	2.85%	3,944
TUSCOLA	15,606	58,266	26.78%	204	171.36	1.31%	1,717
VAN BUREN	21,406	76,263	28.07%	352	295.68	1.64%	2,355
WASHTENAW	71,288	322,895	22.08%	396	332.64	0.56%	7,842
WEST MICHIGAN	16,905	66,480	25.43%	495	415.80	2.93%	1,860
WOODLANDS	13,053	51,104	25.54%	225	189	1.72%	1,436
TOTAL	**2,595,767**	**9,938,444**	**26.12%**	**36,638**	**30,776**	**1.41%**	**285,534**

Michigan

Child - Quantitative Targets

Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

The Michigan Mission Based Performance Indicator System requires a measure of system access related specifically to children with SED. The outcome indicator is based of the percentage of children served by CMHSPs that are diagnosed as having SED. This percentage, based on CAFAS scores, is computed by dividing the number of children reported with CAFAS scores of 50 or more by the number of children reported assessed using the CAFAS.

In keeping with the President's New Freedom Commission Report Goal 3, the following is an estimate of the number of children with a serious emotional disturbance that will receive services through the State of Michigan for FY2009 through FY2011

FY2009	FY2010	FY2011
30,350	30,580	30,630

Michigan

Child - System of Integrated Services

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

Social services;
Educational services, including services provided under the Individuals with Disabilities Education Act;
Juvenile justice services;
Substance abuse services; and

Health and mental health services.

***Children's Services System*:** In Michigan, responsibility for coordination of children's services is delegated to state departments by service area as described below.

Michigan Department of Community Health (MDCH)
The MDCH is a decentralized state agency responsible for assuring mental health services to individuals in the state. Through its contracts with Community Mental Health Services Programs (CMHSPs), PIHPs for Medicaid Specialty Services, and regional substance abuse agencies, MDCH assures mental health and substance abuse services to children with serious emotional disturbance and their families. These contracts require services coordination and integration with key local children's human services providers. Local CMHSP Directors participate as representatives to community human services interagency coordination groups known as Community Collaboratives.

Michigan Department of Human Services (DHS)
The DHS is a centralized state agency responsible for providing child welfare, child protection, and delinquency services in the state. Services are provided through state offices at the county level. Service coordination policies are implemented through community interagency agreements and local office performance contracts. Local DHS directors participate as representatives to Community Collaboratives.

Michigan Family Court System
The Michigan Family Court System, a division of the Circuit Court, has been phased in to replace the former Probate Court system. Child abuse, neglect and delinquency cases fall under the jurisdiction of the Family Court. Family Court judges or court administrators participate as representatives to Community Collaboratives. The State Court Administrator Office, which oversees the Family Courts, has been a key partner in developing and training for the blended funding initiative.

Michigan Department of Education (MDE)
The MDE is a decentralized state agency responsible for assurance of education services in the state. This responsibility includes assurance of special education services as required by the Individuals with Disabilities Education Act. In conjunction with Intermediate School Districts (ISDs), local public school districts are responsible for regular and special education services coordination. Intermediate and local public school superintendents and/or special education directors participate as representatives to Community Collaboratives. Education representatives also serve as members of child and family services planning teams, service level components of interagency individualized services initiatives.

At the state human services systems level, Michigan has incrementally intensified its focus on interdepartmental planning and program development. Under Governor Jennifer

M. Granholm, the Children's Cabinet has been established to work collaboratively to better support and serve Michigan's children. The members of the Children's Cabinet are the Directors of the Departments of Community Health, Labor and Economic Growth, Human Services and the Superintendent of Public Instruction. The Children's Action Network (CAN) has been appointed by the Children's Cabinet to focus on universal prevention and early intervention services for children birth to age five. The CAN includes members of the Children's Cabinet, members of the child advocacy community, and other key state governmental staff. The CAN brings together the Department Directors in human services – to work across state department boundaries to uplift children. Two major initiatives of the Children's Cabinet and CAN are:

School-based Family Resources Centers: Governor Granholm has responded to the challenge of turning around Michigan schools that are not meeting their academic achievement goals with a two-track strategy. The first track emphasizes improved leadership and professional development and better alignment of curriculum to state content guidelines in the "high priority" schools. The second track calls for the creation of School Based Family Resource Centers that will use a collaborative approach to improve human service delivery to school-aged children and their families. These Centers will serve as a "one stop shop" for family services located within or near a neighborhood school. Recognizing that services like health care, nutrition, and family support activities can have significant impact on education achievement, the Centers will help schools achieve their long-term goals of improved reading and math scores be improving services to families. The Centers will also promote greater parental involvement in education by linking human service delivery to the school environment. The DHS is leading this effort.

Project Great Start (PGS) is the Governor's umbrella effort that seeks to coordinate the early childhood work of various public and private entities in Michigan to achieve common targets and measurable results. PGS will seek opportunities for synergy among the many early childhood programs and initiatives that exist in Michigan today and ways to eliminate needless duplication of services and competition for resources. Existing early childhood programs in Michigan that wish to identify themselves with Project Great Start are welcomed and asked to embrace cooperative action. PGS will work to see that more resources, public and private, are devoted to achieving an early childhood vision of "A Great Start for every child in Michigan: safe, healthy, and eager to succeed in school and in life." and, in particular, will use the Children's Action Network to maximize the impact to reaching this vision. The Early Childhood Comprehensive System Project, which is funded by a federal Maternal and Child Health grant, is developing a strategic plan to assure a coordinated system of community resources and supports to assure the vision of a "Great Start" for every child. The Early Childhood Core Team, a group of state staff and local community representatives, and parents, is guiding the process.

In addition, several state interagency structures have been established to facilitate planning and coordination in the development and delivery of education, child welfare and children's mental health services. These interagency administrative committees are steering cross-system activities in the implementation of Part C of IDEA, wraparound services for children and families, and the Blended Funding Workgroup.

Child Care Expulsion Prevention (CCEP)
CCEP programs provide trained early childhood mental health professionals who consult with child care providers and parents of children under the age of six who are experiencing behavioral and emotional challenges in their child care setting. CCEP aims to reduce expulsions and increase the number of families and child care providers who successfully nurture the social and emotional development of children ages 0-5 in licensed child care programs. These projects are a collaborative effort funded through DHS and implemented by the MDCH through local CMHSPs and the Michigan Community Coordinated Child Care Association and the Michigan State University Cooperative Extension both of whom provide information to child care providers. This program supports Goal 4 of the PNFC Report by promoting mental health of young children.

Community Collaborative
At the community level, interagency administrative groups, counterparts to each of the aforementioned structures, 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 local Community Collaborative which functions to oversee children's services planning and development. The local collaborative bodies are comprised of local public agency directors (public health, community mental health, DHS, substance abuse agencies), family court judges, prosecutors, and families and sometimes youth, private agencies and community representatives.

Juvenile Justice Diversion
In collaboration with the DHS, the State Court Administrators Office, parents of children with SED, CMHSPs, and the Circuit Court Family Division, the MDCH has created a model for juvenile justice screening diversion to occur at the local level. The mental health system, in cooperation with the local juvenile justice system, has a role to play at each stage in the adjudication process. Youth with mental health needs may be identified for diversion from the juvenile justice system at any point, including pre-adjudication (before formal charges are brought) or during the disposition process. Pre-adjudication diversion occurs at the point of contact with law enforcement officers and relies heavily on effective interactions between police and community mental health services. During the disposition process, youth may be screened and evaluated for the presence of serious emotional disturbance. After the determination of serious emotional disturbance is made, diversion may include negotiations with prosecutors, defense attorneys, community-based mental health providers, the local DHS, and the courts to produce a community-based disposition in lieu of prosecution or as a condition of a reduction in charges. In the diversion process, youth and families would be linked to an array of community-based services.

Michigan has been transforming its system since FY00, when Federal Mental Health Block Grant funding was made available to CMHSPs for the purpose of providing screening and assessment services for the juvenile justice population served by the local

DHS and Circuit Court-Family Division and to provide services to youth who are screened and assessed and determined to be in need of mental health services. This supports Goal 4 of the PNFC to screen for mental disorders and connect these children to treatment supports.

MDCH, DHS and CMHSPs will partner with the local DHS and the juvenile justice system to continue to divert youth with serious emotional disturbance from the juvenile justice system. Family and youth input into the development and implementation of these services is required.

Health and Rehabilitation Services for Children
The majority of Medicaid beneficiaries receiving services through a PIHP are enrolled in a Medicaid Health Plan (MHP) for their health care services. In addition to primary health care, MHPs in Michigan are responsible for providing non-specialty level mental health services to their enrollees up to 20 outpatient visits. PIHPs/CMHSPs are, by contract, required to collaborate and coordinate with other health service providers at their local level. The following is a description of dental and health services for children with Medicaid.

Dental Benefits for Children
Dental benefits are available to beneficiaries under 21 years of age through Medicaid, which provides Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Upon completion of a well-child visit (EPSDT), providers must refer beneficiaries to a dental provider for a thorough dental examination. It is recommended that a dental appointment be made every six months and that it include a complete dental examination, appropriate x-rays, and preventive care such as a prophylaxis and fluoride treatment. If additional treatment is needed, follow-up dental visits are to be scheduled at the end of the examination so dental treatment can be completed.

Services Covered By Medicaid Health Plans (MHPs)
The following services must be covered by MHPs:

- Blood lead services for individuals under age 21
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Childbirth and parenting classes
- Chiropractic services for individuals under age 21
- Ambulance and other emergency medical transportation
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment and medical supplies
- Emergency services
- End Stage Renal Disease (ESRD) services
- Family planning services
- Health education
- Hearing and speech services
- Hearing aids for individuals under age 21
- Home health services

- Hospice services (if requested by enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative nursing care (in or out of a facility)
- Maternal and Infant Support Services (MSS/ISS)
- Medically necessary transportation for enrollees without other transportation options
- Medically necessary weight reduction services
- Mental health care (up to 20 outpatient visits per contract year)
- Out-of-state services authorized by the MHP
- Outreach for included services, especially pregnancy-related and well-child care
- Pharmacy services
- Podiatry services for individuals under age 21
- Practitioner services (such as those provided by physicians, optometrists, or oral surgeons enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Therapies (speech, language, physical, occupational)
- Transplant services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for individuals under age 21

Additionally, PIHPs are required to provide health services. Health services are provided for purposes of improving the beneficiary's overall health and ability to care for health-related needs. This includes nursing services (on a per-visit basis, not on-going hourly care), dietary/nutritional services, maintenance of health and hygiene, teaching self-administration of medication, care of minor injuries or first aid, recognizing early symptoms of illness and teaching the beneficiary to seek assistance in case of emergencies. Health assessments are also covered. A registered nurse, nurse practitioner, or dietician must provide these services, according to their scope of practice. Health services must be carefully coordinated with the beneficiary's health care plan so that the PIHP does not provide services that are the responsibility of the MHP.

Regarding rehabilitation services, skill-building assistance, social skills training, daily and community-living skills, and vocational planning/rehabilitation are provided by or in collaboration with, other community partners, such as schools, courts, the Department of Labor and Economic Growth and the DHS (child welfare).

Substance Abuse Services for Children
Covered services under Medicaid for substance abuse include:

- Access Assessment and Referral Services
- Outpatient Treatment
- Intensive Outpatient Treatment
- Office of Pharmacological and Alternative Therapies/Center for Substance Abuse Treatment (OPAT/CSAT) approved Pharmacological Supports

Some Medicaid-covered services are available to substance abuse beneficiaries, but are provided outside of the PIHP Plan. The PIHPs are not responsible to pay for the following:

- Acute detoxification.
- Laboratory services related to substance abuse (with the exception of lab services required for Methadone and LAAM).
- Medications used in the treatment/management of addictive disorders.
- Emergency medical care.
- Emergency transportation.
- Substance abuse prevention and treatment that occurs routinely in the context of providing primary health care.
- Routine transportation to substance abuse treatment services which is the responsibility of the local DHS.

CMHSPs are required to work with the substance abuse coordinating agency in systems planning to identify ways that the respective systems, working together, can bring about appreciable improvements in services, management or both. They are further required to have a documented policy and set of procedures to assure that coordination regarding mutual consumers is occurring. Several PIHPs also are the responsible Coordinating Agency for Substance Abuse and provide integrated assessments and treatment for mental health and substance abuse. In FY04, CAFAS data indicated that participants in the Level of Functioning Project were treating youth with moderate or severe maladaptive substance use with great success, showing a significant improvement (a decrease of 20 points or more on the CAFAS) for 75.3% of youth.

Michigan

Child - Geographic Area Definition

Child - Establishes defined geographic area for the provision of the services of such system.

Michigan Department of Community Health (MDCH)
MDCH contracts with 18 Prepaid Inpatient Health Plans (PIHPs), which are single or multiple CMHSPs, for Medicaid services to children with SED, Adults with SMI, and children and adults with developmental disabilities. MDCH also contracts with 46 CMHSPs for delivery of non-Medicaid funded services (including block grant). The public mental health services delivery system also contains a small (20 outpatient) mental health benefit within Medicaid health plans that are contracted with MDCH through the Medicaid 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 mental health specialty services and supports provided through PIHPs under a 1915(b)(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, Inpatient Psychiatric Hospitalization. "In lieu of" services offered under the authority of 1915(b)(3) included in the MDCH contract are: Community Inclusion and Integration Services, Crisis Response Extended Observation Beds, Family Support and Training including parent-to-Parent Support, Respite Care, Housing Assistance, Peer Delivered or Operated Support Services, Prevention and Consultation Services, Specialized Behavioral Health (Wraparound Services). In addition, MDCH has a 1915(c) home and community based waiver for children with SED that provides intensive community based services in 8 CMHSPs covering 13 counties. Currently, this waiver can serve a maximum capacity of 76 children. The five year renewal of this SED Waiver funding beginning in FY2009 will allow for a maximum of 79 children to be served and will progressively increase to a maximum capacity of 108 in FY2013.

Michigan Department of Human Services (DHS)
The DHS is a centralized state agency responsible for providing child welfare, child protection, and delinquency services in the state. Services are provided through state offices at the county level. Service coordination policies are implemented through community interagency agreements and local office performance contracts. Local DHS directors participate as representatives to Community Collaboratives.

Michigan Family Court System
The Michigan Family Court System, a division of the Circuit Court, has been phased in to replace the former Probate Court system. Child abuse, neglect and delinquency cases fall under the jurisdiction of the Family Court. Family Court judges or court administrators participate as representatives to Community Collaboratives. The State Court Administrator Office, which oversees the Family Courts, has been a key partner in developing and training for the blended funding initiative.

Michigan Department of Education (MDE)
The MDE is a decentralized state agency responsible for assurance of education services in the state. This responsibility includes assurance of special education services as required by the Individuals with Disabilities Education Act. In conjunction with Intermediate School Districts (ISDs), local public school districts are responsible for regular and special education services coordination. Intermediate and local public school superintendents and/or special education directors participate as representatives to Community Collaboratives. Education representatives also serve as members of child and family services planning teams, service level components of interagency individualized services initiatives.

Michigan

Child - Outreach to Homeless

Child - Describe State's outreach to and services for individuals who are homeless

Population Description: Michigan commissioned a study called, "The State of Homelessness in Michigan" which is supported by the Michigan Interagency Committee on Homelessness, a federally mandated entity comprised of representatives from all state agencies that provide homeless assistance programs. The 17-month study was released in June of 1995. The study attempted to estimate the numbers of homeless persons and families, and to survey homeless individuals and families presently provided services in order to gather demographic information and descriptive information regarding services involvement, including mental health services, substance abuse history, school involvement (for children), etc., both to identify what services homeless individuals and families are receiving and to identify what services they feel they need. The study was commissioned to provide baseline information to the state for planning purposes. The study estimates that there are 77,000 to 136,000 incidents of homelessness among school age children each year.

Services Provided: The Michigan Department of Education (MDE) was awarded funding to maintain approximately 31 local Intermediate School District projects for outreach and support of homeless children to attend and be successful in school by providing tutorial services, transportation, and other related support services to families (case management).

Housing and Homelessness Programs/Partnerships
Supportive Housing Program and Ending Homelessness Partnership: This program is in its 9th year of existence and continues to produce more than 100 units per year in 9 counties.

10 Year Plan to End Homelessness: Every community across the state has developed a 10-YearPlan to End Homelessness. To assist in implementation of their plans, the Michigan State Housing Development Authority (MSHDA) has made $14,500,000 available to create supportive housing for homeless families with children, homeless youth, chronically homeless, and homeless survivors of domestic violence. In addition, supportive housing developments in Detroit, Grand Rapids, and Battle Creek are being proposed targeted to homeless veterans. This initiative will create approximately 275 units of supportive housing for homeless veterans and has been effective in bringing new partners, both private and public, to the table.

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

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

Since FY95, annual appropriations, through the Department of Human Services have maintained Michigan's runaway programs and homeless youth programs. Currently DHS funds, 27 runaway programs and 11 homeless youth programs to meet the evolving needs of local communities. The programs provide a variety of counseling services, case management, emergency shelter, support services, and 24-hour crisis intervention. Although, data is not available for specific diagnosis, it is assumed that a number of these children are SED and are being served within the programs on a short-term basis and referred for mental health services. Several agencies and CMHSPs have established relationships to facilitate services for mutual clients. In these instances, the programs are able to provide emergency crisis intervention and referral for the CMHSP, emergency respite services, or foster care and parent support groups. The CMHSP is able to provide counseling and other services for the clients with mental health needs. MDCH continues to encourage the development of these relationships.

Michigan

Child - Rural Area Services

Child - Describes how community-based services will be provided to individuals in rural areas

The majority of Michigan's population lives in the 7 counties that are urban. The remaining 76 counties are classified as rural. Michigan has assured the availability of mental health services to all residents by requiring the full array of services in each CMHSP region. Access standards related to timeliness and geographic availability are required by contract. For office or site-based mental health services, the individual's primary service providers must be within 30 miles or 30 minutes of the individual's residence in urban areas, and within 60 miles or 60 minutes in rural areas CMHSPs in rural areas are encouraged to submit proposals for one-time block grant funding for service areas identified in the MDCH annual Request for Proposals. Innovative proposals developed by CMHSPs in areas not identified by MDCH are also accepted. Program specialists continue to work with CMHSPs in rural areas to support their successful applications for funding. MDCH aggressively pursues federal resources (from US Department of Housing and Urban Development) for permanent supportive housing for homeless persons in rural areas in Michigan. Examples of projects for rural CMHSPs funded for FY2009 include: 1) early childhood mental health; 2) juvenile justice; 3) wraparound; 4) youth suicide prevention/awareness; 5) evidence-based practices like MST, TFC and PMTO; and 6) respite.

Michigan

Child - Resources for Providers

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

Funds for FY2009 are targeted for continuing to develop local systems of care and intensive, evidence-based, community-based services that are alternatives to outpatient and inpatient services. Promising practices such as wraparound continue to be a major area of focus as well. The block grant funding is targeted at all children 0-18 years with a special focus on meeting the mental health needs of children in child welfare and juvenile justice systems. Michigan will fund approximately 17 evidence based practice projects, 20 Wraparound and 13 juvenile justice diversion projects. In addition, block grant funds will be used to support transition services, respite, other training and supportive services. Block grant dollars are also directed to training in wraparound and family-centered services. Funds will be used to continue to support parent to parent support activities and parent involvement in systems planning. Lastly, State level positions are funded (as they relate to children) to 1) coordinate the planning process required by P.L. 1002-321; 2) provide oversight of the Mental health Block Grant; 3) monitor and evaluate outcomes and fidelity of evidence-based and promising practices; and 4) provide technical assistance to CMHSPs regarding system of care, evidence-based practice, wraparound services, family-centered practice and respite services. One staff member is employed full-time by MDCH to help with implementation of the Federal Mental Health Block Grant related to children's services. The majority of projects funded in FY09 are multi-year projects (either in their 2nd or 3rd year of funding or starting a new cycle of multi-year funding that could be for up to 5 years.) and/or ongoing training or outcomes evaluation projects. These projects addressed the areas of focus of the FY09 RFP and will continue to be areas of focus into FY10 and FY11. The plan is to continue to fund training projects in the next two fiscal years.

Michigan

Child - Emergency Service Provider Training

Child - Provides for training of providers of emergency health services regarding mental health;

Police officers and other emergency services personnel receive both formal and informal training through CMHSP staff. Some have formal agreements with their local emergency agencies, although there is not a requirement at present for this in the contract. CMHSPs are required to have collaborative agreements with primary care physicians in their communities. Wraparound training has included paramedics. Each CMHSP has at least one jail diversion program and community police are training in responding to emergency mental health needs.

Michigan

Child - Grant Expenditure Manner

Child - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

FY09 PROPOSALS		
CHILDREN'S MENTAL HEALTH BLOCK GRANT		
08/22/2008		
FY09 PCA	**CONTRACT TITLE**	**FY09**
09-27839	**ACMH Family Advocacy Project**	154,199.00
09-27887	**CEI JJD Training and TA**	66,615.00
09-27430	**CEI Trauma Informed CBT Coordination and Training**	214,385.00
	CEI Home Based Service Manualization	133,783.00
09-27842	**EMU LOF Project**	120,540.00
09-27899	**MACMHB Training ISII**	100,000.00
09-27846	**MPHI Family Centered Practice**	232,414.00
09-27760	**SEMHA Community Collaborative Planning/Early Intervention**	231,803.00
	Wraparound National Consultants	60,000.00
08-27929	**Parent Leadership Training**	20,000.00
09-27957	**Random Moment Sampling**	68,498.00
09-27802	**ACMI Parent Support**	2,000.00
09-27850	**CSSM**	4,000.00
09-27801	**MHSCF Travel**	9,136.00
09-27800	**MHSCF Staff**	142,526.00
09-27958	**MHSCF Staff Indirect**	10,333.00
09-27840	**MSU Wraparound Fidelity Instrument Devel/Implementation**	30,811.00
09-27428	**PMTO Trg Support North Care PIHP (Pathways)**	50,000.00
09-27426	**PMTO Trg Support CMH for Central MI PIHP (Central)**	50,000.00
09-27427	**PMTO Trg Support SW MI Urban & Rural Cons PIHP (Net 180)**	50,000.00
09-27425	**PMTO Trg Support CMH Partnership of SE MI (Washtenaw)**	50,000.00
09-27429	**PMTO Trg Support CMH Affiliation of Mid MI PIHP (CEI)**	50,000.00
09-27434	**DECA-I/T Pilot Coordinator**	15,267.00
09-27435	**Youth Peer to Peer Training (ACMH)**	24,000.00
09-27815	**Inter-Tribal Council(Grand Traverse Ottawa/Chippewa Indians)**	7,800.00
	SUBTOTAL	**1,898,110.00**
09-27959	**Allegan Early Risers Program**	40,000.00
09-27886	**Allegan JJ Diversion**	30,000.00
09-27803	**Allegan Wraparound**	20,000.00
09-27409	**Allegan Child Expulsion Prevention**	50,000.00
09-27960	**AuSable Valley Functional Family Therapy**	5,859.00
09-27878	**Bay-Arenac JJ Diversion**	28,594.00
	Bay-Arenac CBT for Children	49,355.00
09-27964	**CMHCM Clare/Gladwin JJ Diversion**	30,200.00
09-27965	**CMHCM Mecosta/Osceola JJ Diversion**	30,200.00
09-27755	**CMHCM Midland JJ Diversion**	27,940.00
09-27966	**CMHCM Structured Mentoring**	28,000.00
09-27806	**CMHCM Wraparound**	20,000.00
09-27410	**CMHCM HOPE Campaign Youth Suicide**	11,144.00
09-27436	**CMHCM Parent Child Interaction Therapy**	64,468.00

09-27967	**Copper Aggression Replacement Training**	40,000.00
09-27517	**Copper Wraparound**	20,000.00
09-27844	**Detroit-Wayne Child**	1,043,582.00
09-27437	**Detroit-Wayne Parent Partners**	75,000.00
09-27438	**Detroit-Wayne Support our Young Moms**	75,000.00
09-27439	**Genesee Maltreated Infant-Toddlers Court**	75,000.00
09-27888	**Genesee JJ Diversion**	40,000.00
09-27745	**Genesee MST**	40,000.00
09-27761	**Gratiot JJ Diversion**	25,000.00
09-27810	**Gratiot Wraparound**	8,000.00
09-27808	**Hiawatha Wraparound**	40,000.00
09-27747	**Ionia JJ Diversion**	28,000.00
09-27812	**Ionia Wraparound**	40,000.00
09-27813	**Kalamazoo Wraparound**	25,000.00
09-27411	**Kalamazoo PMTO Training & TA**	153,661.00
09-27814	**Lapeer Wraparound**	40,000.00
09-27412	**Lapeer Infant/Young Child Mental Health**	23,602.00
09-27440	**Lapeer System of Care Planning**	25,200.00
09-27890	**Lifeways JJ Diversion**	26,300.00
09-27750	**Lifeways MST**	18,000.00
09-27441	**Lifeways Wraparound**	65,000.00
09-27413	**Macomb Prep Parent/Rela SED Children**	50,000.00
09-27414	**Macomb No SEDW Treatment FC SED Ch**	50,000.00
09-27442	**Macomb System of Care Planning Grant**	75,000.00
09-27443	**Macomb Trauma Informed Community**	10,000.00
09-27444	**Macomb Juvenile Justice**	51,100.00
09-27862	**Manistee-Benzie Wraparound**	50,000.00
09-27759	**Monroe Therapeutic Foster Care**	26,300.00
09-27807	**Muskegon Family Resource Centers**	34,968.00
09-27445	**Muskegon Wraparound**	67,000.00
09-27851	**network180 MST**	40,000.00
09-27830	**network180 Respite**	34,884.00
09-27852	**network180 TeenScreen**	24,175.00
09-27446	**Network180 Prevention Group**	75,000.00
09-27447	**Network180 Parent Mentor Program**	29,700.00
09-27449	**Network 180 MST Staff Training**	4,637.00
09-27450	**Network180 Access Clinician at DHS**	54,077.00
09-27451	**North Country System of Care Parent Consultants**	9,570.00
09-27452	**North County (Antrim/Kalkaska) Wraparound**	43,450.00
09-27453	**Northeast CMH System of Care**	39,262.00
09-27540	**Northern Lakes Respite**	10,000.00
09-27454	**Northern Lakes Training for Family/Providers in Youth GF**	65,000.00
09-27455	**Northern Lakes Wraparound 6 counties**	74,317.00
09-27456	**Oakland CCEP**	75,000.00
09-27419	**Oakland Access Parent Guides**	50,000.00
09-27457	**Saginaw Mobile Crisis Team**	75,000.00
09-27458	**Saginaw Creating a Trained Inform Workplace CBT**	47,625.00
09-27459	**Saginaw System of Care Development**	75,000.00
09-27860	**Sanilac Infant Mental Health**	34,743.00

09-27885	**Sanilac JJ Diversion**	10,300.00
09-27863	**Sanilac MST**	34,743.00
09-27821	**Shiawassee Wraparound**	40,000.00
09-27895	**St. Clair Juvenile Justice Screening**	37,940.00
09-27422	**St. Clair Wraparound**	48,341.00
09-27866	**St. Joseph Infant Mental Health**	27,466.00
09-27535	**Summit Pointe Out & About**	8,000.00
09-27824	**Van Buren Wraparound**	40,000.00
09-27875	**WCHO Youth Aging Out of Foster Care**	40,000.00
09-27826	**WMCMHS Wraparound**	40,000.00
09-27876	**WMCMHS Youth & Family Enrichment**	40,000.00
09-27423	**Woodlands (Cass) Wraparound**	36,000.00
	SUBTOTAL	**4,040,703.00**
	TOTAL	**5,938,813.00**
	FY09 Award	**4,428,808.00**
	FY08 Carry Forward (est)	**4,048,169.00**
	TOTAL	**8,476,977.00**
	REMAINING TOTAL	**2,538,164.00**

The majority of projects funded in FY09 are multi-year projects (either in their 2nd or 3rd year of funding or starting a new cycle of multi-year funding that could be for up to 5 years) and/or ongoing training or outcomes evaluation projects. These projects addressed the areas of focus of the FY09 RFP and will continue to be areas of focus into FY10 and FY11. The plan is to fund these types of projects in the next two fiscal years.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	31,623	30,776	31,199	31,249	31,299	31,349
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Assure the provision of mental health services to children with serious emotional disturbance through community mental health services programs.

Target: To maintain or increase the number of children with serious emotional disturbance accessing services, based upon the FY2005 actual rate which was 27,362 children.

Population: Children diagnosed with serious emotional disturbance

Criterion: 2:Mental Health System Data Epidemiology
3:Children"s Services

Indicator: Number of SED children served by CMHSPs

Measure: Number of SED children served by CMHSPs

Sources of Information: CMHSP Data Reports and Michigan Level of Functioning Project

Special Issues: The above outcome indicator is based on the percentage of children served by CMHSP that are diagnosed as having SED. This percentage, based on the CAFAS scores, is computed by dividing the number of children reported with specific combinations or levels of CAFAS scores by the number of children reported assessed using the CAFAS. The number reported above is 84% of the total number of children served by the CMHSPs each fiscal year. This percentage was increased from 75% to 84% due to a review of CAFAS data in FY08 that determined the percentage of children with SED served(per above CAFAS criteria)is now 84% of the total number of children served by CMHSPs.

Significance: The number of children with SED being served by CMHSPs is an important indicator to reflect the rate at which the public system is serving children with SED.

Action Plan: Activities to meet the target identified include: 1) Michigan will continue to monitor and gather data on the number of children served by the CMHSPs. 2) Use block grant and possibly new Medicaid funding throught the 1915(b) waiver to serve more children with SED. 3) Use the 1915(c)waiver to expand wraparound services across the state.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	6.20	10.11	9.05	9	8.90	8.80
Numerator	172	71	--	--	--	--
Denominator	2,772	702	--	--	--	--

Table Descriptors:

Goal: Maintain a statewide integrated children's services system to provide comprehensive community-based care.

Target: The percentage of children with SED readmitted to inpatient psychiatric care within 30 days will remain under 15%.

Population: Children diagnosed with serious emotional disturbance.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: The percentage of inpatient readmissions at 30 days for children with serious emotional disturbance.

Measure: Numerator: The number of children with SED readmitted to inpatient psychiatric care within 30 days of discharge.
Denominator: The total number of children with SED who are discharged.

Sources of Information: CMHSP Data Reports, Performance Indicator Reports.

Special Issues: For some children with serious emotional disturbance, the occasional use of inpatient psychiatric care is necessary. However, a rapid readmission following discharge may suggest that persons were prematurely discharged or that the post discharge follow-up was not timely or sufficient. The department standard for this indicator is 15% or lower.

Significance: The percent of children with serious emotional disturbance readmitted to inpatient psychiatric care within 30 days of discharge is a significant indicator that helps to determine appropriate discharge and follow-up from restrictive inpatient care.

Action Plan: Activities to meet this target include: 1) Michigan will continue to gather data on the number of children readmitted to a inpatient psychiatric hospital within 30 days; 2) Michigan will monitor the CMHSPs that do not meet the 15% standard set by the department; 3) Michigan will publish the results of this indicator and make these available to the public; and 4) Michigan will take contractual action to assure compliance with this indicator with the PIHPs/CMHSPs if necessary.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	18.46	19.73	18.95	18.75	17	15
Numerator	309	474	--	--	--	--
Denominator	1,674	2,402	--	--	--	--

Table Descriptors:

Goal: Percent of children readmitted within 180 days

Target: To decrease the percentage of children with serious emotional disturbance readmitted to inpatient psychiatric care within 180 days of discharge to 15% by FY2011.

Population: Children diagnosed with serious emotional disturbance.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: The percentage of inpatient readmissions at 180 days for children with serious emotional disturbance.

Measure: Numerator: The number of children with SED readmitted to inpatient psychiatric care within 180 days of discharge.

Denominator: The total number of children with SED who are discharged.

Sources of Information: CMHSP Data Reports, Performance Indicator Reports.

Special Issues: For some children with serious emotional disturbance, the occasional use of inpatient psychiatric care is necessary. However, a rapid readmission following discharge may suggest that persons were prematurely discharged or that the post discharge follow-up was not timely or sufficient.

Significance: The percent of children with serious emotional disturbance readmitted to inpatient psychiatric care within 180 days of discharge is a significant indicator that helps to determine appropriate discharge and follow-up from restrictive inpatient care.

Action Plan: Activities to meet this target include: 1) Michigan will continue to gather data on the number of children readmitted to a inpatient psychiatric hospital within 180 days; 2) Michigan will monitor the CMHSPs that do not meet the 15% standard set by the department; 3) Michigan will publish the results of this indicator and make these available to the public; 4) Michigan will take contractual action to assure compliance with this indicator with the PIHPs/CMHSPs if necessary; and 5) Michigan is monitoring home-based programs statewide to determine if this service is providing adequate and appropriate support to families in this area.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	8	70	6	.04	.05	.06
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Maintain a statewide integrated children's services system to provide comprehensive community-based care.

Target: Through FY08:To increase the number of children with serious emotional disturbance who receive Therapeutic Foster Care (TFC) to 15 by 2010.
From FY09 forward: To increase the percentage of chidren with serious emotional disturbance served who receive Therapeutic Foster Care.

Population: Children diagnosed with serious emotional disturbance.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Through FY08: The number of children with serious emotional disturbance served who receive Therapeutic Foster Care.
From FY09 forward: The percentage of children with serious emotional disturbance served who receive Therapeutic Foster Care.

Measure: Through FY 08: The number of children with serious emotional disturbance served who receive Therapeutic Foster Care.
From FY09 forward: Numerator: The number of children with serious emotional disturbance served who receive Therapeutic Foster Care.
Denominator: The number of children with serious emotional disturbance served by CMHSPs

Sources of Information: Reports from CMHSPs

Special Issues: Therapeutic Foster Care is an evidence-based practice for children with serious emotional disturbance. Michigan is training staff in this service for children with serious emotional disturbance at this time. This evidence-based practice will allow for children to be provided treatment in out-of-home therapeutic environments in closer proximity to their home, in a less restrictive placement than congregate care and in a therapeutic model which is evidence-based and will achieve better outcomes for the child. The data in FY07 included any child who received any therapeutic service while in foster care. This artificially inflated the number served for FY07. The data for FY08 and forward will include only those children receiving Therapeutic Foster Care services that follow the evidence-based model of TFC. Also, data through FY08 will be reported in number of SED children served in TFC and from FY09 forward will be reported in percentage of SED children served who receive TFC.

Significance: The number or percentage of children with serious emotional disturbance who receive Therapeutic Foster Care is significant in helping to determine access to this evidence-based practice.

Action Plan: Activities to meet the target include: 1) Therapeutic Foster Care will increase through the 1915

(c) Home and Community Based Waiver in several communities; and 2) Two communities are implementing Therapeutic Foster Care with the support of block grant funding to improve their array of services for children with SED.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	6	N/A	283	.91	.92	.93
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Maintain a statewide integrated children's services system to provide comprehensive community-based care.

Target: Through FY08: To increase the number of individuals who receive Multi Systemic Therapy (MST) to 180 by FY2010.
From FY09 and forward: To increase the percentage of children with serious emotional disturbance served who receive Multi-Systemic Therapy.

Population: Children diagnosed with serious emotional disturbance.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Through FY 08: The number of individuals who receive Multi Systemic Therapy (MST)
From FY09 forward: The percentage of children with SED served who receive Multi-Systemic Therapy

Measure: Through FY08: The number of individuals who receive Multi Systemic Therapy (MST)
From FY09 forward: Numerator: The number of children with SED served who receive Multi-Systemic Therapy
Denominator: The number of children with SED served by CMHSPs.

Sources of Information: Reports from CMHSPs

Special Issues: MST is an evidence-based practice for children involved with the juvenile justice system and Michigan is currently training staff in this evidence-based practice. This will allow children with a conduct disorder diagnosis to receive an evidence-based practice and to achieve better outcomes. The system will not allow the changing or reporting of a number for FY06 and FY07 (because a percentage is required from FY09 on.) The number of individuals served in MST for FY06 is 72 for FY07 is 120.

Significance: The number or percentage of children receiving MST is significant in helping to determine access to this evidence-based practice.

Action Plan: Activities to meet the target include: 1) Provide additional training for therapists across the state in MST; 2) Monitor development of MST across the state; 3) Track number of children who receive MST to determine a percentage.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	N/A	25	.08	.09	.10
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Maintain a statewide integrated children's services system to provide comprehensive community-based care.

Target: Through FY08: To increase the number of individuals who receive Functional Family Therapy (FFT) to 12 by 2010.
From FY09 forward: To increase the percentage of children with SED served who receive Family Functional Therapy.

Population: Children diagnosed with serious emotional disturbance.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Through FY 08: The number of individuals who receive FFT.
From FY09 forward: The percentage of children with SED served who receive FFT.

Measure: Through FY 08:The number of individuals who receive FFT.
From FY09 forward: Numerator: The number of children with SED served who receive FFT
Denominator: The number of children with SED served by CMHSPs

Sources of Information: Reports from CMHSPs

Special Issues: FFT is an evidence-based practice for children with a serious emotional disturbance. Michigan is currently training staff in this evidence-based practice to improve the outcomes for the children being served. Michigan is also training therapists in MST which is similiar to FFT, therefore the number of therapists learning FFT will be small across the state. The system will not allow the reporting of a number for FY07 (because a percentage is required from FY09 on.) The number of individuals served by FFT in FY07 is 4.

Significance: The number or percentage of children with SED served who receive FFT is significant in helping to determine access to this evidence-based practice.

Action Plan: Activities to meet this target include: 1) Provide additional training for therapists in FFT; 2) Monitor development of FFT across the state; 3)Track the number of children with SED served who receive FFT to determine a percentage.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	87.83	N/A	N/A	N/A	N/A
Numerator	N/A	1,032	--	--	--	--
Denominator	N/A	1,175	--	--	--	--

Table Descriptors:

Goal: The Department of Community Health will monitor the quality, access, timeliness, and outcomes of community based services.

Target: To establish a baseline for children with serious emotional disturbance and their families who report positively on outcomes.

Population: Children diagnosed with serious emotional disturbance.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Percentage of children with serious emotional disturbance and their families surveyed who report positively on outcomes.

Measure: Numerator: Percentage of children with serious emotional disturbance and their families surveyed who report positively on outcomes.

Denominator: Children with serious emotional disturbance and their families who are surveyed.

Sources of Information: MDCH/CMHSP Consumer Surveys

Special Issues: This indicator focuses on child and families satisfaction with the services they received using the Youth Satisfaction Survey for Families. The FY08 data is currently being cleaned and analyzed. The data will be ready to report on in the fall of FY08. In FY09, MDCH will continue to implement the survey with the CMHSPs and a baseline will be established using data from the administration of the youth satisfaction survey in FY07 and FY08. Because the FY08 data is not available, a baseline cannot be determined at this time. With no baseline available, there is no way to make projections or set targets. Once FY08 data is available, we can complete this indicator.

Significance: The percentage of children with serious emotional disturbance and their families surveyed who report positively on outcomes is a significant indicator in helping to establish that treatment is meeting children's and families' needs.

Action Plan: Activities to meet this target include: 1) Complete statewide satisfaction survey in FY07 and FY08 and determine baseline; 2) Continue to implement the survey in FY09 and forward; 3) Review results of survey with a variety of stakeholders; and 4) Publish results of the survey for public review.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	47.20	47.25	51.40	47.30	47.40	47.50
Numerator	1,734	2,453	--	--	--	--
Denominator	3,674	5,191	--	--	--	--

Table Descriptors:

Goal: Maintain a statewide integrated children's service system to provide comprehensive community-based care.

Target: 47% of the youth served with a CAFAS score of 10, 20 or 30 at intake have a decrease in their school subscale score by at least 10 points by 2011.

Population: Children with a Serious Emotional Disturbance.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Percent of children who had 10, 20, or 30 on the school sub scale score of the Child and Adolescent Functional Assessment Scale (CAFAS) whose score decreased by at least 10 points.

Measure: Numerator: The number of children who had a 10, 20 or 30 on the school sub scale score and their score decreased by at least 10 points.

Denominator: The number of children who had a 10, 20, or 30 on the school subscale score at intake.

Sources of Information: The Michigan Level of Functioning Project (MLOF)

Special Issues: Scoring a 10, 20 or 30 on the school subscale score means a child is missing or has been expelled from school, is missing a great deal of school or is is having behavior problems in school and is not completing assigned work. Maintaining a child in the community also means keeping him/her in school.

Significance: Helping children remain in school also helps maintain them in the community. School success is also important to future success for the student. A reduction of 10 points or more means there has been some positive change in a child's functioning in school.

Action Plan: 1) Monitor the number of youth who score 10, 20 or 30 on a school subscale score of the CAFAS and whose score decreases by 10 or more points on the school sub-scale score; and 2)provide this information to the PIHPs/CMHSPs.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	50	48.26	56.80	50	50.50	51
Numerator	807	984	--	--	--	--
Denominator	1,614	2,039	--	--	--	--

Table Descriptors:

Goal: Maintain a statewide integrated children's services system to provide comprehensive community-based care.

Target: For youth receiving Public Mental Health Services, a baseline will be established in FY2008 and be exceeded in FY2009 by .5% and by another .5% in FY2010 and another .5% in FY2011 for youth who scored a 10, 20, or 30 on the community subscale of the Child and Adolescent Functional Scale (CAFAS)at intake, and decreased 10 or more points on the community sub-scale score during the course of treatment.

Population: Children diagnosed with serious emotional disturbance.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Percentage of youth who scored a 10, 20, or 30 on the community sub-scale of the CAFAS during any time in treatment and dropped 10 or more points on the community subscale score.

Measure: Numerator: The number of youth with a 10, 20, or 30 on the community subscale who drop 10 or more points.

Denominator: The number of youth assessed with a 10, 20, or 30 on the community sub-scale at intake.

Sources of Information: The Michigan Level of Functioning Project.(MLOF)

Special Issues: Because of the difficuliuty in gathering data from CMHSP staff in tracking youth involvement with the court for six months after they have been screened and diverted from the courts to mental health services,the measure for this indicator is going to be changed in 2008. The measure will rely on CAFAS data from the Michigan Level of Functioning Project. The measure is the percentage of youth who scored a 10, 20, or 30 on the Community sub-scale of the CAFAS at intake and decreased 10 or more points during the course of treatment on the community sub-scale. This indicates that the youth is improving in his/her behavior in the community and therefore is not as much of a risk to the community or at as much risk for removal from the community. This is an indicator that the mental health services are helping the youth to remain in the community and be less likely to be involved in the juvenile justice system. Because we do not have a full year of data for FY08 and the current partial data percentage appears significantly higher than the previous two FYs, targets are currently based on a the percentages reported for the two previous FYs.

Significance: The percentage of youth who show a reduction on the community subscale of the CAFAS of at least 10 points indicates that a youth is functioning better in the community and is not at as much risk for removal from the community.

Action Plan: Activities to meet this target include: 1) Youth will continue to be screened and assessed and

diverted to keep youth with mental health needs out of the juvenile justice system; 2) Outcome data will be collected; 3) Mental Health Block Grant Funds will continue to be targeted for projects providing screening and assessments to children involved in the juvenile justice system; 4) Block grant funds will continue to be used to support training and technical assistance for counties involved in screening and assessing children involved with the juvenile justice system; and 5) Block grant will be used to support the Michigan Level of Functioning Project. Block grant funds will be used to maintain staff in MST and PMTO.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	.35	.36	.31	.34	.33	.32
Numerator	111	110	--	--	--	--
Denominator	31,623	30,776	--	--	--	--

Table Descriptors:

Goal: Maintain a statewide integrated children's services system to provide comprehensive community-based care.

Target: The percentage of children with serious emotional disturbance served who are homeless or in a shelter will remain below 1.0%.

Population: Children diagnosed with serious emotional disturbance.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: The percentage of children with serious emotional disturbance served who are homeless or in a shelter.

Measure: Numerator: The number of children with SED served who are homeless or in a shelter.
Denominator: The number of children with SED served by CMHSPs.

Sources of Information: CMHSP data reports.

Special Issues: In a 1995 report (the most recent homelessness study in Michigan) on the youth served by Runaway and Homeless Youth Programs, over 2,000 reported depression; 1,318 indicated loss or grief; 992 reported being abandoned; 735 were treated as suicidal; 694 displayed behavioral disorders; 454 had family mental health problems. Although, data is not available for specific diagnosis, it is assumed that a number of these children are SED and are being served within programs on a short-term basis and referred for mental health services. Because of their transient “homeless” lifestyle, it is difficult to consistently track and document service needs and service outcomes for this population. Several agencies and CMHSPs have established relationships to facilitate services for mutual clients. MDCH continues to encourage the development of these relationships. Addressing housing stabilty before a youth or family becomes homeless could preempt some of these ongoing issues.

Significance: The percentage of children with SED served who are not in stable housing is significant because research as far a back as Maslow (1943) has supported the premise that positive treatment outcomes are more likely when families have basic needs met and can focus on higher level needs.

Action Plan: Actvities to meet this target include: 1) CMHSPs will continue to partner with local agencies who provide services to homeless youth; 2) Comprehensive services like Wraparound and case management will continue to be supported and expanded in Michigan to assist families in identifying and addressing needs like stability in housing.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	2.59	2.98	3.05	3.06	3.07	3.08
Numerator	818	918	--	--	--	--
Denominator	31,623	30,776	--	--	--	--

Table Descriptors:

Goal: Increase social supports and connectedness

Target: To maintain or increase the percentage of children with severe emotional disturbance served who receive wraparound services.

Population: Children diagnosed with serious emotional disturbance

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: The percentage of children with serious emotional disturbance served who receive wraparound services.

Measure: Numerator: The number of children with SED served who receive wraparound services.
Denominator: The number of children with SED served by CMHSPs.

Sources of Information: CMHSP data reports.

Special Issues: The percentage of children with SED who receive wraparound services also receive increased social supports and social connectedness. More accurate data was obtained for FY06, so data was updated to reflect accurate numbers.

Significance: Children need social supports and their families need to be connected to others in the community . Wraparound is a process that builds upon natural supports to help reduce social isolation and involve children and families in their communities.

Action Plan: 1) Provide additional wraparound services, 2) implement the 1915(c) waiver; and 3) continue to partner with the Department of Human Services in the implementation of Wraparound Services.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	53.96	53.46	56.50	53.50	53.55	53.60
Numerator	2,294	3,182	--	--	--	--
Denominator	4,251	5,952	--	--	--	--

Table Descriptors:

Goal: The Department of Community Health will monitor the quality, access, timeliness, and outcomes of community based services.

Target: Through FY2011, the percentage of children with serious emotional disturbance with meaningful improvement on the CAFAS will remain consistent or increase.

Population: Children diagnosed with serious emotional disturbance.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services
4:Targeted Services to Rural and Homeless Populations

Indicator: Percentage of children with serious emotional disturbance that have greater than or equal to a 20 point reduction on Child and Adolescent Functional Assessment Scale in the Michigan Level of Functioning Project (MLOF).

Measure: Numerator: Number of children with serious emotional disturbance that have greater than or equal to a 20 point reduction on Child and Adolescent Functional Assessment Scale in the MLOF.

Denominator: Number of children participating in the MLOF that completed treatment.

Sources of Information: Michigan Level of Functioning Project

Special Issues: This indicator reviews significant and meaningful change in the level of functioning for a child and family. CMHSPs that participate in the MLOF (participation is voluntary) also tend to be those that are interested in outcomes and using information for continuous quality improvement efforts. CMHSPs that are new to the MLOF may bring averages down due to previous lack of organized efforts to improve services. Thus, as new CMHSPs continue to join the project, the average for this indicator may continue to fall slightly until continuous quality improvement process is fully implemented.

Significance: A 20 point reduction or greater on the CAFAS is an indicator of significant and meaningful change in the life of a child and family.

Action Plan: Activities to meet this target include: 1) Michigan will continue to gather data on this outcome measure and give the information back to participating PIHPs/CMHSPs for quality improvement purposes; 2) Michigan has made this a dashboard indicator for participating PIHPs/CMHSPs for 2007 and will monitor this indicator; 3) Michigan will highlight and recognize the PIHPs/CMHSPs that achieve superior outcomes; and 4) Michigan will contact the PIHPs/CMHSPs that achieve poor results and discuss a plan of action for improvement with them.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: Access to assessment

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	97	97.76	98.25	98.30	98.35	98.40
Numerator	3,138	2,884	--	--	--	--
Denominator	3,234	2,950	--	--	--	--

Table Descriptors:

Goal: The Department of Community Health will monitor the quality, access, timeliness, and outcomes of community-based services.

Target: Through FY2011, the percentage of new children with serious emotional disturbance who received a face-to-face meeting with a professional within 14 calendar days of a non-emergent request for service will average 95% or above.

Population: Children diagnosed with serious emotional disturbance.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of new children with serious emotional disturbance who received a face-to-face meeting with a professional within 14 calendar days.

Measure: Numerator: New children with serious emotional disturbance who received a face-to-face meeting with a professional within 14 calendar days.

Denominator: New children with serious emotional disturbance who received a face-to-face meeting with a professional.

Sources of Information: CMHSP Performance Indicator Report.

Special Issues: In the FY07 Application Update of the 2-Year Plan, this indicator was revised because data is now being collected differently. The revision is the percentage of "new" children. Quick, convenient entry in the mental health system is a critical aspect of accessibility of services. Delays can result in inappropriate care or exacerbation of symptomatology. It is crucial to families and children to be able to access services in a short time frame to promote follow through with services and decrease the rate of dropout. By measuring and focusing on quick access to services, the MDCH is encouraging CMHSPs to be responsive to the needs of children and families. The Department standard is 95%

Significance: The time it takes to have a face-to-face contact with a mental health professional from the request for service is a critical component.

Action Plan: Activities to meet the target include: 1) Michigan will continue to gather data on the quality, access and timeliness of services; 2) Michigan will continue to monitor the quality, access, and timeliness of services; 3) Michigan will publish the results of the quality access, and timeliness data in various reports and make these available to the public; and 4) Michigan will take contractual action to assure compliance with this indicator with the participating PIHPs/CMHSPs if necessary.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: CCEP successful placement outcome

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	81	92	81	81.25	81.50	81.75
Numerator	131	226	--	--	--	--
Denominator	165	245	--	--	--	--

Table Descriptors:

Goal: Maintain a statewide integrated children's services system to provide comprehensive community-based care.

Target: For children receiving child care expulsion prevention services, 80% or more will have a successful placement outcome.

Population: Children diagnosed with serious emotional disturbance.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of children receiving child care expulsion prevention services who graduate, stay in their current setting or move to a new setting by parent choice.

Measure: Numerator: The number of children receiving child care expulsion prevention services who graduate, stay in their current setting or move to a new setting by parent choice.

Denominator: The total number of children who are closed from services.

Sources of Information: Child Care Expulsion Prevention (CCEP) quarterly reports

Special Issues: CCEP programs provide trained mental health professionals who consult with child care providers and parents caring for children under the age of 6 who are experiencing behavioral and emotional challenges in their child care setting. This is a collaborative effort funded by the Department of Human Services and the Department of Community Health and provided through cooperation with CMHSPs, the Michigan Coordinated Child Care Association and MSU Extension. In Michigan 60.9% of children under the age of six are in child care. The Performance Indicator for FY07 was inflated due to limited data collection categories. In FY08, data is being collected much more specifically to accurately reflect outcomes.

Significance: The percentage of children receiving child care expulsion prevention who graduate, stay in their current setting or move to a new setting by parent choice is an important outcome indicator addressing the effectiveness of CCEP services.

Action Plan: Activities to meet the target include: 1) Training will continue to be provided across the state in the CCEP program model; 2) Michigan will continue to monitor outcomes; 3) Michigan will continue to review quarterly reports submitted by the programs; and 4) Michigan will evaluate the CCEP program in 2008.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: Family Centered training

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	1,283	1,877	2,337	2,340	2,345	2,350
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Increase the knowledge and skills of children's services staff and parents regarding coordinated, family-centered, community-based services.

Target: To maintain or expand the number of parents and professionals trained in family-centered community-based services.

Population: Children diagnosed with serious emotional disturbance

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
5:Management Systems

Indicator: Number of people attending trainings.

Measure: Count of parents and professionals attending family-centered trainings.

Sources of Information: Attendance lists from training coordinator, counts collected by training coordinators--unduplicated count.

Special Issues: Training for parents and professionals in family-centered practice has been essential in moving Michigan forward to meet the needs of children and families through a process that allows for partnerships between families and professionals and gives families voice and choice. Michigan has devoted resources to these efforts to help improve the system of care and continue to help all systems use a family-centered approach that is comprehensive and meets the needs of children and families.

Significance: In FY 2008, there continued to be a significant amount of training provided to parents and professionals in family-centered practice, wraparound and other collaborative efforts. Training in family-centereed practice will continue in Michigan for the next 3 years.

Action Plan: Provide training in family-centered practice, wraparound, in the various systems.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: No severe impairments at exit

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	50.10	51.20	57.30	51.30	51.40	51.50
Numerator	1,103	1,556	--	--	--	--
Denominator	2,201	3,041	--	--	--	--

Table Descriptors:

Goal: The Department of Community Health will monitor the quality, access, timeliness and outcomes of community based services.

Target: Through FY 2011, the percentage of children with serious emotional disturbance who complete treatment with no severe impairments will remain consistent or increase.

Population: Children diagnosed with serious emotional disturbance.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage of children with serious emotional disturbance who complete treatment with no severe impairment at exit.

Measure: Numerator: The number of children with serious emotional disturbance that complete treatment and have no severe impairments at exit on the CAFAS.

Denominator: The number of children participating in MLOF who had a severe impariment at intake and that completed treatment.

Sources of Information: Michigan Level of Functioning Project (MLOF)

Special Issues: This indicator focuses on the success of treatment for children and families exiting services. For CMHSPs that are part of the MLOF, this indicator monitors all children who entered the CMHSP with a severe impairment and who leave treatment with no severe impairments. Children with a severe impairment on any one sub-scale at exit will have a hard time functioning in the community.

Significance: Not having a 30 on any one sub-scale will increase the likelyhood that a child can remain in the community.

Action Plan: Continue to support the MLOF. The MLOF has gained national recognition for monitoring outcomes of children and families and CMHSPs and is a national model that has been producing results for the past ten years. This is one of three outcome indicators that demonstrate effectiveness of treatment.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: Rural Case Management

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	34.26	34.37	34.40	34.45	34.50	34.55
Numerator	5,262	5,001	--	--	--	--
Denominator	15,358	14,550	--	--	--	--

Table Descriptors:

Goal: Continue to implement programs for children with serious emotional deisturbance in rural areas.

Target: To maintain or increase the rate of children with serious emotional disturbance receiving case management services in rural settings based upon the FY2006 actual rate.

Population: Children diagnosed with serious emotional disturbance.

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Percentage of children with serious emotional disturbance served receiving case management services in rural settings.

Measure: Numerator: The number of children (rural) diagnosed with SED served who received case management services during the fiscal year.

Denominator: The number of children (rural) diagnosed with SED and their families who received a mental health service during the fiscal year.

Sources of Information: CMHSP Budget reports, CMHSP Data reports.

Special Issues: Case management may be provided as a single service through community mental health or may be provided under home-based services or as part of wraparound, or supports coordination. The number of urban counties (population of 250,000 or more) has dropped from 11 to 7 counties thus creating a need to update this indicator. Data for FY06 was amended to refelct accurate numbers. This is essential as FY06 is the year that is used to compare future FY data.

Significance: The percentage of children with serious emotional disturbance receiving case management services indicate that intensive community-based services continue to be provided, thus reducing the need for more restrictive out-of-home placements.

Action Plan: Activities to meet this target include: 1) Michigan will continue to monitor and gather data on the development of intensive community based services in rural areas. Case management is either a stand alone service or part of the intensive community based services being developed in rural areas of the state; 2) Use block grant funding to support the initial development and implementation of MST, a home-based service, and Wraparound, both of which include case management services in rural areas of the state; 3) Use federal Medicaid funding to sustain the development of MST as well as Wraparound; 4) Use the 1915 (c) waiver to expand wraparound across the state; and 5) Continue to develop alternative intensive community based services through the use of 1915 (b) (3) services family support and training and wraparound in rural areas of the state.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Transformation Outcome PMTO

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	6	11	93	.29	.34	.39
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Maintain a statewide integrated children's services system to provide comprehensive community-based care.

Target: Through FY 08: To increase the number of therapists qualified to provide Parent Management Training–Oregon Model PMTO in FY08, FY09, FY10.
From FY09 forward: To increase the percentage of children with serious emotional disturbance served who received PMTO.

Population: Children diagnosed with serious emotional disturbance.

Criterion: 3:Children"s Services

Indicator: Through FY 08: The number of therapists qualified to provide PMTO.
From FY09 forward: The percentage of chidren with SED served who receive PMTO.

Measure: Through FY 08: The number of therapists qualified to provide PMTO.
From FY09 forward: Numerator: The number of children with SED served who receive PMTO.
Denominator: The number of children with SED served by CMHSPs.

Sources of Information: Reports from PMTO training coordinator and CHHSPs who provide PMTO.

Special Issues: PMTO is an evidence-based practice for children with behavior disorders and Michigan is currently training staff in this evidence-based practice. This evidence-based practice will allow for children with a behavior disorder to receive an evidence-based practice and will achieve better outcomes.

Significance: Through FY08: The number of therapists who can provide an evidence-based practice is significant. The more therapists that are trained and can provide this service will result in more children with behavior disorders being able to stay in the community.
From FY09 forward: The percentage of children with SED served receiving PMTO is significant in helping to determine access to this evidence-based practice.

Action Plan: Activities to meet the target include: 1) Provide additional training for therapists across the state in PMTO; 2) Continue to provide coaching in PMTO; 3) Continue to provide training in how to teach others PMTO; 4) Begin to collect data on number of children with SED served who receive PMTO to determine a percentage versus the number of therapist trained in PMTO.

Michigan

Planning Council Letter for the Plan

Upload Planning Council Letter for the Plan

ADVISORY COUNCIL ON MENTAL ILLNESS

August 22, 2008
Ms. Janet Olszewski, Director
MI Dept. of Community Health
Lewis Cass building
320 S. Walnut
Lansing,MI 48913

Dear Ms. Olszewski:

This is to report that the state's Advisory Council on Mental Illness met on August 8, 2008 to review,comment on and discuss with the Department of Community Health officials Michigan's FY 2009-2011 Community Mental Health Block Grant Application.

The Advisory Council, comprised of consumers, family members, advocates, service providers and representatives of state departments, appreciates the chance to offer input on the Block Grant Application, as well as being able to advise on selection and review of funded projects and submission of the annual Block Grant Implementation Report. We hope that that the submission of the Block Grant Application is met with favorably by the federal government.

We look forward to continuing our advisory role related to the state's federal mental health block grant activities, and the opportunity to continue to advise the executive branch on important mental health issues. We appreciate the opportunity to assist with the reccommendations from the Mental Health Commission over the past few years and having the support the Department has continually given to the Council's work.

Sincerely,
Jamie M. Pennell
Jamie M. Pennell
Chair, Advisory Council on Mental Illness

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Michigan

Appendix A (Optional)

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.