Michigan

UNIFORM APPLICATION
FY 2022/2023 Block Grant Application

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

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/16/2021 12.49.42 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year 2022

End Year 2023

State SAPT DUNS Number

Number 113704139

Expiration Date 9/30/2023

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

Agency Name Michigan Department of Health and Human Services

Organizational Unit Federal Reporting

Mailing Address 235 S. Grand Avenue, Suite 800

City Lansing

Zip Code 48933

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

First Name Larry

Last Name Scott

Agency Name Michigan Department of Health and Human Services

Mailing Address Behavioral Health & Developmental Disabilities Administration, Bureau of Community Based Services 320 S. Walnut, 5th Floor

City Lansing

Zip Code 48913

Telephone (517) 335-0174

Fax (517) 241-2969

Email Address ScottL11@michigan.gov

State CMHS DUNS Number

Number 113704139

Expiration Date

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

Agency Name Michigan Department of Health and Human Services

Organizational Unit Federal Reporting

Mailing Address 235 S. Grand Avenue, Suite 800

City Lansing

Zip Code 48933

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

First Name Jeffery

Last Name Wieferich

Agency Name Michigan Department of Health and Human Services

Mailing Address	Behavioral Health & Developmental Disabilities Administration, Bureau of Community Based Services 320 S. Walnut, 5th Floor
City	Lansing
Zip Code	48913
Telephone	(517) 335-0499
Fax	(517) 241-2969
Email Address	wieferichj@michigan.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

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

From	
To	

V. Date Submitted

Submission Date	
Revision Date	

VI. Contact Person Responsible for Application Submission

First Name	Karen
Last Name	Cashen
Telephone	(517) 335-5934
Fax	(517) 241-2969
Email Address	cashenk@michigan.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2022

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of 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 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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Fiscal Year 2022

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Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
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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).

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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of 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 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
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2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

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

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Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

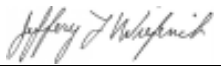
The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

Name of Chief Executive Officer (CEO) or Designee: Jeffery L. Wieferich

Signature of CEO or Designee[1]: 

Title: Director

Date Signed: 08/17/2021

mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2022

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

State: Michigan

Name of Chief Executive Officer (CEO) or Designee: Larry Scott

Signature of CEO or Designee[1]: Larry Scott

Title: Director

Date Signed: 8/17/2021

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2022

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

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of 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 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

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1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

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

Narrative Question:

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

OVERVIEW

In Michigan, behavioral health prevention, early identification, treatment, and recovery support systems are the primary responsibility of the State's mental health and substance use disorder services authorities, collectively known as the Behavioral Health and Developmental Disabilities Administration (BHDDA), located within the Michigan Department of Health and Human Services (MDHHS). MDHHS, one of the largest of the 1 departments in Michigan's State government, is responsible for health policy and management of the State's publicly funded health and human service systems. The Michigan Public Health Code, Public Act 368 of 1978 (as amended) Sections 6201 and 6203, and Public Act 500, establishes the state substance abuse authority (SSA) and its duties. BHDDA functions as the Michigan SSA and duties include the administration and coordination of public funds such as Substance Abuse Prevention and Treatment (SAPT) Block Grant for the prevention and treatment of substance abuse and gambling addictions.

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

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

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

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

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

In April 2014 Michigan expanded Medicaid by offering of the Healthy Michigan Plan. As of July 26, 2021, 929,237 previously uninsured persons are enrolled in the Healthy Michigan Plan receiving both comprehensive physical and mental health outpatient services through the MHPs. These individuals also have access to the full continuum of specialty behavioral health services available as needed through the PIHPs and CMHSPs. Formerly, these services were supported by block grant funding, state general funds and local funds, none of which were entitlements and all of which were prioritized within a capped amount of resources available.

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

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

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

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

To support integration and good collaboration, each PIHP is required to have agreements in place with MHPs and human services agencies that serve people in the mental health system. Both MHP and PIHP contracts have key common indicators of population health that are shared. The quality withholds and financial incentive systems for both PIHPs and MHPs incorporate the common metrics that both entities are accountable together for, as well as the metrics that are unique to the PIHP and MHPs' quality systems. Each PIHP is also required to have a specific substance use disorder advisory and policy board that monitors prevention, treatment and recovery functions of the PIHP to ensure these services continue to be evidenced based, and result in positive outcomes.

The Population Health Administration (PHA) within MDHHS is responsible for behavioral health promotion and early intervention activities and other activities which complement the behavioral health services offered by BHDDA. The PHA is also responsible for statewide suicide prevention planning and activities, maternal, infant and early childhood programs that include behavioral health screenings and referrals, tobacco use prevention and treatment programs, fetal alcohol syndrome prevention programs, the coordinated school health program, chronic disease prevention and management programs and health integration activities.

Based on the 2019 American Community Survey of United States Census Bureau information, Michigan's population is 9,986,857, no increase from the 2010 Census estimates. Race/ethnic origins are White- 78.2%; Black of African American- 13.7%; American Indian and Alaska Native-0.6%; Asian- 3.3%; two or more races (unspecified) - 3.0%; Hispanic or Latino- 5.3%.

Population characteristics from 2019 include 520,129 (6.6%) Veterans and 7.0% foreign born persons. Females comprise a slight majority (50.8%) of Michigan's population, compared to males (49.2%). Although there continues to be a lack of adequate data on specific demographic subsets of Michigan's population in relation to alcohol, tobacco and other drugs, depression and trauma, processes have continued to improve the collection of this information via an oversampling on the Michigan Behavior Risk Factor Survey (BRFS).

Michigan's behavioral health system addresses the needs of diverse racial, ethnic and gender minorities in multiple ways. MDHHS is committed to developing a culturally competent behavioral health service delivery system with activities implemented and monitored in adherence to the National Standards for Culturally and Linguistic Appropriate Services (CLAS) in Health and Health Care. Best practices in the performance of service delivery, regulatory, and business functions necessitates responding to clients, customers, communities and employees in a culturally appropriate manner, which includes the recognition that race historically has played a major role in health and economic disparities. MDHHS understands that these disparities continue today and encourages staff at all level (department and provider networks) have opportunities to learn about how race and racism are related to health inequities and to discuss how to improve minority health outcomes. More information on department efforts is located at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2985---,00.html

Public Act (PA) 653 was passed by Michigan's 93rd Legislature in 2006 and became effective in January 2007. PA 653 focuses on five racial, ethnic and tribal population groups in Michigan: African American, Hispanic/Latino, American Indian/Alaska Native, Asian American/ Pacific Islander, and Arab and Chaldean American. In accordance with this law, MDHHS has the responsibility to develop and implement a departmental structure to address racial and ethnic minority health disparities in Michigan. A report on efforts across the department is prepared for the legislature each year. In 2015, population health, health equity, and social

determinants of health requirements began to be integrated into Medicaid Managed Care Request for Proposal (RFP). (Bureau of Medicaid Care Management and Quality Assurance/Managed Care Plan).

MDHHS also worked with community partners to increase the adoption of CLAS standards among all Michigan organizations.

In 2018, MDHHS released its Diversity, Equity and Inclusion (DEI) Plan. This plan outlines key actions the department should take toward achieving diversity, equity and inclusion throughout the organization. Given the diverse structures, functions and work environments of the various areas within the department, the DEI committee took a broad, high-level approach and created a plan that allows local offices, state hospitals and other organizational areas within MDHHS to be successful at achieving diversity, equity and inclusion in their unique setting. The DEI Plan provides a framework that is applicable to all of the administrations, bureaus and divisions within the department and is adaptable to their individual needs. The guiding framework is built around five key areas or indicators of success: (1) Leadership; (2) Culture and Climate; (3) Recruitment, Hiring and Retention; (4) Training and Professional Development; and (5) Service Delivery. In 2019 administered structured, department-wide assessment in order to gather data to further inform the work of Action Teams, including where to focus their efforts. This assessment data will also provide a baseline from which to measure progress and impact of DEI Plan initiatives. BHDDA actively participates in the DEI committee.

OROSC, a division within MDHHS/BHDDA, developed a toolkit a few years ago titled *Transforming Cultural and Linguistic Theory into Action: A Toolkit for Communities.* This cultural competency toolkit identifies cultural competency as an integral component to the MDHHS strategic plan and system. Core components of this document must be infused into routine business practices and operations, requires continuous quality improvement, must be data driven, must be administratively friendly versus burdensome, and need to identify roles and responsibilities throughout the system. In addition, six key implementation principles were identified: inclusion, diversity, respect, excellence, relationships, and accountability. This document and more information are available at: https://www.michigan.gov/documents/mdch/Transform_Cultural-Linguistic_Theory_into_Action_390866_7.pdf

The Michigan Legislature appropriates restricted general fund dollars for multicultural integration funding. MDHHS/BHDDA contracts this funding for behavioral health services to CMHSPs and other agencies for special populations, including Chinese/Asians, Native Americans, Hispanics, Arab/Chaldeans, Jewish, and Vietnam Veterans. BHDDA also provides block grant funding through the Inter-Tribal Council (umbrella organization) to several of the federally recognized Tribes. Future Requests for Applications (RFAs) to the PIHP and CMHSPs for block grant funded projects will include information on CLAS standards and the MDHHS DEI Plan. Potential applicants will be directed to review the DEI Plan and the Toolkit described above as they respond to the RFA, minimally identifying how their project will address racial, ethnic and gender minorities in their communities.

ADULTS WITH SERIOUS MENTAL ILLNESS (SMI)

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

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

In response to these findings and calls for action, a concerted effort was initiated by SAMHSA to provide the information and tools necessary for States to know about, to develop, and to implement any number of evidence-based practices that have been shown to improve the well-being and recovery of service recipients facing various mental and emotional health challenges. From the development of various toolkits (made available to provider systems at no- cost), to the ongoing availability of information about newly developed practices with demonstrable bases of evidence, SAMHSA equipped the field with foundational models to improve quality of services for recipients of our care. On January 12, 2018, the National Registry of Evidence-based Programs and Practices (http://www.nrepp.samhsa.gov/), was indefinitely suspended, however was replaced with SAMHSA's Evidence-Based Practices Resource Center (https://www.samhsa.gov/ebp- resource-center.

Assisted by available block grant resources, Michigan has continued to make strides in improving our system of care to include the availability and delivery of many of these recommended practices. Among the strengths demonstrated across our State, efforts have continued to progress in the development and implementation of a range of SAMHSA-endorsed evidence-based practices (EBPs) and cross-cutting initiatives across our PIHP and CMHSP provider system. Initiated in FY20 and continuing for FY22 and FY23, Michigan's ***Assuring Clinical Excellence (ACE) for Individuals in the Publicly Funded Behavioral Health System*** program will help achieve these initiatives. The overarching purpose of ACE is to ensure individuals served by the state's publicly funded behavioral health system have access to effective, evidence-based quality treatment and services. This will increase their ability to lead full and vibrant lives, and positively impact the communities in which they live.

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

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

ACE and the corresponding projects are implemented through a contract with the Community Mental Health Association of Michigan (CMHAM), and are grouped in the following categories: Adults with Serious Mental Illness; Children and Adolescents with Serious Emotional Disturbance; Substance Use Disorders and Co-Occurring Conditions; and All Populations in the Publicly Funded Behavioral healthcare System (including person centered planning, self-determination, behavior treatment, supported employment, anti-stigma, deaf, deaf-blind, and hard-of-hearing, Veteran services, and Improving MI Practices).

These block grant-supported projects target the service practice areas below. As many of these practices are only partially implemented and/or are encountering sustainability challenges, they continue to represent ongoing needs for the coming Fiscal Year 2022-23 grant cycle: Veterans and Military Families Walking with Warriors project (including recreational therapy and faith-based initiatives; Trauma Informed Care; Co-occurring Disorders Project; Behavior Treatment Plans; Behavior Treatment Plans Family Psycho-Education; Motivational Interviewing; Dialectical Behavioral Therapy; Level of Care Utilization System (LOCUS); Behavioral Health Crisis Response for Deaf, Deaf Blind, and Hard of Hearing Individuals; Mental Health Frist Aid (MHFA) Instructor Certification Trainings; Individual Placement & Support-IPS (supported employment); Systems Change Benefits Planning; Older Adult Behavioral Health Initiatives; Assertive Community Treatment (ACT); State Lead Trainer – Benefit to Work Coach (BTW); Certified Peer Support Recovery Coach Training State Lead Trainer, Reviewer, & Liaison – Individual Placement & Support; Michigan Clubhouse Training and Development; Self Determination – Autonomy, Freedom, Choice; MHHHS/BHDDA Knowledge Services Person Centered Planning/Support Services Review (PCP/SSR); Children's Evidence Based Practices (EBP's); CAFAS/PECFAS Trainings; Trauma Training, including Prolonged Exposure Therapy; and hosting an Annual Anti-Stigma Day. It is also anticipated overall Cognitive Behavioral Therapy (CBT) training will be implemented during this two-year grant cycle, including CBT-focused Mindfulness for both clinicians and individuals being served.

Assertive Community Treatment

As of January, 2021, 80 community-based Michigan Assertive Community Treatment (ACT) teams engage and work with adults who experience the most severe and troubling symptoms of serious mental illness. Firmly embedded in the public mental health system and a Medicaid covered service, ACT uses proactive engagement to provide continuous, rapid, flexible, twenty-four hour a day, seven days a week, three hundred and sixty-five days a year treatment. Although there is a well- established 20+-year history of ACT, assuring the necessary skills and information in workforce development and support of this very high intensity evidence-based practice remains a priority. An ACT-specific training is required annually by Medicaid, and the Quality Management Site Review Team emphasizes adherence to Medicaid. A quality improvement tool, the *Michigan Field Guide to ACT* was created, adopted and is used to support ACT teamwork addressing consumer relations, satisfaction and outcomes.

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

Fully integrated into the public behavioral health system, ACT smoothly interfaces with many other evidence-based practices such as Integrated Dual Disorder Treatment (IDDT) and Family Psychoeducation (FPE) supported in Michigan. ACT culture has traditionally assured that necessary treatment skills and ACT knowledge are instilled across the workforce. Basic ACT team requirements are specified in the Michigan Medicaid Provider Manual and available through the PIHP contract's service array. More detailed and specific ACT program implementation information is provided in the *Michigan Field Guide to ACT*.

A Michigan Fidelity Assistance and Support Team (MiFAST) visit process has been implemented that measures numerous anchors of program implementation and fidelity. Each MiFAST team visit, conducted by trained ACT peers, concludes with a post visit consultative call, identification of potential areas for technical assistance, and related supportive follow-up. This consultative approach has resulted in additional attention dedicated to supporting individual ACT team development while at the same time identifying state-wide developmental needs to address. This 'three-legged' stool is the basis of support for solid ACT teams.

Because early treatment is critical to engagement and long-term recovery, in FY20, two pilot sites were developed to treat up to five people experiencing First Episode Psychosis (FEP) using Navigate on existing ACT teams. The pilot ACT teams received Navigate training, supportive consultation and information that compares, contrasts and sensitizes ACT staff to differences in FEP and most traditional ACT consumers. As the two pilot sites completed training and were preparing to admit individuals needing these services, COVID-19 guidelines and restrictions directly impacted the ability to fully initiate this process. These pilot sites have been re-established, will continue in FY 22-23, and there are plans to establish at least one additional site once the pilot phase has been completed.

FEP / ACT will provide early and intense treatment focused on improving clinical and functional symptoms and gaining or regaining critical life skills, especially in employment and education. ACT provides most care and visits in the community, not in the office, so few dropouts and no shows are expected. An example, one current individual being treated in ACT stated that 'ACT has the therapists you can't get away from, they even come to your house'… 'I love the ACT team'; he further credited ACT team treatment and support for his adherence, employment and current success. He noted it is easy to just not show up or participate after a time or two with case management, which for him lead to further episodes and symptoms. ACT team persistence, intensity and perseverance, medication and parental involvement are identified as critical to success. Stand alone Navigate outcomes did not decrease hospitalization. It is anticipated by pairing with already existing ACT teams' capabilities, decreased hospitalization rates is an anticipated outcome. Some deviations in Navigate fidelity are anticipated, such as the delivery of certain modules in Individual Resiliency Training, others may be determined later.

Standard agency enrollment requirements for ACT, such as a history of multiple hospitalizations, LOCUS score, or ACT waiting list, can be waived to participate in the pilot, bypassing waiting lists and less intensive services to immediately access ACT treatment.

CMHSPs primarily provide treatment through Medicaid and not private insurance, thus eliminating access to coordinated intensive team delivered care consistent with the ACT (and RAISE /Navigate) model. In agencies that accept private insurance, ACT is not a covered service. Block grant funds will support ACT for FEP for those who are not covered by Medicaid assuring a path to intensive timely treatment.

Family Psychoeducation

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

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

Over time a significant structure to support FPE has been achieved. A part-time contractual State Coordinator works with MDHHS and the Steering Committee to plan and implement the Facilitator, Advanced Facilitator and Trainer/Regional Supervisor training. An FPE Sustainability document has been updated, and a toolkit created. Quarterly Steering Committee meetings focus on FPE staff's current needs and challenges. In effort to maintain high fidelity, technical assistance/fidelity reviews are offered to PIHPs annually. There are 21 active supervisors/trainers spread regionally to provide regular supervision throughout the State.

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

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

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

- MIFAST:Integrated Dual Disorder Treatment (IDDT) readiness assessment, onsite fidelity reviews, and follow-up technical assistance including training, coaching and consulting.
- Practice Improvement Steering Committee (PISC) and the Co-Occurring Leadership Group:

The PISC has goals and objectives for the continuance of implementation sustainability and improvement of the standards of evidence-based treatment. Quarterly meetings of this Committee include a standing agenda for Co-occurring Competency in both Mental Health and Substance Use Disorder Treatment as well as Integrated Treatment for Co-occurring Disorders (formerly Integrated Dual Disorder Treatment) which is specialized care for Co-occurring disorders for those who need higher levels of treatment than standard outpatient and for those who need the intensity of ACT level services. The project leader reports on the prior quarter activities as well as implementation plans and activities for the next quarter. Evaluation of the program and improvements targeting performance trends are discussed.

The Co-Occurring Leadership Committee meets with leadership from MDHHS and leadership from the PIHP's and CMHSP's to discuss projects, grants, updates, and progress regarding integrated treatment. Technical assistance needs or resources are discussed. Each region of the PIHP report out what they are doing regarding implementation.

Evaluation of the program and improvements targeting performance trends are discussed.

The MIFAST group reviews programs for the purpose of assisting them in developing and sustaining IDDT/ACT teams that practice with a high level of fidelity. MIFAST does this by conducting a technical assistance conference to help agencies develop an implementation plan for IDDT, followed by an onsite visit to determine the degree to which the agency has achieved implementation by fidelity scoring of the 26 scorecard elements, and subsequent provision of technical assistance to aid in the improvement of areas that are shown to need further development. The MIFAST team has added the DDCMHT site review process to its menu of assistive activities. The MIFAST team underwent formal training through SAMHSA in order to provide system wide review of "dual disorder" treatment capabilities across all programs at the outpatient level of care. For the agencies that request DDCMHT site-reviews of their outpatient treatment programs, each site is provided with a scoring report and a work plan with suggested activities for enhancing supports and services in each area reviewed.

The FY22-23 plan for MIFAST Integrated Treatment Co-occurring Disorders (ITCOD (formerly IDDT) is to ascertain the number of teams practicing across the State of Michigan; determine the number of teams who have had four or more site visits since

2006; determine the number of protocols that consistently score above a 4 and organize site reviews to target areas that score below 3.1; provide both review and technical assistance for areas below 3.1 in site reviews and follow-up; initiate site reviews for IDDT teams who have not yet participated or have had <3 reviews; develop a survey for teams to evaluate the effectiveness the MIFAST reviews and technical assistance and how the state can provide on-going support, assess how teams are reducing barriers to treatment related to diversity, equity, and inclusion; ongoing evaluation and improvement of fidelity review tools, conduct MIFAST inter-rater reliability enhancement training for veteran and new reviewer team members; and continue to recruit and induct additional peer support specialists or persons with lived experience onto the review team as consultants to MIFAST and as part of the site visit process.

An annual Co-Occurring College is a separate activity which provides focused trainings for providers from various specialized supports and services who want to ensure they are addressing comorbidity. This event includes various classes specific to clinical supports and services. Participants may attend classes on screening, assessment, facilitation skills for developing and individualized plan of service from the person-centered planning process, interventions specific to co-morbid effects of both disorders on functioning, matching treatment approaches to level of readiness and evaluating and adjusting treatment goals, supports and services.

In addition to MIFAST and the PISC, a combined Conference Planning group meets to plan the annual Substance Use Disorder and Co-Occurring Conference. The annual Substance Abuse and Co-occurring Conference provides workshops on topics that are intended to improve and enhance knowledge and practice across staff from administrative and practice levels. Topics include the best examples of co-occurring mission, vision, policy and practice initiatives, and research, while considering diversity, equity, and inclusion, as well training on evidence-based practices developed, and adapted for co-occurring treatment. The Substance Abuse and Co-occurring Conference planning group meets to review submissions from presenters who wish to participate in this conference. Reviews are conducted to determine if presentations meet the goals of the conference for integrated treatment, evidence-based, and strength-based and recovery characteristics. Plenary speakers are also reviewed and chosen based on their ability to meet the goals of the conference.

Improvingmipractices.org is a website providing opportunities for providers to receive online training regarding evidence-based, evidence-informed, best, and promising practices including information on substance use disorders and co-occurring treatment. This site is used for advisory groups and MIFAST reviewers to report up-to-date information regarding reviews and information related to evidence-based treatment. This site is consistently under construction to update, improve, and add new material to support those who serve individuals struggling with severe mental illness and co-occurring disorders. At least, 2-4 new training modules will be added to support treatment regarding co-occurring disorders.

The Prevention and Treatment Section and the Community Practices and Innovation Section are working collaboratively to provide seamless Integrated Care for Co-Occurring Disorders. These two divisions are evaluating gaps in the public behavioral health system where mental health and substance use services are not fully integrated. Some of the areas that are continuing to be explored are assessments, co-occurring, trauma, and women specific treatment.

Motivational Interviewing

Motivational Interviewing (MI) is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalence resulting from conflicting beliefs about change is the primary obstacle to behavioral change. Motivational Interviewing is an evocative, assistive and collaborative facilitation strategy that helps to resolve ambivalence by finding and strengthening intra-personal motivation for the overcoming of ambivalence and promoting changes in behavior. MI represents a philosophy as well as a set of skills for

effectively engaging and assisting Michigan's behavioral health system's service recipients facing one or more areas of difficult behavior change. Behaviors over a wide range, including participation and follow-through with supports and services, improving effectiveness of medications and treatments, behaviors for remaining in safe and affordable housing, benefiting from achieving and sustaining employment, relationships and increasing the ability to manage recovery activities independently are all examples of the beneficence of Motivational Interviewing practice.

Goals for FY22-23 and beyond regarding MI include:

- Review and improve current modules and add at least 2-4 new MI training modules on www.improvingmipractices.org.
- Provide Motivational Interviewing Competency Assessment training to veteran and new MI trainers to enhance competency of MI within CMHSP's.
- Provide regional and on-site MI training with emphasis on coaching, and consultation, based on outcome of ascertainment visit through MIFAST for motivational interviewing.
- Work on recruitment and retention of MI trainers within CMHSP's to support sustainability through the MI Learn and Share.
- Develop MIFAST fidelity tool specific for MI
- Create trainings to demonstrate utilization of MI in conjunction with other evidence-based practices.

Dialectical Behavior Therapy (DBT)

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

- With approximately 40 DBT teams delivering services across Michigan's public behavioral health system, most PIHP regions feature one or more DBT team providing this evidence-based treatment to service recipients with Borderline Personality Disorder.
- Ongoing core and refresher training continues to be provided annually to Michigan's public behavioral health workforce, along with evaluation of the effectiveness of the current training approach, using outcomes from training surveys as well as information on the continuing development of the model to make improvements that are cost- effective and help strengthen and sustain program and practitioner skills. An annual DBT Summit provides workshops on topics that are intended to improve and enhance knowledge and practice across staff from administrative and practice levels. Topics include creating life worth living goals, breaking down the chain analysis, running effective DBT consultation, and more in-depth look at diary cards. Other evidence-based treatment approaches have been presented at the summit such as: Radically Open Dialectical Behavior Therapy. At the 2021 DBT Summit, the focus is on the Collaborative Assessment and Management of Suicidality (CAMS).
- Increase use of the practice knowledge exam, which has been developed to better gauge the level of core knowledge and skills of DBT practitioners, as well as to inform future training and support for performance quality. The DBT practice knowledge exam is available via the www.improvingmipractices.org website. Test results are immediately available to MDHHS for aggregation and analysis for the purposes of supporting high-quality service delivery, and to help inform needed training moving forward.

- Statewide efforts to improve and expand the quality and availability of DBT services is being guided by a DBT Subcommittee, led by experienced practitioners from within Michigan's behavioral health service network, and includes DBT team leaders, which advances the products of its work to the PISC.
- The sub-committee formed into an arm of the MIFAST for DBT. The team trained on the Global Informational Index (GOI) as an on-site evaluation tool and used it in nine site visits to assist teams in identifying the degree to which they have achieved implementation and identify areas for further development. A DBT specific tool developed in 2015 for use along with the GOI for site assistance has resulted in 36 reviews and follow-up technical assistance and training for areas identified by the site visit activity as requiring further development.

Goals for FY22-23 and beyond regarding DBT include:

- Compile data on all current DBT teams and outreach to teams who have not completed MIFAST reviews.
- Review and improve current modules and add at least 1-2 new DBT training modules on www.improvingmipractices.org.
- Bi-monthly statewide DBT Conference Calls.
- Provide regional and on-site MI training based on identified themes from site reviews, technical assistance, and DBT conference calls.
- Review and improve DBT specific fidelity tool.
- Provide DBT-Prolonged Exposure training.

Cognitive Behavior Therapy

Cognitive Behavior Therapy (CBT) is an evidence-based practice with demonstrated effectiveness in over 400 clinical trials used alone or in conjunction with medication. It has been shown to be an effective treatment for a wide variety of mental health issues including depression, anxiety, eating disorders, substance abuse, personality disorders, anger, relationship difficulties, low self-esteem, grief and loss, and problems associated with aging. CBT is also an effective treatment for physical health issues including chronic/acute pain, chronic fatigue syndrome, colitis, sleep disorders, obesity, irritable bowel syndrome, hypertension, post-myocardial infarction, non-cardiac chest pain, cancer, diabetes, and migraine. CBT can be utilized with adults, children, or older adults in individual or in group settings.

BHDDA has supported multiple evidence-based practices that include components of cognitive behavior therapy. The Community Practices and Innovation (CPI) section of BHDDA utilizes Integrated Treatment for Co-Occurring Disorders, Prolonged Exposure, and Dialectical Behavior Therapy. Many evidence-based treatments can be used in conjunction with CBT. The plan for FY22-23 is ensuring that providers are trained in CBT to have a solid foundation in the structure and techniques of Cognitive Behavior Therapy and to continue to assess what other evidence-based practices that include CBT are effective for those struggling with severe mental illnesses and co-occurring disorders.

Mindfulness Based Interventions

Mindfulness is the practice of purposely bringing one's attention in the present moment without judgment, a skill one develops through meditation or other practices like yoga movement, walking, sitting, and breathing. Mindfulness has been shown to relieve symptoms related to stress, depression, anxiety, pain, trauma, and other chronic issues. Dialectical Behavior Therapy, Acceptance and Commitment Therapy, Mindfulness Based Cognitive Behavioral Therapy, and Mindfulness Based Relapse Prevention are treatments that incorporate mindfulness. Other EBP's like Motivational Interviewing are discussing how mindfulness may fit in with their philosophies.

Two areas are being looked at regarding the use of evidence-based mindfulness treatment for FY22-23— the behavioral health workforce as well as for the individuals served. Support to the behavioral health workforce who are providing services to those struggling with severe mental illness and co-occurring disorders is imperative. According to a 2016 report by the Health Resources and Services Administration's (HRSA) National Center for Health Workforce Analysis forecasts a shortage of psychiatrists; clinical, counseling, and school psychologists; mental health and substance use disorder (SUD) social workers; school counselors; and marriage and family therapists through 2025. This doesn't consider the impact of Covid-19 on the workforce, burnout, or compassion fatigue. Data from the Health Resources and Services Administration indicate that 42.31% of the population in Michigan live in a mental health shortage area. Mindfulness has proven to reduce stress, depression, anxiety, improve focus and performance, improve health, increase sense of calmness, and improve sleep. Looking at FY22-23 we would be providing an evidence-based mindfulness training such as Mindfulness Based Stress Reduction or Mindfulness Based Cognitive Therapy to those providing services to individuals with severe mental illness and/or co-occurring disorders. As the workforce utilizes these mindfulness practices, they can then work on providing evidence-based mindfulness treatment to individuals served.

Supported Employment / Individual Placement and Support

Michigan presently has 23 recognized Individual Placement and Support (IPS) sites actively providing services and striving to achieve or maintain at least fair fidelity. These IPS sites represent 12 of the 46 Community Mental Health Services Programs (CMHSPs) in Michigan and provide these services in 21 of the 83 counties in Michigan. During COVID one agency chose to discontinue providing the service. The Upper Peninsula as well as other rural areas struggle with efforts to build and/or follow the IPS model and are challenged to determine enough potential candidates to merit a full-time staff. Funding and budgeting for IPS employment staff is also challenging given its clear focus on INDIVIDUAL Competitive Integrated employment versus historical models. Outreach has continued through technical assistance for counties considering the IPS model. Two new CMHSPs have expressed sincere interest, and we will learn if they follow through during FY 22.

The COVID Pandemic had both negative and positive implications on Michigan's IPS programs.

- Negative implications include:
    - Perhaps five of the 24 sites; struggled converting to virtual contacts with individuals. (Yet two sites discontinued in-person services for only about 60 days as they quickly adapted to meeting needs for individuals via virtual means.)
    - Several sites have and continue to struggle hiring or retaining employment specialists perhaps related initially to the significant level of unemployment payments and now due to the very competitive labor market. At least three teams are presently down to only one employment specialist. Efforts are ongoing to address this challenge.
- Positive implications include:
    - Past quarterly meetings with supervisors were increased to monthly conversations that remain appreciated by most sites.
    - In addition, the State lead trainer and fidelity reviewer initiated "Power Hour" events each month to focus on specific areas. He also started an employment specialists weekly meeting so teams and individuals could network, raise questions, and learn from one another. This may slow down as IPS teams are now meeting more often in person with individuals.
    - Several sites report that individuals receiving services and supports actually prefer the virtually services/contacts and are asking these continue. They report feeling less invasive and don't need to solve for transportation.
- One IPS site captured a grant and purchased "notebooks" for all individuals it supported allowing some individuals their first initial and readily available access to technology.

- We have all learned that we can save time and resources if/as we wisely use virtual technology to enhance our work.
- At least two IPS sites acknowledged that they discovered that individuals "stepped up" to solving their own challenges to seek out employers, make meetings, find and use more local resources. This enhanced independence by these individuals and several secured work that didn't expect to be successful.
- A highlight was that the aggregate average employment rate for all sites during FY 20 remained near 37%. The 1st and 2nd quarters of FY 21 are averaging 41.8%. During the 2nd quarter over 1600 individuals were supported with 656 working some portion of the quarter averaging near 16 hours a week.
- Four sites had employment rates over 50% and another several sites were over 45%.
- Note: These average hours are lower than the previous report but are a truer averaging across all individuals for all hours worked during a quarter.

All jobs were reported as competitive, integrated employment. Productive partnerships with vocational rehabilitation are growing. Recent cross-agency training has occurred. Vocational rehabilitation leadership will lead focused networking discussions during Michigan's virtual IPS Summit event in August of 2021.

Key focus areas to increase quality employment outcomes for FY 2022 and beyond include:

Core Review Team:

There is now a State lead IPS fidelity reviewer and trainer. The core review team has consistently maintained several active members. The State lead anticipates one or two of these individuals may leave the team due to retirement and work changes. New individuals are being sought and will begin a very intentional year of more of orientation, which is expected to meet the review needs for the immediate future.

Funding Challenges:

There continues to be significant variance in the rates and/or staffing costs associated with these 23 IPS providers. Six of the IPS providers offer services directly through their CMHSP staff and reflected average costs are clearly more than rates shown for those providers that are contracted by other CMHSPs to provide the services. Detroit Wayne Mental Health Authority continues working with its current IPS sites

It continues to be clear that in order to grow the IPS model in Michigan, a strategy must be developed to not only develop new IPS sites but to provide the framework to support that growth through timely reviews, training events, and even consideration/implementation of incentives to gain heightened provider commitment. A virtual Michigan IPS Summit will be held in August 2021 with national presenters, facilitation of interactive sessions with vocational rehabilitation partners, peers, and focus topic areas driven by discussions with the IPS teams.

Staff Development/Training Events include:

- Enhancing Supervisor Outcomes
- Basic IPS "101" training is needed annually for new staff
- Job Development & Retention
- Increased emphasis on data collection
- Cross-walking effective Motivational Interviewing (MI) with IPS
- Peer Support Specialist's role(s) in IPS
- Benefits Planning for effective IPS
- Strengthening Vocational Rehabilitation partnerships

Michigan DB101 - Disability Benefits 101 at http://www.mi.db101.org has grown with six videos available to address basic SSI/Medicaid and SSDI/Medicare concerns related to employment. Utilizing this site, ideally saves IPS professionals time working with individuals, and provided almost immediate information on changes to disability benefits when planning employment or changing jobs.

Communications and Michigan Specific Resource Development:

Michigan is continuing to create a growing on-line presence at www.improvingmipractices.org.for IPS related documents, reporting, and training. This website was established for other evidence-based practices. It has also become the home for tracking ongoing fidelity reviews, calendar of events, IPS webinar events, possibly interactive on-line training, and more.

Documentation and Data Tracking:

Michigan has implemented a requirement that each IPS site will report quarterly the number of individuals employed (focused on individual, competitive, integrated employment), average hours and average wage. Michigan is also collecting an additional 24 data points ranging from 90, 180, & 365 job retention, vocational rehabilitation eligibility, Healthy Michigan Plan eligibility, number of employment specialists, and other data points. Collecting such quarterly data is allowing the State to more effectively create policy, procedures and contracts to advance IPS. CMHSPs or providers better recognize the need to attain State approval to before presenting themselves as a recognized IPS site.

Michigan remains committed to the IPS initiative and seeks strategies for effective growth that honors high quality fidelity and increased employment outcomes for Michigan citizens with serious mental illness.

Older Adults

Older adults are eligible for the same service array as younger adults within the public behavioral health system. In FY 2019 over 11,844 older adults (65 and over) received public behavioral health services, which is approximately 5% of the total number of adults served. Approximately 3,973 of these individuals had an Intellectual/Developmental Disability, 7,745 had a mental illness, and 1,092 had both.

The Older Adult Wellbeing Workgroup is an MDHHS planning and networking group meeting monthly with department specialists and stakeholders focusing on older adult behavioral health issues in serious mental illness and substance use disorder. There is a particular emphasis on prevention through the Office of Recovery Oriented Systems of Care. A comprehensive five-year work plan was developed in 2020 which developed goals that include data analysis, environmental scans across the state for SUD prevalence and treatment options for older adults.

MDHHS continues to partner with Lansing Community College in the Mental Health and Aging Project (MHAP), to provide a variety of seminars and workshops related to both mental illness and dementia. An annual Mental Health and Aging Conference and regional seminars focus on the mental health needs of elders. Other partnerships include collaborative work with the Michigan Assisted Living Association (MALA), providing materials, curriculum, and training on dementia care to staff of facilities whose residents include over half persons with dementia. MDHHS continues to support MALA's two-day Dementia Conference which includes national and international speakers as well as workshops by persons living with dementia. MALA has been cultivating support groups of individuals with lived experience: Dementia Minds and Black Dementia Minds. The groups provide support to individuals who are newly diagnosed, their care partners, and tips on how to lead their best lives with dementia.

The work of the Michigan Dementia Coalition, a grassroots collaboration of representatives of universities, community agencies, and state government units continues. MDHHS is reviewing their newly developed 2019-2022 Roadmap for Creating a Dementia Capable Michigan. In 2019, several workgroups were formed based on the roadmaps to network, inform colleagues and discuss resources.

Clubhouse

Currently there are 43 Clubhouses that serve over 4,500 consumers in the state. Forty (40) of these Clubhouses are fully accredited with Clubhouse International. The balance of the clubhouses will be fully accredited by the end of FY22. We would have met the above goal last year, however due to the COVID-19 pandemic accreditation will not be met until FY22.

There are clear differences in outcomes between Clubhouse International (CI)-Accredited clubhouses and non-CI-Accredited clubhouses, particularly in transitional employment (TE). Based on the latest Michigan Clubhouse Survey, 67% of the directors and staff/members have had training from CI. Notably all clubhouses have provided outreach services to members and have been engaged in some form of health and wellness initiative. Forty-five percent (45%) of Clubhouses have a Wellness Committee; 63% have had wellness presentations; 85% have implemented wellness-minded social activity planning; 95% have implemented walks at lunchtime; 80% have other exercise opportunities available at the Clubhouse (e.g., yoga, Wii Fit, etc.); 75% have shared stop smoking resources; and 88% have prioritized wellness-minded menu planning.

In the employment arena, it appears that TE is very much associated with CI-Accredited clubhouses with some patterns that show better employment outcomes than non-CI Accredited clubhouses. Independent employment (IE) is the most common form of employment across clubhouses (23%) and has continued to slowly rise each year. The correlations between the different types of employment and services extended to clubhouse members reveal a pattern that suggests that the type of employment that a member holds may be related to different services. For example, the number of members connected to Michigan Rehabilitation Services or Michigan Commission for the Blind was significantly related to IE, not to supported employment (SE) or TE. The IE number was significantly related to access to clubhouse activities on weekend, evenings, and holidays. Finally, the numbers holding SE was related to the number of face-to-face outreach services provided. Clearly the pattern of not seeing any significant relationships with these services and TE employment is notable. Perhaps people in TE are receiving supports from clubhouses through their participation in TE which involves staff who are highly integrated into the core clubhouse activities. A multi-year survey conducted by Michigan State University and MDHHS provides much of the information above.

Comprehensive 2-3 immersion training: In FY20 MDHHS sponsored 20 different Michigan Clubhouses to participate in 2-3 immersion training though-out the United States. Mentoring activities will be continued in FY22 and beyond. The initiative provided funding for Clubhouse colleagues (members and staff) to attend comprehensive trainings at any of the 6 accredited training bases in North America. Comprehensive trainings come in the form of 3-week or 2-week courses. All trainings are for 1 staff and 1 member for the full duration, and one administrator for the final week. The trainings follow a uniquely experiential program where colleagues are immersed in the practices of some of the strongest Clubhouses in the world. Training content includes Employment Development, Education Support, Meaningful Work-Ordered Day & Relationships Opportunities, Physical Wellness and more. Many Michigan Clubhouses need assistance to attain model fidelity, and comprehensive trainings like these are a catalyst for strong, positive changes. High fidelity Clubhouses provide a better experience, significantly improve mental health, and are very cost-effective. MDHHS will continue to sponsor 20 Clubhouses annual to attend immersion training.

Clubhouse Mentoring: FY22 will be the fifth year of the Clubhouse Mentoring program. Eight (8) accredited Clubhouses volunteered to mentor newly accredited Clubhouses, or those who are in the beginning stages of the accreditation application process. Each Mentor Clubhouse maintains consistent communication and provides mentoring with several Clubhouses across the state, based on proximity. A total of 30 Clubhouses are currently being mentored. MDHHS will continue to support this effort in FY22 and beyond. Unfortunately, the mentoring during the past 16 months has been on the decline due to limitations and travel restrictions, however it is showing signs of recovery.

Data Collection: Michigan is in the process of finding ways to improve data collection capabilities for Clubhouses. Better data will shed light on program effectiveness and will identify gaps for improvement. In FY20, Michigan started to roll out a data pilot program with three to five identified sites. The pilot program will allow data from all Clubhouses in the state to be centrally collected. This could illuminate trends in member employment, education, wellness, service costs, mental health outcomes, and housing/homelessness prevention. This Flourish data collection software program is being rolled out statewide to all 43 PSR programs during FY22. The deeper value of integrating data into a Clubhouse is that members get to work hands-on in the collection and analysis of the information, thereby teaching them more skills that can be utilized in other real-world applications such as employment. New user feedback would be shared as needed during the pilot year.

Jail Diversion

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

The MDHHS authority in diversion efforts is guided by the Michigan Mental Health Code, Act 258 of 1974, 330.1207, Diversion From Jail Incarceration, Sec. 207 which states that "Each community mental health service program shall provide services designed to divert persons with serious mental illness, serious emotional disturbance, or developmental disability from possible jail incarceration when appropriate. These services shall be consistent with policy established by the department." While diversion programs and services overseen by the Diversion Council and the adult component of the MHBG program vary by size and location, they all have the same goal in common. Diverting individuals who have a serious mental illness, including those with co-occurring substance use disorder, or who have a developmental disability and have contact with the criminal justice system around misdemeanor or non-violent felony offences is the goal.

Specifically, the MHBG diversion funds serves to enhance current efforts and services at the regional or local level. In FY 20, four diversion projects were funded where activities included software enhancements to booking processes to better identify those appropriate for diversion, dedicated navigators assisting diverted persons into behavioral health services, and case management for a mental health court. Despite the restrictions in jail access due to the pandemic, FY 20 saw 547 persons successfully diverted into mental health services.

Currently, five jail diversion projects are funded in Wayne, Muskegon, Washtenaw, Ottawa, Branch, and Sanilac counties. Of the five projects, one is mental health court expansion effort in partnership with the State Court Administrative Office (SCAO) which is the State's lead agency in problem solving court funding. MDHHS and the SCAO continue to partner in funding, expanding drug treatment courts and mental health courts since 2000. The remaining projects are post- booking efforts where individuals are identified at the local county jail during the booking process as potentially needing behavioral health services rather than jail. Individuals are then assessed by the local CMHSP to determine appropriateness and service need upon release.

Stepping Up Technical Assistance:

The Center for Behavioral Health and Justice (CBHJ) through Wayne State University is providing technical assistance to those communities around the state that are seeking to bolster their jail diversion efforts through the national Stepping Up initiative. This initiative utilizes a community's County Commission as it's focal point and the CBHJ assists county's by shepherding them through a series of questions that get them to a point of working with stakeholders more effectively and helps them gather data to seek the best path of diversion programming.

Statewide Law Enforcement Trainings:

The Mental Health Diversion Council is funding statewide law enforcement trainings to coincide with Crisis Intervention Team efforts that many of the pilot initiatives are currently implementing. The Managing Mental Health Crisis trainings are being proliferated across the state as an intensive two-day training that highlights many of the CIT principles and is noted for its policy of being co-facilitated by both treatment and law enforcement staff.

Juvenile Justice Initiatives:

The Mental Health Diversion Council currently funds many juvenile justice initiatives including a statewide juvenile justice assessment system, juvenile competency trainings and juvenile urgent response teams. The MHDC recognizes the importance of diversion starting at a young age to address the needs of juveniles in an effort to avoid future interaction with the justice system.

Veteran and Military Family Members

The MDHHS/BHDDA Veteran Liaison, established in 2016, is the recognized resource between MDHHS/BHDDA and the Military and Veteran Affairs Administration for Veteran- related activity within the publicly funded behavioral health system. The State of Michigan is, for the most part, a National Guard and Reserve state. Many of these families have struggled with multiple deployments, significant changes, and are left with little support upon their return. Veterans and Military families face mental health and substance abuse issues that, more often than not, remain unmet.

As a result of these unmet needs, these individuals and families struggle to reintegrate, thrive, and effectively engage in their local community. With no large active duty bases to provide significant support and resources, BHDDA is leading an effort with creative, innovative, collaborative and intentional approaches regarding Veterans, members of the military, and their families.

The overarching goal of this position and project is to create a system that will ensure Veterans, Military members, and their families receive efficient, comprehensive and sustained behavioral health services in the publicly funded system, which includes access to other community resources to address their identified needs.

The following objectives were part of a three-year (2016-2019) Strategic Plan that has been implemented:

1. Conduct cross-training initiatives to assure the publicly funded behavioral health care system is appropriately trained on Veteran and Military culture; and provide training on effective behavioral health care screening and referral for Veteran and Military groups as requested.

2. Engage in inter-and-intra agency collaboration in order to leverage resources and partnerships.
3. Identify, train and embed Veteran Navigators/Liaisons into the publicly funded behavioral health care system throughout the State of Michigan.
4. Provide the publicly funded behavioral health care system with resources to evidence- based programs in order to strengthen Military families.
5. Develop processes and systems to gather and utilize data to gain a clearer perspective on Veteran and Military families in Michigan, their needs and gaps in services.
6. Leverage additional resources for long-term sustainability of this plan.

The core of this BHDDA plan has been designed around a 5-pronged coordinated approach among key stakeholders and their partners to meet the comprehensive needs of Veterans and Military family members across the state: (1) MDHHS, including BHDDA and provider network of PIHPs, CMHSPs, and SUD treatment and prevention providers, as well as Adult/Family Services local offices and the Director's office Veteran Liaison; (2) Veteran's Affairs and Michigan Veterans Affairs Agency, in conjunction with Veterans Community Action Teams (VCAT), Michigan Veteran Trust Fund, and VCAT Regional Coordinators; (3) Michigan Army National Guard; (4) Other significant community assets including 211, Give an Hour, Partners in Care, Military Support Programs and Network-Buddy-to-Buddy and service groups such as the Veterans of Foreign Wars and American Legion; and (5) Cross- Training on military culture for the behavioral health care field and training on behavioral health issues for Military units.

Beginning in FY17 combined MHBG and SABG began funding a PIHP Regional Veteran Navigator in all ten PIHP regions. During the first year of implementation, performance indicators on number of individuals reached were exceeded by 1200%. Since then, 70% of Veterans, Military Members and their families connected to the Veteran Navigator program report being better equipped to reach out for help. These efforts will continue and be improved upon from FY22-23.

Based on the new Strategic Plan being implemented between FY20 – FY24, FY22 will provide opportunities to implement new projects in the areas of Faith based initiatives as well as Recreation/Adventure Healthy Habits programs that will add therapeutic approaches to treatment. It will also help Walking With Warriors increase capacity to meet identified needs. Walking With Warriors will have increased data assessment. This will demonstrate cost savings across the spectrum of Veteran care in Michigan. New Performance Indicators for FY22-23 will also reflect the goal of obtaining more in-depth outcome based information from Veterans and Military families.

Other efforts being initiated or continuing in FY22-23 through the use of both mental health and SUD block grant funds include:

- Cross-training of mental health and substance use disorder (treatment and prevention) professionals on military cultural competency.
- Leveraging Veteran Navigators to further build collaborative and coordinated approach to care with the five VA systems in Michigan.
- Expanding on the ADAPT4U pilot project initiated in FY19 to other areas of the state. This evidence-based program mirrors Parent Management Training-Oregon (PMTO) model and has been adapted specifically for military families.
- Expansion of a Female Veteran Peer Support program.
- Continuation of the Veteran Justice and Faith Based Initiatives.
- Continued roll-out of Walking with Warriors media campaign to reduce mental health and SUD stigma and connect Veterans, Military Members and their families to publicly funded behavioral health care.

Recovery-Oriented Care / Recovery Support Services

Michigan uses SAMHSA's working definition of recovery including the four dimensions and 10 guiding principles. This framework is used to as a foundation in trainings and events related to recovery. We are recognized for the variety of peer certifications based on individuals and their lived experience. We currently have trained and certified over 2105 peer support specialists in a lived journey of mental health recovery some who have a co-occurring diagnosis of addictions. Certified Peer Support Specialists work in an array of services some examples include; consumer run drop in centers, Assertive Community Treatment Teams, clubhouse programs, jails and other justice involved settings, care management teams, and Federally Qualified Health Centers as Community Health Workers. A peer conference has been held every year to education consumers, family members, mental health staff and other interested stakeholders on recovery and the value of peer support workers. A training specifically for supervisors and peers in working collaboratively has been provided statewide.

Recovery-based services and supports remain a strong foundation of publicly funded behavioral health programs in the state. As part of Michigan's Certified Peer Support Specialist (CPSS) initiative, over 2,000 individuals have been trained and certified in the state. Individuals work in a variety of areas including supports coordination, psychosocial rehabilitation programs, access centers, drug and mental health courts, crisis settings, drop-in centers, employment, housing outreach, jail diversion, Assertive Community Treatment, and a variety of other evidence-based practices. A strong relationship with the Veterans Administration has led to over 160 Veterans receiving certification working at community mental health programs, provider agencies and VA centers.

In addition to the CPSS initiative, a certification for peer recovery coaches with lived experience in addictions has been implemented. Currently over 500 individuals are state certified. Individuals with co-occurring conditions are often dually certified.

This fiscal year a partnership with the Michigan Community Health Worker Alliance (MICHWA) provided the opportunity to train both CPSS and Certified Peer Recovery Coaches (CPRC). Forty-two individuals have achieved certification requirements. The Community Health Worker (CHW) training has increased the skills of the workforce in assisting individuals served by the public behavioral health system to self-manage their physical health conditions.

Ongoing continuing education trainings for CPSS and CPRC peer specialists are provided throughout the year. Trainings include Wellness Recovery Action Planning (WRAP), emotional CPR, ethics, grief and loss, art and skill of facilitating effective groups, smoking cessation, motivational interviewing, Whole Health Action Management (WHAM), trauma informed care, housing outreach, and development and forensic peer support. Training is focused on developing recovery cultures and practices statewide.

Expansion with a former BRSS TACS grant to train individuals in prisons across the state as a peer support specialist and/or peer recovery coach has resulted in 94 individuals receiving certification. Michigan Department of Corrections has sustained and expanded the project.

Additional continuing education training is provided to assist with re-entry into communities as returning citizens and to provide job opportunities as peers.

Consumer/Peer-Run Services and Advocacy

MDHHS provides funding to Justice in Mental Health Organization (JIMHO), which is a 100% consumer-run agency established to provide peer review services and peer technical assistance to forty-eight 501(c)3 peer-run drop-in centers in the State of Michigan. JIMHO provides support and technical assistance to peer-run organizations in the areas of start-up, board development, legal paperwork, financial management, relationships with CMHSPs, and ongoing operations of a peer-run organization. JIMHO also provides technical assistance to individuals, peer-run organizations, and CMHSPs in the area of self-help support groups and support group facilitation.

As a portion of the Peer-Review process, JIMHO monitors the quality, appropriateness, and efficacy of drop-in centers in Michigan. They accomplish this through on-site visits, communication with both the organization and funding agencies, and providing close oversight of operations. Included is also training for Medicaid certification and billing under the requirements of the Michigan Medicaid Manual.

Integrated Physical & Behavioral Health

MDHHS continues to fund efforts to better integrate mental health and substance use disorder treatment services with physical health services. This occurs in a variety of settings including Federally Qualified Health Centers (FQHCs), in primary care clinics, CMHSPs and other health care settings.

Each fiscal year, an increasing number of projects have requested and received funding for integrated health efforts. For FY 20, twenty-one projects received funding and for FY21, thirty-three projects are receiving funding for integrated health.

Activities funded include technology enhancements to the electronic health record and data analytics for population health, dedicated integrated health team staff such as nurse practitioners, peers as health coaches, and health navigators/care coordinators. Many of Michigan's Federally Recognized Native American Tribes have continued to request and receive funding for integrated health efforts to secure, enhance dedicated psychiatric services and clinical staff, assist with transportation, focus on the health and wellness needs of elderly members, and enhance health and wellness activities such as traditional healing.

Of note for FY20 is the significant amount of work achieved despite the pandemic. Projects adjusted to restrictions on face-to-face group activities and the shutdown of public transportation in some of the urban areas by transitioning to services provided virtually, or by email, text, and phone calls. As restrictions relaxed, most programs regained momentum even exceeding expectations, although some not at pre-pandemic levels but quite near to anticipated outcomes. Some of the outcomes achieved are:

- 21 projects served over 2,368 individuals.
- 15 of the 21 projects met or exceeded their goals and objectives.
- 7 projects reported significant improvement in health conditions.
- The Michigan tribes of Bay Mills Indian Community, LacVieux Desert Band of Lake Superior Chippewa Indians, Little River Band of Ottawa Indians saw reductions in no-show rates due to successful transition to audio/visual and safe transportation efforts.
- The Northern Lakes Community Mental Health Services Program (CMHSP) expanded access to care in three co-located clinics across Northern Michigan in Traverse City, Houghton Lake, and Grayling.

Data in the form of statistics and percentage measures are important reporting mechanisms to track program progress, however, it is also important to recognize that the individuals that we serve in Michigan, are the faces behind these statistics that represent these measures. Two PIHPs, Oakland Community Health Network and Ottawa CMH, provided specific examples of successful impact on individuals:

OCHN nurses supported an individual weekly to remind her to attend a therapy group session needed to complete for probation (due to her illness she is a bit forgetful), linked her to a vision plan and now she has glasses. The nurses also linked her to Meals on Wheels she continues to receive and a community dentist to work towards obtaining dentures.

It is anticipated that communities will continue to seek Mental Health Block Grant funding for new strategies or to enhance existing integrated health strategies.

In addition to, but separate from the block grant activities described above, integrated health efforts are enhanced by the MDHHS web-based tool, Care Connect 360, which continues to manage a joint care management process where the PIHPs and MHPs demonstrate that quarterly joint care plans exist for shared consumers that have been identified as receiving services from both entities. The tool generates a stratified list for each PIHP of consumers who in the past six months have had six or more ED visits, have four or more chronic conditions, and show lack of a primary care visit. From the list, the PIHP, MHP and CMHSP develop an interactive care plan with goals, objectives, and planned outcomes. Each entity has the ability to include real-time notes in the plans to track how cases are progressing. MDHHS randomly reviews existing care plans. On average, a joint care plan is open for about four months. Analysis of basic statistics for these plans indicate that major depression is most common at 58% among consumers with care plans and 52% are Bi-Polar. Although Care Connect 360 is not funded with block grant funds, it does provide Michigan's PIHP, CMH, and MHP users a tool to better coordinate services and complements existing integrated health care efforts to assist in improving health outcomes for Michigan's most vulnerable consumers.

Trauma-specific and Trauma-informed Services

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

The Trauma Subcommittee continues work to advance statewide development and implementation of trauma-informed and trauma-specific services. Efforts of this subcommittee (which reports up to the PISC) included facilitating statewide training to our behavioral health workforce and conducting a statewide needs-assessment survey to help inform training plans moving forward.

Trauma specific Evidence Based Practices have been included in this project and include Trauma Focused Cognitive Behavioral Therapy, Trauma Recovery and Empowerment (TREM), and MTREM), Seeking Safety, and Prolonged Exposure Therapy. Other Trauma specific treatment EBP's that have been utilized are Beyond Trauma and Healing Trauma.

An arm of the MIFAST has been developed to provide an ascertainment of the degree to which agencies have achieved implementation of Trauma Informed Care. A standardized tool for measuring the degree to which agencies provide trauma informed and trauma specific supports and series is used and a cadre of staff who are experts in Trauma-Informed Care provide on-site reviews, training, consultation, and coaching.

Goals for FY2-23 regarding Trauma include:

- Review and improve current modules and add at least 1 training module on www.improvingmipractices.org.
- Work on recruitment and retention of trauma trainers and members of the MIFAST team.
- Schedule at least 6 MIFAST visits each year.

- Provide regional and on-site trainings with emphasis technical assistance based on outcome of ascertainment visit through MIFAST.
- Provide a Trauma Summit annually.
- Train the Oakland County Cohort in Prolonged Exposure in 2021 and identify the next cohort for 2022.
- Support those trained in PE with ongoing technical assistance and provide at least two advanced trainings annually.
- On-going evaluation of other trauma-specific treatment to implement.

Other

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

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

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

Children with Serious Emotional Disturbance (SED)

The organization of Michigan's system of care (SOC) for children with SED includes many state and local agencies, advocacy groups, family members, and local providers of services. State agencies in Michigan area organized in such a way that each agency may provide multiple services. The Michigan Department of Health and Human Services (MDHHS) is responsible for public health and behavioral health services, medical and dental health services, Medicaid and Children's Special Health Care Services (Title V), employment and other disability related and state assistance programs. The Family Division of County Circuit Courts is responsible for juvenile court services. The state level policy direction to the local public mental health and substance use disorder service delivery system is provided by the Behavioral Health and Developmental Disabilities Administration which includes the Mental Health Services to Children and Families Division and Quality Management and Planning. The Michigan Department of Education (MDE) is responsible for educational services and the implementation of Parts B and C of the Individuals with Disabilities Education Act. The Michigan State Housing Development Authority, a division of the Department of Licensing and Regulatory Affairs, is responsible for housing services.

The array of Medicaid mental health specialty services and supports provided through PHIPs, under a 1115 capitated managed care authority 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 (mobile crisis response), 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 . Additional state plan services were added through the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for youth up to age 21. These additional specialty services and supports include community living supports, supports coordination, supported employment, family support and training, peer-directed services, skill-building, wraparound and prevention-direct parent education and services for children of adults with mental illness and infant and Early Childhood Mental Health Consultation.

PIHP/CMHSP providers are required to have the capacity to treat co-occurring disorders (COD) as well. Some PHIP/CMHSP's have specifically focused on the treatment of COD in youth and these include Oakland and Central Michigan. Oakland County PHIP has held training in Motivational Interviewing in order to increase engagement of families in treatment, as well as addressing the mental health and substance use issues of adolescents and family members. CMH for Central Michigan also includes a specific COD focus on children/adolescents to assist with meeting goals around reducing their substance use. Several other PHIP's use Multi-Systemic Therapy (MST) as a strategy for addressing COD's. MDHHS is sponsoring a Motivational Interviewing for adolescents training for CMHSP staff who serve youth and families using MHBG funding. Additionally, Michigan received a State Youth Treatment-Planning (SYT-P) grant in Fiscal Year 2015 to develop and expand the infrastructure for adolescent and transitional age youth treatment and recovery support services. Through the STY-P grant, an Interagency Council was formed, consisting of state agencies invested in the successful treatment of adolescents and transitional age youth. With the help of the Interagency Council and subcommittees, a financial map and strategic plan were developed to help identify gaps in funding and needed services and activities to support youth and families. In Fiscal Year 2017, Michigan received a Youth Treatment-Intervention (YT-I) grant to continue the work identified in the SYT-P grant in fiscal years 2018-2021. As a result, providers who serve adolescents and transitional age youth have received training and coaching in identified evidence-based practices such as Motivational Interviewing, Seeking Safety, Adolescent Community Reinforcement Approach (A-ACRA), and Trauma Informed Cognitive Behavioral Therapy (TF-CBT). A youth peer recovery coach curriculum was development, and training piloted in 2021. The grant has improved statewide knowledge of resources and available treatment for youth and families/caregivers impacted by SUD and co-occurring mental health issues.

Michigan continues to focus on increased interagency collaboration in the state which has contributed to a more comprehensive SOC for children with SED that will continue into FY22-23. In responding to Request for Proposals (RFP) for the children's portion of the federal mental health block grant for FY16, CMHSP's were asked to take the lead with their community stakeholders including the other agencies (child welfare, juvenile justice, education, etc.,) to propose projects in their RFP submissions that would provide mental health screening for youth involved in or at-risk for involvement in the juvenile justice system. This RFP was offered again in FY18 and additional sites were added. These projects are ongoing.

However, many barriers remain in the development of a statewide comprehensive SOC and access to mental health services for children who need them, Human service agencies recognize that they need to continue to explore ways to reduce the duplication of services and maximize the use of funds.

Historically in Michigan and currently, efforts have been made to move children into communities from more restrictive out-of-home placement, while still providing beneficial and helpful treatment interventions. This movement has continued and will continue to be supported with mental health block grant funding. The development and implementation of intensive community-based services has been crucial to moving children into the least restrictive environment without compromising treatment effectiveness. Mental Health Block Grant (MHBG) dollars were offered to CMHSP's in FY 18,19, 20 and 21 for startup of Intensive Crisis Stabilization Services (mobile crisis). These services are essential pieces of the continuum of service for children with SED and providers continue to work on establishing and supporting these services in sufficient capacity. A major part of Michigan's transformation plan has been the incorporation of family-driven and youth-guided practice, which has led to increased consumer choice and treatment interventions that are designed as the child and family desires. MDHHS has

previously supplied the SAMHSA Mental Health Block Grant application with a copy of the Family-Driven and Youth-Guided Policy and Practice Guidelines document that is an attachment to all PHIP/CMHSP contracts with MDHHS that requires provides to utilize a family-driven, youth-guided approach to services provided in the public mental health system. This guidance has been updated recently and also includes application to persons 18-21 years of age.

MDHHS is continuing to pilot the evidence-based practice of Treatment Foster Care – Oregon in four communities. The hope is that these type of approaches will provide additional options for children requiring out-of-home care to receive appropriate mental health treatment and return to their communities as soon as possible.

Michigan has also successfully utilized the 10% set-aside for the First Episode Psychosis services for young adults. There are four pilot sites in Michigan. These sites using the NAVIGATE approach from the RAISE model, which began serving people in FY 15 will continue into FY22-23 if funding continues from SAMHSA for this purpose, as proposed. This is another way Michigan is attempting to utilize community-bases services and supports to maintain youth with SED and young adults with SMI in their homes and communities.

MDHHS has been a leader in increasing collaboration with other state agencies, local communities and families. MDHHS participates in many interagency groups and emphasizes collaboration for children's services. Through these groups, the SOC has improved through the elimination of duplicative efforts and new projects being planned with joint efforts in development, implementation and evaluation of services. Michigan has been awarded several collaborative federal grants in which MDHHS is a partner including the Project AWARE SEA and, in its third year of funding, the HRSA Pediatric Mental Health Care Access grant (Michigan Child Collaborative Care-Connect), and the SAMHSA Health Transitions grant. Michigan is their third year of funding of the Health Transitions Grant, which is a partnership between MDHHS and SAMHSA, with a focus on improving access to treatment and support services for youth and young adults aged 16-25, who have SED or SMI. The Health Transition Grant focuses on the implementation of the Transition to Independence Process (TIP) within two pilot sites. Michigan continues to work towards improving best practices that meet the unique needs of youth and young adults using MHBG dollars. In FY20 and 21, MDHHS partnered with the Star Academy to introduce the TIP through two separate virtual community orientation trainings. Michigan has also trained one CMHSP in TIP and are working with other sites to determine their level of readiness to add a program that helps bridge the gap between child and adult mental health systems by increasing access to services to young adults.

Fidelity data will be reviewed to determine if certain wraparound practices and services are leading to improved outcomes. Michigan has achieved some success in creating the foundation for a statewide SOC for children with SED. All public mental health providers in Michigan utilize a standard definition of SED and uniform access standards, as outlined in an attachment to the MDHHS contract with the PHIP's and with the CMHSP's. Standardized validated and reliable outcome measures, the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges 1998)[1] for youth ages 7-17 and its counterpart for children ages 3-7 the Preschool Early Childhood Functional Assessment (PECFAS) (Hodges, 1994)[2] are used to assess treatment effectiveness for all children served in the public mental health system. With regard to MDHHS monitoring the effectiveness of public mental health services to children and youth with SED, MDHHS contracts with Michigan State University (MSU) to procure the services of Dr. Jon Carlson and student assistants required to produce the Level of Functioning (LOF) Project, which evaluates the functional assessment data collected on every child with SED served by the public mental health system. MSU LOF Project Staff works collaboratively with Multi-Health Systems (MHS), the purveyor of the CAFAS and PECFAS tools, to obtain information entered into the FAS Outcomes system by direct service providers who serve children with SED. This information is analyzed and used to generate reports that demonstrate the amount of improvement in functioning of children with SED served that has occurred under several pre-determined conditions. Special attention is given to analysis to the variables associated with positive outcomes as measured by both initial (from previous fiscal years) and most recent/exit CAFAS and PECFAS ratings. For those receiving evidence-based practices (EBP's), scores prior to receiving those services will be used to

reflect the potential improvements result from the EBP. Reports are shared with CMHSP's/PHIP's annually to utilize in children's mental health services quality improvement activities. MDHHS continues to utilize block grant funds to support implementation of evidence-based practices Parent Management Training-Oregon Model (PMTO) (Bank, Rains, & Forgatch, 2004; Forgatch 1994)[3], Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Cohen, Mannarino, Deblinger, 2006.)[4]

[1] Hodges, K. (1989). Child and Adolescent Functional Assessment Scale. Ypsilanti, MI: Eastern Michigan University.
[2] Hodges, K. The Preschool and Early Childhood Functional Assessment Scale. Ypsilanti, MI: Eastern Michigan University, Department of Psychology: 1994a.
[3] Bank, N., Rains, L., & Forgatch, M.S.(2004). A course in the basic PMTO model: Workshops 1-3. Unpublished Manuscript, Eugene: Oregon Social Learning Center,: FOrgatch, M.S. (1994). Parenting through change A training manual. Eugene: Oregon Social Learning Center
[4] Cohen, J., Mannarino, A., Deblinger, E. (2006) Treating Trauma and Traumatic Grief in Children and Adolescents. London and New York; The Guilford Press

In FY 20, the SOC planning process was formally incorporated into the public mental health system through the Program Policy Guidelines (PPG's) through which the MDHHS required CMHSP's to provide an assessment of their local SOC and how they plan

to move forward to improve outcomes for children with SED and their families and children with intellectual and developmental disabilities and their families. MDHHS continues to work individually with PIHP's to provide technical assistance regarding progressing to more comprehensive SOCs. CMHSP's were also required to utilize a SOC planning to prepare their applications for funding through the children's portion of MHBG and/or in implementing the 1915 (c) waiver for children with SED (SEDW). MDHHS has been particularly interested in increasing access to specialty mental health services and supports for Medicaid eligible children/youth with SED in child welfare (i.e., abuse/neglect, foster care and/or adopted children/youth) and juvenile justice. As an example of this, MDHHS provides an incentive payment so PHIPs/CMHSP's who serve children involved in various levels of child welfare services to encourage access to the public mental health system for those children.

At the community level, interagency administrative groups serve to assure interagency planning and coordination. Of these various local committees, the most prevalent group is the Community Collaborative. Community Collaboratives, which can function to facilitate planning and development of children's services in communities around the state, are comprised of local public agency directors (public health, community mental health, child welfare, juvenile justice and substance abuse agencies), family court judges, prosecutors, families and sometimes a youth, private agencies and community representatives.

Key components of SOC (family-driven and youth-guided, cross system funding for services for child welfare, foster care children with SED, etc.) have been the focus of interagency planning at the state level for many years and great strides have been made in recent years. The official MDHHS policy guidance on Family-Driven and Youth-Guided Practice is utilized by PHIP/CMHSP providers to operationalize the concepts of family-driven and youth-guided service provision.

A statewide Parent Support Partner training curriculum was developed in a partnership between the statewide family organization and MDHHS, and training began in 2010 and will continue in FY22-23. MDHHS has also worked with youth and other stakeholders to develop a youth peer curriculum and training protocol for statewide implementation of youth peer support. This Medicaid covered service in Michigan, which is supported with training and technical assistance in partnership with the statewide family organization and will continue in FY22-23.

Another key component of SOC has become an important factor in being able to serve children who are not traditionally Medicaid eligible in the public mental health system is the expansion of the SED Wavier (SEDW) to all counties in Michigan. The SEDW provides access to SOC grantee sites to provide leadership in collaborative efforts to develop SOC in their communities and impact state level efforts. MDHHS staff have meetings with sites to discuss strategies, progress, outcomes and sustaining the gains made during the grant period. The lessons learned by these sites provide a wealth of knowledge about what has been successful and what has been challenging in implementing SOC at a local level. BHDDA partners closely with the Association for Children's Mental Health (ACMH) around activities that are outlined in their SAMHSA statewide family network grant and other activities.
MDHHS is also very interested in making sure that the community-based services and supports that are available in the public mental health system to serve children with SED are resulting in positive outcomes for these children and families. In addition to the LOF project mentioned above, MDHHS will continue to contract with MSU to procure the services of Dr John Carlson and student assistants required to evaluate particular approaches and services to ensure that public mental health services funded by all sources, are producing optimal results.

The following MHBG funded projects target specific approaches or services for evaluation:

- Children's Trauma Initiative – MDHHS and MSU - Outcome and fidelity information is collected and analyzed to determine the effectiveness of services being provided to children who have experienced trauma.
- Parent Support Partner – MDHHS, MSU, ACMH and direct Parent Support Partner (PSP) service provider. These agencies work together to collect and analyze online, real time information about provision of PSP service to parent participants receiving those services in the public mental health system.
- Wraparound – MDHHS, MSU and direct Wraparound service providers work together to determine and demonstrate the effectiveness and fidelity/acceptability of services.
- Children with SED and Neuro Developmental Disorders (NDD) Strategies – MDHHS, MSU – This project evaluates SED/NDD outcome and fidelity variables to measure outcomes and inform future treatment.
- Infant and Early Childhood Mental Health Consultation (IECMHC) – MDHHS, MSU This project evaluate the effectiveness of IECMHC intervention and assessment of program impact on children with SED.
- Infant Mental Health Home Visiting –MDHHS, MSU – Outcome and fidelity variables are collected and analyzed to determine intervention effectiveness with a special report on the use of tele-health approaches during the pandemic.
- Dialectical Behavioral Therapy for Adolescents (DBT-A) – MDHHS, MSU – Outcome and fidelity variables are analyzed to determine effectiveness of this evidence-based intervention.
- Motivational Interviewing for Adolescents (MI-A) – Client surveys, model fidelity checklists and pre and post-skill acquisition will be studied.

These evaluation project are for the betterment of the public mental health system for children and the good of the people of Michigan.

SUBSTANCE USE PREVENTION

Michigan Department of Health and Human Services (MDHHS) is responsible for health policy and management of the state's publicly funded health service systems. The Michigan Public Health Code, Public Act 368 of 1978 (as amended), Sections 6201 and 6203, establishes the state's single state authority (SSA) and its duties. The Office of Recovery Oriented Systems of Care (OROSC) functions as the SSA within MDHHS. Responsibilities include the administration of federal and state funding for substance abuse prevention, treatment, recovery, and gambling disorder. OROSC allocates Substance Abuse Block Grant (SABG) funding through 10 regional Prepaid Inpatient Health Plans (PIHPs), whose responsibilities include planning, administering, funding, and maintaining the provision of substance use disorder prevention, treatment, and recovery services for 83 counties in Michigan. All PIHPs have Substance Use Directors and Prevention Coordinators (PCs), who receive input from and empower local communities in their response to Substance Use Disorder (SUD) prevention needs. PIHPs contract with local prevention coalitions and providers to implement the specific prevention activities in the target communities in their respective regions.

In addition, OROSC allocates funding to Prevention Michigan, Inc., a statewide prevention organization, for coordination of three vital prevention programs. 1. The Michigan Higher Education Network provides colleges and universities the tools, resources, and support to launch alcohol and drug misuse prevention and recovery programs on campuses. 2. The mission of the Michigan Coalition to Reduce Underage Drinking is to provide leadership on state and national issues and to assist individuals, grassroots groups, and organizations to reduce underage drinking locally. 3. Parenting Awareness Michigan celebrates people raising children and promotes year-round education and resources for parents and caregivers. Its mission is to promote parenting awareness, education, and resources through state outreach and local effort.

Overall, a sound-functioning and well-organized community prevention infrastructure exists in Michigan. PIHPs are contractually required to submit multi-year strategic plan to OROSC, which addresses identified priority problems, and target specific interventions related to the appropriate intervening variables. These prevention strategies illustrate evidence of the five step Strategic Prevention Framework planning process by utilizing local community coalitions, prevention providers, key

stakeholders, parents, and youth as part of this ongoing planning process. The PIHPs must complete a comprehensive strategic plan, based on this data-driven planning model process, and complete a planning chart using a logic model approach with their submission. In addition, PIHPs are required to address leveraging and aligning with other resources to address prevention in their communities as part of their plans.

In alignment with SAMHSA's Strategic Plan FY2019 – FY2023, Priority 1: Combating the Opioid Crisis through the Expansion of Prevention, Treatment, and Recovery Support Systems and Priority 3: Advancing Prevention, Treatment, and Recovery Support Services for Substance Use, OROSC's approach to prevention aligns with the following objectives: 1.3: Improve access to, utilization of, and engagement and retention in prevention, treatment, and recovery support services; 1.4: Target the availability and distribution of overdose-reversing drugs; 3.1: Increase public awareness and subsequent behavior change regarding the risks of substance use with a focus on alcohol, marijuana, and stimulants; 3.2 Expand community engagement around substance use prevention, treatment, and recovery; 3.3 Reduce youth substance use initiation through strengthening protective factors and reducing risk factors; and, 3.4 Support the identification and adoption of evidence-based practices, programs, and policies that prevent substance use, increase provision of substance use disorder treatment, and enable individuals to achieve long-term recovery. The overall purpose of OROSC's prevention efforts is to utilize both community and individual level interventions to address the prevention priorities - reducing underage drinking and marijuana use among persons aged 12-20, prescription drug misuse and abuse and heroin use among persons aged 12-25, and youth tobacco use - by building upon and enhancing the current community substance abuse prevention infrastructure and capacity at the PIHP regional level by strengthening collaboration and partnerships with a focus on primary care providers, local intermediate school districts and school health centers and the communities they serve. In addition, there is an emphasis on prevention with older adults ages 55+.

For a substantial period, OROSC has been awarded multiple discretionary grants specific to substance abuse prevention, most recently the Partnership for Success 2015-2020 grant, the State Targeted Response to the Opioid Crisis Grant and State Opioid Response Grants. Deliverables from these awards have had and will continue to have a cumulative effect and strengthened our infrastructure systemically to foster the use of a data-driven planning process lead by the continued work of the SEOW, expanded the use of evidence-based programs (EBPs), developed epidemiological profiles and logic models, and increased the capacity to address behavioral health conditions to support and improve the quality of life for citizens of Michigan.

As a mechanism to collaborate with Native American Tribes and communities in Michigan, the Michigan Inter-Tribal Council (ITC) has been a partner for SPF/SIG, SEOW and PFS II, PFS 2015-2020, STR/SOR Grant Projects as well as individual Federally Recognized Tribes through a variety of grants; and OROSC has supported substance use disorder training and technical assistance to tribes who offer prevention services. This relationship exemplifies an open-ended process and support system that addresses and responds to the substance abuse prevention related needs of tribes and tribal organizations in the state.

The required inclusion of government agencies and community stakeholders in previous discretionary grants has helped to facilitate the re-engineering of our prevention and treatment delivery system to a recovery-oriented system of care (ROSC) in Michigan. The ROSC Transformation Steering Committee (TSC), an advisory group to OROSC, has established several workgroups, one of which is the Prevention Workgroup (TSC-PW). Membership of this group includes PIHPs, substance abuse prevention coalitions, Department of Education, Children Services Agency, Michigan State Police/Office of Highway Safety Planning, Mental Health Services to Children and Families, Public Health Administration, faith-based agencies, providers, and administrators. The TSC-PW served as the advisory council for the PFS II and PFS 2015-2020 grant projects.

In addition, OROSC has established partnerships and collaborative initiatives with:

- MDHHS Pathways to Potential Program – OROSC encourages PIHPs to establish prevention programs in school districts with a Pathways to Potential program. Pathways is an innovative approach to providing human services that targets five

outcome areas: attendance, education, health, safety, and self-sufficiency.

- Michigan Department of Education – The Head Start Collaboration Office (HSCO) facilitates partnerships between Head Start agencies and other state entities that provide services to benefit children and their families identified as low-income. OROSC participates in the HSCO Opioid Misuse Prevention Team.
- MDHHS Mental Health Services to Children and Families – The Infant and Early Childhood Mental Health Consultation works with childcare providers and families to improve the social, emotional, and behavioral health of young children. OROSC facilitates connections with social/emotional consultants and local prevention coordinators.
- Michigan State Police, Office of Highway Safety Planning (OHSP) – OROSC staff serve on the OHSP Impaired Driving Action Team.
- OROSC's Youth Access to Tobacco Workgroup – The Michigan Office of the Attorney General, PIHPs, Community Coalitions, Prevention Providers, Midwest Independent Retailers Association, Michigan State Police and the Michigan Liquor Control Commission are represented on OROSC's Youth Access to Tobacco Workgroup to provide council and advice to the state strategic plan to reduce youth access to tobacco.
- MDHHS Tobacco Section – OROSC staff collaborates with the Tobacco Section on a behavioral health tobacco project. The project aims to reduce the rates of tobacco use by providing specialty training, capacity building, and strategic planning for community providers and partners to form a wellness committee and create an action plan.

Building on previous technical assistance the TSC-PW has continued to provide oversight and coordination of environmental scans to assess capacity and gaps. These environmental scans have helped develop the sustainability plan for prevention prepared communities, including the development of a comprehensive multi-year strategic plan targeted to underserved populations and emerging substance trends as well as enhancing workforce development and developing state policy to support needed service system improvements. In addition, OROSC will provide training and technical assistance to strengthen community coalitions.

Despite the solid infrastructure in place, there is the need to enhance and increase the capacity to implement, sustain and improve effective substance abuse prevention services to address underage drinking among persons aged 12 to 20 and prescription drug misuse and abuse and among persons aged 12 to 25. The following needs or capacity gaps have been identified by OROSC, the State Epidemiological Outcomes Workgroup (SEOW) and the TSC-PW:

· The lack of adequate data on specific demographic subsets of Michigan's population (e.g., Native Americans, Hispanics, Arab Americans, lesbian/gay/bisexual/transgender, etc.). Since significant differences on alcohol, tobacco and other drug (ATOD) rates and consequences often exist between racial and cultural groups, it is important to improve the collection of this data for all Michigan ATOD indicators. Although progress has been made in recent years, there is room for continued improvement. Currently, MiBRFS estimates for chronic health conditions, risk factors, health indicators, and preventive health practices by race and ethnicity are available at www.michigan.gov/bfrs. In addition, ATOD rates by sexual orientation are being monitored using MiBRFS and MiYRBS.

· Limited data being collected on specific drugs (e.g., methamphetamine, prescription and over-the-counter drugs, etc.) or other specific variables that may be correlated (e.g., the link between child health and maternal alcohol consumption related to fetal alcohol spectrum disorders or potential mental health indicators, the link between substance use/abuse and child abuse and neglect cases, etc.). Regarding prescription drug use among youth, MiYRBS is tracking lifetime prescription drug use without a prescription and past 30-day painkiller use without a prescription of high school students. Michigan Profile of Healthy Youth (MiPHY) is tracking past 30-day prescription drug use without a prescription and past 30-day painkiller use without a prescription of high school students.

- Local level risk and protective factor data related to family, school, community, and individual domains, as well as among specific populations (e.g., college students, adjudicated youth, the elderly, etc.). To better understand about

young adults' substance use behavior, Michigan Young Adult Survey (targeting aged 18 to 25) has been implemented to examine substance use behaviors including some risk factors.

- To respond to the public's needs on accessing near real-time data on opioid issues, a data dashboard has been developed and launched by Michigan Overdose Data to Action team, funded by the Center for Disease Control. The dashboard holds information including provisional overdose deaths, overdose Emergency Department (ED) visits, opioid prescription, publicly funded substance use treatment, https://www.michigan.gov/opioids/0,9238,7-377-94655--,00.html. For overdose deaths and overdose ED visits, the data can be viewed by race, ethnicity, sex and age group as well as by local regions (i.e., PIHPs) and county.
- Increase use of the Michigan Prevention Data System (MPDS) to collect and process data among community coalitions. Although the MPDS is used for all PIHP direct-funded providers, coalitions who do not receive SABG funds are under no obligation to use this system; and most do not. As information sharing and dissemination, the annual summary of MPDS data have been shared with PIHPs.

INDIVIDUALS WITH SUBSTANCE USE DISORDERS (SUD)

The BHDDA currently allocates SABG funding through the 10 regional PIHPs, whose responsibilities include planning, administering, funding, and maintaining the provision of substance use disorder prevention, treatment, and recovery services for Michigan's 83 counties. The PIHPs are required to provide a full continuum of services: outpatient services (including intensive outpatient), residential services, medication-assisted treatment, case management, early intervention, peer coaching and recovery support, prevention, and integrated treatment for co-occurring mental health and substance use disorders.

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

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

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

Early Intervention Screening, Brief Intervention and Referral to Treatment (SBIRT), an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs will be further developed and implemented in Michigan as part of early identification efforts. Many components of SBIRT models are also applicable to prevention strategies that address Problem Identification and Referral. Community coalitions across the state continue to collaborate with primary care entities such as Federally Qualified Health Centers (FQHCs) and other primary care agencies,

such as hospitals, local public health departments (LPHDs) clinics and school-based health centers to employ SBIRT to individuals at risk for substance use disorders. These efforts have been expanded to include individuals in rural communities.

Treatment is intended to assist those individuals identified as having a substance use disorder diagnosis. Each regional PIHP utilizes an Access Management Process that acts as a gatekeeper to publicly funded services in their region. Through this process, individuals and their families are screened and referred to services at the appropriate level of care, and the provider of their choice. Just as the SSA maintains contracts with the regional PIHPs, the PIHPs maintain contracts with their provider panel for publicly funded services to ensure that policies and procedures are followed, and a full continuum of services is maintained statewide. Services vary by region and are frequently based on the identified needs of the region's population. Each region is required to maintain and adhere to a cultural competency plan that includes population demographics, hiring expectations and practices at the PIHP and provider level based on the demographics of the regional population, practices that are in place to ensure appropriate cultural training for staff and culturally appropriate resources for the individuals accessing services. The access process is the same for adults and adolescents, and an adolescent or parent would contact the PIHP or provider to initiate services for the adolescent.

Recovery Support Systems are a network of supports put into place to assist an individual in maintaining their recovery or sobriety. These supports can be in the form of, but not limited to, peer mentors, recovery coaches, aftercare programming, employment assistance, housing assistance, educational counseling, supportive housing, and a commitment to supporting an individual throughout their recovery journey. Recovery supports are organized at the regional level and vary by PIHP. Michigan has developed a Recovery Coach Technical Advisory for the SUD field and a Recovery Coach Curriculum has been developed for training and credentialing efforts statewide. Continuing education opportunities for peer recovery support specialists and coaches are currently being delivered.

An adolescent Recovery Coach Curriculum has been developed for youth peer coaches is in the process of being piloted and training will begin in 2022 to continue building the youth peer recovery workforce. The implementation of recovery coaches for adolescents is intended to provide increased supports in the home community after the formal treatment has been completed.

The adolescent population is currently underserved with respect to recovery supports, and OROSC will dedicate funds to expanding the recovery community, recovery high schools, peer services, and pro-social activities for this population. Adolescents have distinctly different needs than the adult population and the state intends to develop a Community Center model for young people, focused on helping to sustain recovery through education, skill building, recreation, and wellness. The Community Center will feature age and developmentally appropriate recovery support groups, links to resources, self-care and social skills development, and family engagement events.

Recovery community grants include the development of Recovery Community Organizations (RCO) to expand the availability of recovery support services in underserved regions of the state. Many programs have expressed an interest in becoming an RCO, but lack the resources needed to further develop the infrastructure needed to become successful. The support will help legitimize their agency and enable them to contract for service delivery in their region. Additionally, OROSC will work with entities who are just beginning to establish themselves as recovery providers to develop the tools needed to apply for RCO status and assist them in connecting to funding opportunities at the federal, state, and local level for sustainability. In addition, the department will continue to support the recovery support services offered through existing RCOs.

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

Diverse racial and ethnic minorities: Through our contracts with PIHPs, we require the clinicians and staff reflect the population they serve. This builds rapport with the diverse racial and ethnic minorities they serve to ensure that they understand the specific and unique needs of that population. Implicit bias and diversity, equity and inclusion training is delivered state-wide to ensure services are culturally competent.

Members of religious minorities: Programs offer welcoming spaces to all religions; providing space and time to reflect and practice their religions. Faith-based conferences are offered yearly in specific PIHPs regions to embrace the diversity of religious beliefs across the populations they serve.

Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+): PFS grants support addressing health disparities in communities. This includes the development and institution of programming to address alcohol use and prescription drug misuse among the LGBTQ+ population. Gender-competent training is offered on an on-going basis to all providers to increase their knowledge of the specific needs of this population, best practices and to decrease the stigma and bias associated with this population. Policies are reflective of pronoun diversity and inclusion of individuals who are non-binary or do not identify with their gender assigned at birth. Michigan is supporting the development of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) recovery homes in an effort to more adequately provide safe housing for this disparity population. OROSC continues to provide technical assistance and training for SUD treatment to enhance service delivery to the LGBTQ+ community. Ongoing identification of targeted prevention services specific to the population are implemented in communities.

Persons with disabilities: In accordance with the ADA, all residential services are ADA compliant. All written materials distributed and produced by MDHHS are required to be ADA compliant to make accessible to all individuals. All service providers are required to provide interpretation services, including ASL, to individuals in their programs. Michigan has a provider that specializes in the deaf and hard of hearing population throughout the continuum of care.

Persons who live in rural areas: In our most rural counties, using Medicaid funding, Michigan developed Opioid Health Homes (OHH) which provide coordinated health care, treatment and recovery services. OHH have expanded to other communities as well, increasing access and continuity of care. Telehealth efforts and mobile units have been deployed with an emphasis on addressing behavioral health needs with individuals in our rural regions. Multiple regions are in planning stages for implementing telehealth hubs to decrease the impact of transportation issues, lack of broadband internet capability in rural households, and scarcity of providers in rural areas. Clinicians in rural areas have an increased availability to attend trainings as they have moved online due to the public health crisis. Prevention providers continue to use virtual means to engage.

Persons experiencing homelessness: Prevention providers offer individual and family education programs in homeless shelters and partner with school districts to offer support programs for students identified as displaced or homeless. Recovery coaches and outreach workers spend time in communities connecting with individuals experiencing homelessness and encouraging engagement in behavioral health services if appropriate. In addition, individual treatment plans address housing needs of those seeking behavioral health services. Mobile care units have been deployed to help serve this vulnerable population. They provide connections to SUD services, distribute naloxone, have peer recovery coaches available to connect with those interested, as well as hand out donated personal care items and food. Many provider agencies employ street outreach workers, or also function as shelters and this ensures the population is not overlooked.

Persons otherwise adversely affected by poverty or inequality: Our tribal members are significantly impacted by poverty. OHH began in rural areas and are spreading to more urban regions who are impoverished. Rural populations historically have had a lack of access higher education opportunities, geographical access to high-paying trade jobs as well as a high migrant population. Prevention programming services are being provided to economically disadvantaged family and individuals offered across the state. Financial needs are assessed during ASAM placement and addressed in treatment plans. Treatment and

prevention providers make referrals to other services to address housing, employment, education, transportation, food insecurity, and childcare needs.

SABG Priority Populations

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

Persons who inject drugs (PWIDs): All individuals who are intravenous drug users are considered a priority population in Michigan, with pregnant women who are IDUs being admitted first to treatment. Individuals who are IDUs are offered both drug free and medication assisted treatment (MAT) by the access management process. Many choose MAT, and this can result in wait times, depending on what is available in their region, how far they can travel, and their financial situation. Individuals placed on the waiting list for MAT are offered interim services, as well as services at a lower level of care to keep them engaged while they wait for the opportunity to attend the service of their choice. Michigan has benefitted from the implementation of OHH in multiple PIHP regions across the state. The OHH model helps maintain beneficiary contact, with an emphasis on in-person contact, manages integrated primary and specialty medical services, behavioral health services, physical health services, and social, educational, vocational, housing, and community services and organization of all aspects of a beneficiary's care.

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

Individuals who need primary substance use prevention: Through the strategic plan development at state, tribal, regional, and local levels, communities and individuals in need of primary prevention services were identified. Problem identification and services were provided to address specific needs of universal, selective, and indicated populations.

Additional Populations

Adolescents with mental and substance use disorder: The majority of adolescent SUD programs in Michigan are considered co-occurring capable programs, as the population trends show that the majority of adolescents with a SUD also have a mental health concern. There are several residential programs in the state that offer services to the adolescent population, as well as numerous outpatient treatment centers. Children and youth who are at risk for mental, emotional, and behavioral disorders, including but not limited to addiction, conduct disorder and depression: This population is not served through the SUD treatment system, but can access prevention and mental health services.

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

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

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

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

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

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

Based on vulnerability needs assessments conducted by CDC and Michigan's own rendition, specific counties were identified as needing harm reduction programs. Part of the SSPs responsibilities include providing or partnering with appropriate entities to address communicable disease education and/or testing.

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system of care.
States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

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Footnotes:

ADULTS WITH SERIOUS MENTAL ILLNESS (SMI)

Michigan's estimated population was around 9,986,857 persons as reported by the July 1, 2019 United States Census Bureau. Of that number 78.5% were over the age of 18. Race and Hispanic origin are as follows: White alone (79.2%); Black or African American alone (14.1%); Asian alone (3.4%); two or more races (2.5%); and Hispanic or Latino (5.3%).

Per the 2019 National Survey on Drug Use and Health (NSDUH), 387,000 (5.0%) of Michigan's adult population are estimated to have serious mental illness, and there were 232,945 persons served through the Michigan mental health services system in FY 2019. According to the SAMHSA 2020 Mental Health National Outcome Measures (NOMS) Uniform Reporting System (URS) Report, Michigan's penetration rate per 1000 was 23.33, slightly lower than national rate of 24.58. Nearly 70.8% of these persons served met the federal definition of having a serious mental illness, also slightly below the US average of 71.6%. According to this same data set, 32.3% of adults served were individuals with a co-occurring MH/SUD disorder, significantly higher when compared to the national rate of 28%.

These figures suggest a significant gap between the prevalence of serious mental illness estimated in Michigan's population and the penetration of public sector mental health services. It is unlikely this difference of 154,055 individuals can be fully accounted for by being served in the private-sector, or via other systems. Improvement in identifying, engaging, and serving adults who may be in need of public sector mental health services in Michigan continues to be needed. This gap between prevalence and service penetration continues to support the global need for greater availability of and access to care for Michigan's adult serious mental health population. These are needs that block grant funding resources can assist in meeting.

Based on the NOMS URS, characteristics of adults served in Michigan show the largest age group is aged 25-44 (29.7%), with a 27.9 per 1000 population penetration rate. Across the nation, this is also the largest age group receiving services among adults (32%), with a slightly higher penetration rate of 29.8 per 1000. The next largest age group receiving services in Michigan are aged 45-64 (24.8%) with a 21.8 penetration rate, compared to national data showing 24% served with a 23.6 per 1000 penetration rate.

Other age demographics and percentage of Michigan adults served were age 18-20 (4.3%) with a penetration rate of 25.4; 21-24 (5.5%) with a penetration rate of 23.2; age 45-64 (24.8%) with a penetration rate of 21.8; 65-74 (3.7%) with a penetration rate of 8.3; and age 75 and over (.9%) with a penetration rate of 2.7. Michigan demographic percentages of adults served are lower in each age group when compared to the U.S. with the exception of age 45-64 (US 24 %).

Compared to the US, Michigan has a lower percentage of women receiving services than men at 44.3%; national percentage of 52%. Males receiving services in Michigan comprises 48.8%, compared to US at 47.5%. This could be indicative of the lower penetration rates in Michigan for women as compared to men. In Michigan, the penetration rate for women is 20.4, compared to the Midwest at 27.5 and the US at 25.2. The penetration rate for men in Michigan is 23.1, compared to the Midwest at 25.6 and the US at 23.7.

In terms of race, individuals who are white comprise 56.2% of persons served in Michigan as compared to the US at 59.3%, with the corresponding penetration rates of 16.6 in Michigan compared to 19.2 in the US. The next largest racial group receiving services is Black/African American at 21.9% in Michigan compared to 17.5% in the US. Michigan has a higher penetration rate of 36.2 per 1000, compared to the US at 33.3. Individuals identifying being Multi-racial comprise 10% of persons served with a penetration rate of 92.4 per 1000, compared to the US 2.7% of persons served (26.3 penetration rate). In Michigan, 5.7% of individuals receiving services identified Hispanic/Latino ethnicity, compared to 16.9% in the US, with penetration rates being higher in Michigan (25.3) versus the US (21.5). Race was not available for 10.8% of individuals receiving services in Michigan, compared to 17% in the US.

As previously noted, nearly 70.8% of adults served in Michigan met the federal definition of having a serious mental illness. In Michigan, slightly more women (50.1%) than men (49.9%) met this definition, which is similar to national figures of 52.9% women and 46.8% men.

Data supplied by SAMHSA's Uniform Reporting System – 2020 State Mental Health Measures report indicates that Michigan continues to lag behind the reported national average in the following areas of adult evidence-based practice (EBP) delivery: Family Psychoeducation (Michigan rate 0.1% compared to US rate 3.1%) and Integrated Dual Disorder Treatment (Michigan rate 1.3% compared to US rate 9.5%).

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

Michigan uses the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) and the Dual Diagnosis Capability in Addiction Treatment (DDCAT) to review program readiness and support the continued development and implementation of Dual Diagnosis Treatment services across the entire continuum of service type and intensity of need. Michigan utilizes a fidelity review support team to survey organizations and to offer ongoing technical assistance as the agencies seek to further develop their capacities to provide services. We further support co-occurring disorder treatment by providing Motivational Interviewing training that is specific to the working with the co-occurring disorder population. During the past year, changes have started to be made to more accurately reflect and account for co-occurring disorder services. We suspect partly why Michigan has lagged behind the national average for integrated dual disorder treatment is a coding/reporting issue. This is being addressed and should be reflected in FY21 data.

According to this same data source, Michigan is above the national average in terms of the evidence-based practices of Assertive Community Treatment (Michigan rate: 4.0%; national rate: 1.8%) and Supported Employment (Michigan rate: 3.9%; national rate 1.9%).

CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

According to 2019 US Census figures, Michigan has an estimated population of 9,986,857, with approximately 2,147,174 of those residents being children ages 0-17. Prevalence data supplied by the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2019 data suggests 6-13% of the 2,147,174 children from ages birth to 17 in Michigan could be identified as having a serious emotional disturbance (SED). That means anywhere from 128,830 to 279,133 children ages birth to 17 might have been eligible for services in the public mental health system in 2019 alone. However, data compiled by MDHHS for FY20 indicates 39,929 children (ages birth through 17) or 49,568 (ages birth through 21) with SED were served in the public mental health system in Michigan. Improvement in identifying and engaging children who may be in need of mental health services in Michigan is needed.

In May 2021, there were 10,497 children in out of home care. Data reported on the National Center for Children in Poverty website (http://www.nccp.org/publications/pub_878.html) indicates untreated mental health problems among adolescents often result in negative outcomes. Mental health problems may lead to poor school performance, school dropout, strained family relationships, involvement with the child welfare or juvenile justice systems, substance abuse, and engaging in risky sexual behavior.

Nationally, up to 50% of children in the child welfare system have mental health problems and 67 to 70% of youth in the juvenile justice system have a diagnosable mental health disorder. Finally, 70% of children and youth with mental health

problems do not receive needed services nationwide. When considering this national data, it is clear that a significant percentage of the children and youth represented in the Michigan education, child welfare and juvenile justice statistics have SED and are not receiving needed services.

Michigan's fiscal climate has shown some improvement in the last few years. According to the State of Michigan the unemployment rate in Michigan was 4.2% in May 2019 which was much better than previous years but remained 0.6% above the national average of 3.6% for that same time. According to the Michigan League for Public Policy's 2019 Kids Count Data Book, (https://mlpp.org/kids-count/national/national-2019-data-book/) Michigan ranked 30th out of 50 states for economic well-being. In 2017, 20% of children in the state lived in a family with income below the poverty line. This is two percentage points above the national average for this same time period. Data reported in the MDHHS' Green Book Report of Key Statistics, May 2019 edition, indicates that 936,611 of Michigan's children were eligible for Medicaid in that month. In addition, Medicaid births in Michigan are now approximately 43% of all births in the state. According to the Child Trends Data Bank (http://www.childtrends.org/?indicators=children-in-poverty,) poverty is related to increased risks of negative health outcomes for young children and adolescents. When compared with all children, poor children are more likely to have poor health and chronic health conditions. As adolescents, poor youth are more likely to suffer from mental health problems, such as personality disorders and depression. Moreover, in comparison to all adolescents, those raised in poverty engage in higher rates of risky health-related behaviors, including smoking and early initiation of sexual activity. Poverty in childhood and adolescence is also associated with a higher risk for poorer cognitive and academic outcomes, lower school attendance, lower reading and math test scores, increased distractibility, and higher rates of grade failure and early high school dropout. Poor children are also more likely than other children to have externalizing and other behavior problems, or emotional problems, and are more likely to engage in delinquent behaviors during adolescence. Poverty continues to be a major issue for children in Michigan.

Although the economy in Michigan has rebounded, the economic downturn in Michigan resulted in fewer resources for all child-serving systems during that time and the funding and support for such resources has not bounced back. This is unfortunate but helped to create an environment where the former MDCH and MDHS (now MDHHS) were open to collaborating and matching funds which resulted in the SEDW pilot expanded statewide. The project has helped the child welfare system to realize that the expertise of the mental health system may assist them in their vision of better outcomes for children. It also has helped the mental health system develop a sense of responsibility for children that are in the child welfare system. There are opportunities to improve fiscal efficiencies and to re-direct dollars from ineffective, costly out-of-home models into effective community-based models inherent in this partnership. The MDHHS SEDW Program expanded statewide in FY20 and continue to achieve strong outcomes for children and families in the community.

There continues to be a need to focus on strengthening the system of care by improving treatment outcomes for children and youth with SED and their families as well as enhancing partnerships that exist to serve children and youth with SED and their families, including traditionally underserved populations, using block grant funds and other resources; that reduce duplication of efforts.

ADULTS AND CHILDREN WITH SUBSTANCE USE DISORDERS

Implemented as part of the Strategic Prevention Framework/State Incentive Grant (SPF/SIG), Michigan continues to maintain a functioning epidemiological workgroup. The State Epidemiological and Outcomes Workgroup (SEOW) is a standing workgroup under the auspices of the ROSC TSC.

The chairperson of the SEOW (or their designee) attends TSC meetings to not only provide input into the overall ROSC efforts from a SEOW perspective, but also to be available as a resource to the TSC if data needs are identified. Recommendations from

the SEOW will be made to the TSC, which in turn will make recommendations to OROSC for ultimate decisions. The project director for the SEOW is an OROSC staff member, as are the SEOW epidemiologist and the SEOW liaison.

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

The primary activities of the SEOW for FY22-23 will be to: 1) expand the scope of the SEOW to include treatment and recovery (not just prevention) and to include mental health disorder prevention and treatment, as well as mental health promotion; 2) continue to gather new data as it becomes available, particularly around prescription and over-the-counter drug abuse; 3) analyze data being gathered, and serve as a resource for both the state and local Community Epidemiology Workgroups (CEWs); 4) continue work on maintaining a web-based central data repository for Michigan that can be easily accessed and updated; and 5) evaluate and prioritize continued data gaps, and develop plans for filling these gaps.

The SEOW is chaired by the Prevention and Outreach Coordinator of Community Mental Health Authority of Clinton, Eaton, Ingham Counties (CMHA-CEI). Membership on the SEOW includes representatives of state-level department including Michigan State Police/Office of Highway Safety Planning, and various divisions and administrations within MDHHS including epidemiology, injury and violence prevention, mental health, and SUD treatment. In addition, regional prevention providers, and the Michigan Primary Care Association are represented on the SEOW. As of July, 2021, the following are SEOW members:

MEMBER NAME	ORGANIZATION	WORKGROUP AFFILIATION
Elizabeth Agius	Wayne State University	Member
Bret Bielawski	Internal Medicine	Consultant
Prashanti Boinapally	Michigan Primary Care Association	Member
Lisa Coleman	MDHHS/OROSC	Member
Joseph Coyle	MDHHS/Division of Communicable Disease	Member
Lindsay DeCamp	MDHHS/Division of Chronic Disease and Injury Control	Member
Mary Franks	MDHHS/Lifecourse Epidemiology & Genomics Division	Member

MEMBER NAME	ORGANIZATION	WORKGROUP AFFILIATION
Jane Goerge	Community Mental Health Partnership of Southeast Michigan	Member
Alicia Goodman	MDHHS/Division of Chronic Disease and Injury Control	Member
Denise Herbert	network180	Member
Brandon Hool	MDHHS/Division of Communicable Disease	Member
Joel Hoepfner	Community Mental Health Authority of Clinton, Eaton, and Ingham Counties	Member/Chairperson
Rachel Jantz	Kent County Health Department	Member
Scott Josephs	Michigan State Police	Member
Jeanne Kapenga	Physician	Member
Alia Lucas	MDHHS/OROSC	Member
Mary Ludtke	MDHHS/Mental Health	Member
Rob Lyerla	Western Michigan University	Member
Janelle Murray	Michigan Primary Care Association	Member
Su Min Oh	MDHHS/OROSC	Member/SEOW Epidemiologist/Staff Liaison
Logan O'Neill	MDHHS/OROSC	Member
Eva Petoskey	Anishnaabek Health Circle Access to Recovery Inter-Tribal Council of Michigan	Consultant
Dawn Radzioch	Macomb County CMH Services	Member
Rachel Rhodes	Oakland Community Health Network	Member
Brooke Rodriguez	Wayne State University	Member
Christy Sanborn	MSP/Office of Highway Safety Planning	Member

MEMBER NAME	ORGANIZATION	WORKGROUP AFFILIATION
Larry Scott	MDHHS/OROSC	Member/PFS 2015-2020 Project Director
Rita Seith	MDHHS/Bureau of Epidemiology and Population Health	Member
Angela Smith-Butterwick	MDHHS/OROSC	Member
Danielle Walsh	Region 10 Prepaid Inpatient Health Plan	Member
Brenda Stoneburner	MDHHS/Mental Health	Member
Gabrielle Stroh Steiner	MDHHS/Bureau of Epidemiology and Population Health	Member
Stephanie VanDerKooi	Lakeshore Regional Entity	Member
Jeff Wieferich	MDHHS/Bureau of Community Based Services	Consultant

Federal Priority and Other Populations:

Based on the data trends in Michigan's SUD systems, the following unmet service needs and critical gaps have been identified: Pregnant Women; Person Who Inject Drugs; Women with Dependent Children; Persons at Risk for Tuberculosis; and Individuals in Need of Primary Substance Use Prevention. Data sources utilized to gather these data trends include: SAMHSA's National Survey on Drug Use and Health (NSDUH); Behavioral Health Treatment Episode Data Set (BH-TEDS); the Behavioral Health Barometer; and state data (e.g., Youth Risk Behavior Survey, Behavioral Risk Factor Survey). These data also are being used for development of state epidemiological report that is distributed bi-annually.

Access to treatment for pregnant women, women with dependent children and pregnant women who inject drugs: NSDUH data from 2018-2019 indicate that 10,000 (0.4%) pregnant women had an opioid use disorder in the past year. The same data indicate that 13,000 (0.6%) among pregnant women misused pain relivers in the past month. In FY2020 there were 16,545 treatment admissions where the route of use was identified as injecting. This number includes primary, secondary and tertiary drugs of choice. Of that number, 6,616 (40%) were women, and 330 were pregnant at the time of admission. Michigan has a long-standing process in place to ensure treatment for pregnant and parenting women, and those who inject drugs. The women's treatment coordinator works with substance use disorder treatment providers regularly to identify those who can provide specialty services to the women and meet the requirements related to services for pregnant and parenting women. To that end, Michigan has more than 60 programs identified as gender specific for pregnant and parenting women with a substance use disorder. Treatment programs are trauma informed and trained in gender specific issues to best serve this population.

Persons who inject drugs: Currently, it takes about 10 days for individuals who inject drugs to access proper care in Michigan. As one travels north in Michigan, there is a significant decrease in the availability of qualified staff to provide services which impacts induction into MAT. This presents a significant challenge to securing and maintaining qualified staffing and providing

timely care. Increased coordination and integration of SSPs with OHHs and PIHP treatment services needs to be explored for barriers and expanded.

Ensure screening and referral to services for people at risk for TB and HIV: The Michigan Department of Health and Human Services (MDHHS) Communicable and Chronic Disease section indicates that there were 131 TB cases reported in 2019, an average of 1.3 cases per 100,000 people which is well below the national average. Michigan has experienced a decline in TB cases from 2015 through 2018, but in 2019, there was a 21% increase in the number of TB cases from 2018. MDHHS estimates that there were 1,605 HIV cases attributed to individuals who inject drugs in 2019. Individuals who inject drugs comprised 9.5% of persons living with HIV in Michigan. However, individuals who inject drugs were more likely to get tested earlier in the progression of HIV infection compared to others with HIV infection. Michigan maintains in contract with PIHPs and subsequently requires that all individuals entering SUD treatment must be screened for communicable disease risk at the time of assessment. If screening indicates an individual has an elevated risk, they are referred for additional testing and services. In addition, any individual who enters residential substance use disorder treatment in Michigan is tested for TB. These policies have been in place for many years and help contribute to decreasing rates in the population.

Individuals in Need of Primary Substance Use Prevention: Strategic plans have identified specific gaps in services and prevention practices, programs, and policies needed to address these gaps. One such population is older adults who are especially impacted by the isolation of the current COVID-19 restrictions, but frequently need assistance learning how to utilize technology available to them in order to participate in any type of virtual service. Michigan will partner with agencies serving older adults to initiate this technical assistance. Michigan's older adult strategic plan includes activities to address alcohol and opioid misuse and ensures professionals within systems are equipped to meet the needs of this population. OROSC plans to support and assist select communities with implementation of environmental prevention activities, including policy and behavior change activities to transform community, school, family and business norms through laws, policy and guidelines and enforcement. Furthermore, community settings for universal, selective, and indicated prevention interventions, including hard-to-reach communities and "late" adopters of prevention strategies will be targeted.

In addition to the above unmet service needs and critical gaps, based on data trends and changes occurring in Michigan, the following issues continue to be priorities: individuals of diverse racial and ethnic minorities (i.e., people of color and indigenous and Native American person, Asian Americans, and Pacific Islanders); members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

Individuals of diverse racial and ethnic minorities (i.e., people of color and indigenous and Native American person, Asian Americans and Pacific Islanders): Inclusion and integration of services to include culturally specific and inclusive care is a necessary and developing area of improvement. Recognition of implicit bias is instrumental in working on diversity, equity and inclusion in SUD practices. Training will reflect this need. In order to address health disparities and availability of access to services, OROSC will build on established research, expand relationships with community agencies across multiple counties who have a trusted, long-term presence in the African American community to overcome the spectrum of barriers to accessing behavioral health care in the community. This project is intended to build the foundation for implementation of community-informed solutions to the challenges and barriers the African American community faces when accessing behavioral health and SUD services. The ultimate goal being to reduce the disparity in access and service delivery.

Members of religious minorities: At this time, there are no known gaps in services. An assessment, including focus groups and surveys will be helpful to identify which religious minorities require more outreach and inclusion. Anchor institutions will be inclusive of religious organizations for religious minority populations and immigrant populations where this is their primary connection to social networks.

Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) persons: OROSC will identify current and improve on data collection among LGBTQ+ populations and evaluation of programs and practices targeted toward LGBTQ+ populations, as well as mainstream programs that serve LGBTQ+ clients. According to the Institute of Medicine (IOM) (2011), LGBTQ+ populations are at substantially greater risk for substance abuse and mental health problems. LGBTQ+ individuals are more likely to use alcohol and drugs, and to continue heavy drinking into later life. In addition, they are more likely to have higher rates of SUD. Gay men, lesbians and transgender females , as a population, use methamphetamine at a higher rate than the rest of the population. A multistate study of high school students found a greater likelihood of engagement in unhealthy risk behaviors such as tobacco use, alcohol and other drug use, suicidal behaviors and violence among LGBTQ+ students. OROSC has increased LGBTQ+ data sources by partnering with Michigan BRFSS for sexual orientation and gender identity data. There is a need and desire to improve data collection, as well as identify and implement evidence-based programs and practices to address this target population.

Persons with disabilities: PIHPs will be encouraged to build connections with anchor institutions to serve as a community resource in connecting health disparity populations and persons with disabilities to services that they may need and would be beneficial to them.

Persons who live in rural areas: Telehealth hubs are being created and established to provide an expansion of telehealth services in underserved rural communities. These will be delivered in community engagement centers to enhance many individuals' ability to access WiFi and technology. Michigan is dedicated to exploring solutions for those in need and will recruit partner agencies who can securely host telehealth outpatient services in communities where treatment services or access to reliable internet services do not exist. Community engagement center partner agencies include libraries with study rooms or office space, prevention agencies, law enforcement and schools.

Persons adversely affected by persistent poverty or inequality: Individuals with socioeconomical disadvantages are being assisted through prevention services to determine the community and neighborhood's gaps in service needs. Persons affected by persistent poverty and inequality through the social determinants of health, generational poverty and historical trauma will be connected to the PIHPs community-identified anchor institutions and serve them where they are while addressing the specific needs of these individuals.

Adolescents with mental and substance use disorders: There is no identified mechanism for conducting effective outreach to this population, direction for collaboration with referral sources, or linkage to resources. The state is engaged in improving the infrastructure for adolescent and young adult treatment, including: investing in training in evidence-based practices; a training curriculum for youth mentors/coaches has been completed and will be implemented in FY22; and supporting the development of a family/caregiver and youth network for those who enter treatment and their families. There is low usage of integrated treatment and recovery support services for this population. An integrated system of support and recovery services for youth and their families will increase their successful recovery potential. Historically only a small number of providers utilized recovery supports (approximately 4%) due to the majority of families not having access to services after formal treatment ends. Michigan is currently expanding the availability and amount of recovery support systems and collaborations as we acknowledge there is an increased need for adolescent providers across the spectrum of care. Residential services have decreased over the past four years with the trend continuing downward. Outpatient services are being utilized more, however, there is still a deficit of providers.

Adult-Use Marijuana: On November 6, 2018, Michigan voters approved Proposal 1, creating the Michigan Regulation and Taxation of Marihuana Act (MRTMA). This legislation allows personal possession and use of marijuana by persons 21 years of age or older as well as cultivation and sale of marijuana and industrial hemp by and to persons 21 years of age or older. Nationally, perceived risk of marijuana use among students in 8th, 10th, and 12th grades decreased since the mid-2000s. Fewer teens now believe using marijuana is harmful, but there is no significant increase in overall use. Coinciding with national

results, marijuana use in the last 30 days among high school students has been leveled, from 19.3% in 2015 to 21.6% in 2019 according to Michigan High School Youth Risk Behavior Survey. Laws legalizing recreational marijuana can lead to easier access of marijuana by children and youth. There is a need to keep marijuana out of hands of children and youth and implement strategies to prevent marijuana use among minors given current movement of legalized marijuana.

Increase in Prescription Opioid Use: As with other states, Michigan was the recipient of a substantial grant from SAMHSA to address Prescription and Illicit Opioid Use. Several evidence-based practices have been identified for prevention and treatment interventions, and training in these interventions will continue. Data from the death certificates file indicate that, from 2018 to 2019, overdose deaths involving heroin declined from 639 to 471 (rates from 6.6 to 4.8 per 100,000) and overdose deaths involving prescription opiate declined from 572 to 450 (rates from 5.7 to 4.5 per 100,000). Recent NSDUH surveys (2018-2019) reported that 0.3% (n=27,000) of Michigan residents, 12 or older, reported heroin use in the past year and 3.8% Michiganders 12 or older reported pain reliever misuse in the past year. Drawing upon the 2018-2019 NSDUH surveys, the estimated prevalence of illicit drug use disorder in the past year for Michigan was 2.8% among persons aged 12 or older.

Individuals who use alcohol under the age of 21: The Michigan Strategic Plan to Reduce Underage Drinking identified the gaps and needs in this area. OROSC is developing a process to collect pertinent data (e.g., Minors In Possession) for community utilization in strategic planning and targeting high risk areas.

Individuals who use tobacco: It has been identified that individuals with mental and substance use disorders use tobacco at a higher rate. OROSC is collaborating with MDHHS tobacco section to create a wellness committee around behavioral health and tobacco policies, practices, and programming.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Supported Employment

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

All individuals with mental illness supported by local community mental health programs have ready access to a currently, micro-certified Benefit to Work Coach.

Strategies to attain the goal:

Maintain at least one (1) well-trained, effective lead trainer to oversee current BTW Coach model and Dispelling Benefit Myths training events. Trainer to maintain needed training events annually to support network of trainers and basic data collection. Add a part-time assistant as the number of BTW Coaches excess 30 individuals.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Benefit to Work Coach model - Increase the number of micro-certified Benefits to Work Coaches

Baseline Measurement: 31 micro-certified Benefit to Work Coaches as of July 15, 2021

First-year target/outcome measurement: 35 micro-certified Benefit to Work Coaches as of July 15, 2022

Second-year target/outcome measurement: 39 micro-certified Benefit to Work Coaches as of July 15, 2023

Data Source:

Benefit to Work Coach report tracking by Benefit to Work Coach lead.

Description of Data:

Trainer to compile and maintain list of training events annually to support network of trainers as well as list of those effectively completing the training. Basic data collection to occur on quarterly basis.

Data issues/caveats that affect outcome measures:

None anticipated.

Indicator #: 2

Indicator: Benefit to Work Coach Model - Increase Dispelling Benefit Myths Training Attendance

Baseline Measurement: 480 people who attended the Dispelling Benefit Myths training over the last 12 months.

First-year target/outcome measurement: 500 people will attend Dispelling Benefit Myths training from July 1 – June 30, 2022

Second-year target/outcome measurement: 525 people will attend Dispelling Benefit Myths training from July 1 – June 30, 2023

Data Source:

Benefit to Work Coach report tracking by Benefit to Work Coach lead.

Description of Data:

Currently micro-certified Benefit to Work (BTW) Coaches report quarterly to BTW lead.

Data issues/caveats that affect outcome measures:

Competing priorities/training events.

Priority #: 2

Priority Area: Individual Placement & Support (IPS)

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Increase the number of individuals receiving high-fidelity IPS services across Michigan.

Strategies to attain the goal:

Require consistent quarterly data reporting and celebrate both objectives with recognition and a modest incentive.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the employment rate of individuals in the IPS model

Baseline Measurement: 41.4% as of FY21, 2nd Quarter (Jan-Mar)

First-year target/outcome measurement: 42%

Second-year target/outcome measurement: 43%

Data Source:

Recognized IPS Sites Quarterly Reporting for 2nd Quarter

Description of Data:

All currently recognized IPS Sites required to report 30 days following each quarter.

Data issues/caveats that affect outcome measures:

Economy, State employment rate, Medicaid funding

Indicator #: 2

Indicator: Increase the successful closure rate of individuals.

Baseline Measurement: 7.6% as of FY21, 2nd Quarter (Jan-Mar)

First-year target/outcome measurement: 8%

Second-year target/outcome measurement: 8.25%

Data Source:

Recognized IPS Sites Quarterly Reporting for 2nd Quarter

Description of Data:

All currently recognized IPS Sites required to report 30 days following each

Data issues/caveats that affect outcome measures:

Economy, State employment rate, Medicaid funding.

Priority #: 3

Priority Area: Veteran Navigator Increased Revenue/Cost Savings

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

To increase Federal funds coming into the State of Michigan through the Veterans Benefit Administration by $1 million each year.

Strategies to attain the goal:

Strategies to attain the objective: 1. Veteran Navigators will work collaboratively with the Veteran Service Officer to ensure that administrative processes are completed. 2. VSO should report back to Veteran Navigator on new or increased benefit percentages void of any PHI or PII. 3. Based on the percentages, the VBA has a percentage table that we use to translate percentages into funds.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Revenue increase/cost-savings

Baseline Measurement: 60 Veterans in 9 months with increases from 0-100% Service Connection - Based on FY21 budget and reporting

First-year target/outcome measurement: Federal Revenue based on VBA benefit increases of 20

Second-year target/outcome measurement: Federal Revenue based on VBA benefit increases of 40%

Data Source:

Veteran Navigator base information of number of Veterans they have personally connected with that have seen a significant increase in Service Connection not previously connected with VBA

Description of Data:

Service Connection increase through VBA

Data issues/caveats that affect outcome measures:

Economy, State employment rate, Medicaid funding

Priority #: 4

Priority Area: Veteran and Military Family Self-Advocacy Growth

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

To create an environment of self-advocacy for the Veteran and Military family members (VMFs)

Strategies to attain the goal:

Require consistent quarterly data reporting.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of those with increased self-advocacy

Baseline Measurement: New Indicator - 5 Survey Questions that will be used to provide clarity on outcomes of process

First-year target/outcome measurement: 10% increase from baseline of all VMFs engaged with WwW project will identify increased confidence in self advocacy.

Second-year target/outcome measurement: Additional 10% increase from previous year of all VMFs engaged with WwW project will identify increased confidence in self advocacy.

Data Source:

Veteran Navigator quarterly report submission

Description of Data:

At least one question will be included in Quarterly VN Report for individuals who had contact during the time period to self-identify response to increased confidence and self-advocacy.

Data issues/caveats that affect outcome measures:

None anticipated

Priority #: 5

Priority Area: Evidence -Based Practice Implementation

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase the impact of the Michigan Fidelity Assistance Support Team (MIFAST) implementation process on agency performance measures for Assertive Community Treatment / Integrated Dual Disorder Treatment (ACT/IDDT), Dialectical Behavior Therapy, Motivational Interviewing, and Trauma.

Strategies to attain the goal:

1. Develop survey for teams completing the MIFAST review process and/or receiving technical assistance to evaluate effectiveness of review and technical assistance.
2. Collect data from surveys and compile report identifying strengths and areas of improvement regarding MIFAST reviews and technical assistance.
3. Review fidelity assessment tools for each MIFAST team and make improvements as indicated.
4. Determine the impact of any subsequent reviews using aggregated data from previous reviews.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Develop, finalize, and implement survey that teams receiving a MIFAST visit and/or technical assistance will complete within 30 days of last contact.

Baseline Measurement: There is not currently any information.

First-year target/outcome measurement: Collect data from all surveys from MIFAST or technical assistance visits. Data will be aggregated in an excel document along with a summary report of the findings and recommendations.

Second-year target/outcome measurement: Collect data from all surveys from MIFAST or technical assistance visits. Data will be aggregated in an excel document with a summary report of the findings and recommendations. The data will be compared to the previous year findings and recommendations.

Data Source:

MIFAST or technical assistance visit surveys.

Description of Data:

Survey Data - Data will focus on areas identified in the survey.

Data issues/caveats that affect outcome measures:

The number of teams who have annual reviews and/or technical assistance may change by the end of the measurement due to staff, program, or funding changes.

Indicator #: 2

Indicator: Develop, finalize, and implement a MIFAST Motivational Interviewing Tool

Baseline Measurement: There is not currently a MIFAST Motivational Interviewing tool.

First-year target/outcome measurement: Develop and train the MIFAST team on the MIFAST Motivational Interviewing Tool.

Second-year target/outcome measurement: Complete at least 5 MIFAST visits and provide feedback to the teams using the MIFAST Motivational Interviewing Tool.

Data Source:

Scoring from the MIFAST Motivational Interviewing Tool

Description of Data:

Data will be presented in an excel template with the scoring from the MIFAST Motivational Interviewing Tool. Feedback will be given to teams utilizing the MIFAST Motivational Interviewing Tool. Aggregated scoring data from all reviews conducted will be presented in a table format.

Data issues/caveats that affect outcome measures:

The number of teams who have annual reviews and/or technical assistance may change by the end of the measurement due to staff, program, or funding changes.

Priority #: 6

Priority Area: Psychosocial Rehabilitation - Clubhouses

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase the average daily attendance for PSR services to pre-COVID 19 pandemic levels.

Strategies to attain the goal:

Compare pre-COVID numbers of average daily attendance to current average daily attendance. Reinstate pre-COVID average daily attendance by sampling four different clubhouses thought the state.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Daily attendance at four randomly selected Clubhouses will show increase to pre-COVID levels

Baseline Measurement: Attendance data from First Quarter, FY20 (last full quarter pre-COVID pandemic)

First-year target/outcome measurement: 50% increase in daily attendance from 10/1/21-9/30/22

Second-year target/outcome measurement: Additional 50% increase from first-year target in daily attendance from 10/1/22-9/3023

Data Source:

Clubhouse attendance reports

Description of Data:

All Clubhouses keep daily attendance logs for coding; information gathered for metric will be de-identified and cumulative

Data issues/caveats that affect outcome measures:

Staffing challenges across system; additional waves of COVID pandemic may continue to impact in FY22

Priority #: 7

Priority Area: Older Adults

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase the community awareness of persons successfully living with dementia to assist those newly diagnosed and their care partners to find support and information they need and to combat the tragedy narrative.

Strategies to attain the goal:

The Michigan Dementia Coalition will develop outreach to various agencies across the state on mission of group to seek increase in membership.
2. Survey will be developed and distributed to known agencies to gather information on services provided.
3. Attendance lists will be maintained for all events.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of active members (newly diagnosed persons with dementia) in Dementia Minds groups by 50%

Baseline Measurement: 8 Members per group

First-year target/outcome measurement: 12 active members (newly diagnosed persons with dementia)

Second-year target/outcome measurement: Missing

Data Source:

Attendance sheet from DM meetings and workgroups

Description of Data:

Each meeting (full group, workgroup, etc.) will gather information on attendance of participants.

Data issues/caveats that affect outcome measures:

None anticipated

Indicator #: 2

Indicator: Increase the number of active members (newly diagnosed persons with dementia) and their care partners in Dementia Minds by 50%

Baseline Measurement: 12 active members (newly diagnosed persons with dementia) and their care partners

First-year target/outcome measurement: 18 active members (newly diagnosed persons with dementia) and their care partners in Dementia Minds groups

Second-year target/outcome measurement: missing

Data Source:

Attendance sheets gathered from events

Description of Data:

Each Dementia Minds event will complete attendance sheet and participants asked to note their role (e.g., individual living with dementia, care partner of individual living with dementia, etc.); count of attendees will be made.

Data issues/caveats that affect outcome measures:

Some individuals may not be comfortable sharing their personal information/connection to the event.

Indicator #: 3

Indicator: Increase the number of professional participants in Dementia Mind events by 50%

Baseline Measurement: 100 Attendees

First-year target/outcome measurement: 150 attendees

Second-year target/outcome measurement: missing

Data Source:

Attendance sheets gathered from events.

Description of Data:

Each Dementia Minds event will complete attendance sheet and participants asked to note their role (e.g., professional); count of attendees will be made.

Data issues/caveats that affect outcome measures:

None anticipated

Priority #: 8

Priority Area: System of Care for Children/Youth with Serious Emotional Disturbance

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Treatment outcomes for children/youth with SED and their families who receive evidence-based practice will improve statewide.

Strategies to attain the goal:

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

2. Utilize block grant funding to support system improvement activities such as statewide evidence-based practice initiatives for children with SED, state supported training and technical assistance in screening and assessment, family-driven, youth-guided service provision and Parent peer support and youth peer support activities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: All children assessed with Devereux Early Childhood Assessment (DECA), PECFAS and CAFAS who received an evidence-based practice and have a statistically significant improvement in their assessed scores (pre-post service period).

Baseline Measurement: FY21—Baseline to be established

First-year target/outcome measurement: 50% of children assessed with have a statistically significant improvement in their assessed scores, pre-post during FY22, as evidenced by the DECA, PECFAS and CAFAS.

Second-year target/outcome measurement: 55% of children assessed with have a statistically significant improvement in their assessed scores, pre-post during FY23, as evidenced by the DECA, PECFAS and CAFAS.

Data Source:

John Carlson, PhD, and the Michigan Level of Functioning Project for CAFAS and PECFAS; Mary Mackrain (DECA Administrator for Michigan) for DECA

Description of Data:

Statewide aggregate DECA, PECFAS and CAFAS data will be used to establish a baseline (FY21) in the percentage of children/youth with statistically significant improvement. This specific indicator has not been tracked previously to show improvement in functioning for children/youth receiving evidence-based treatment(s).

Data issues/caveats that affect outcome measures:

The number of children/youth served in evidence based practice has been impacted by number of clinical staff providing the practice. The COVID pandemic has impacted the number of staff providing the evidence-based practice.

Indicator #: 2

Indicator: The number of clinical staff trained to provide evidence-based practice in the public mental health system (TFCBT, CPP, PMTO, PTC, MI-A, FMF, DBT-A, IECMHC, IMH-HV).

Baseline Measurement: 120--FY21

First-year target/outcome measurement: 125*in FY22

Second-year target/outcome measurement: 130*in FY23

Data Source:

Data will be obtained from each evidence-based practice trainings completed.
*NOTE: Due to workforce issues, the first year and second year targets maybe under baseline.

Description of Data:

The total number of clinical staff trained.

Data issues/caveats that affect outcome measures:

The number of clinical staff available to be trained the evidence-based practice models in each CMHSP has decreased during the pandemic.

Indicator #: 3

Indicator: Promote earlier and increased access to behavioral health services and supports to children and youth with SED that may be involved and/or introduced to the juvenile justice system for delinquency. Number of referrals received in FY22 and FY23 will surpass FY20 baseline.

Baseline Measurement: FY20 1373 referrals

First-year target/outcome measurement: 1399

Second-year target/outcome measurement: 1424

Data Source:

Mental Health Access and Juvenile Justice Diversion Project

Description of Data:

Total number of youth referred per fiscal year.

Data issues/caveats that affect outcome measures:

None

Priority #: 9

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

Priority Type: MHS

Population(s): SED

Goal of the priority area:

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

Strategies to attain the goal:

a) Engage system partners and stakeholders in the process of developing a statewide SOC.
b) Utilize block grant funding to support system improvement activities such as statewide PMTO and Trauma Informed initiative for children with SED. State supported training and technical assistance in screening and assessment, family driven and youth guided service provision and peer to peer parent and youth activities.
c) Utilize data to inform policy and program decision making and improvements

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of Parent Support Partner (PSP's) trained to work in the public mental health system will increase in FY 22 and again in FY23 from a baseline of number trained in 2021.

Baseline Measurement: 296

First-year target/outcome measurement: 305

Second-year target/outcome measurement: 315

Data Source:

Michigan Parent Support Partner Training Project

Description of Data:

Cumulative total number of PSP's trained

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: The number of Youth Peer Support Specialists (YPSS's) trained to work in the public mental health system will increase in FY22 and FY23 from a baseline of number trained in FY21

Baseline Measurement: 125

First-year target/outcome measurement: 130

Second-year target/outcome measurement: 135

Data Source:

Michigan Youth Peer Support Training Project

Description of Data:

Cumulative number of YPSS'

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: The number of children/youth with SED served in the public mental health system that receive Wraparound services will increase in FY22 and again in FY23

Baseline Measurement: 883

First-year target/outcome measurement: 900

Second-year target/outcome measurement: 950

Data Source:

MSU's REDCap Database

Description of Data:

Total number of children/youth served in Wraparound per fiscal year

Data issues/caveats that affect outcome measures:

None

Indicator #: 4

Indicator: The number of CMHSPs that will be implementing TFCO will increase in FY22 and again in FY23 from the current baseline.

Baseline Measurement: 4

First-year target/outcome measurement: 1

Second-year target/outcome measurement: 2

Data Source:

Michigan TFCO Project

Description of Data:

Cumulative number of TFCO sites per fiscal year

Data issues/caveats that affect outcome measures:

None

Indicator #: 5

Indicator: The number of CMHSPs that will be implementing the full Transition to Independence Process with youth and young adults will increase in FY21 and again in FY23 from the current baseline of three.

Baseline Measurement: 3

First-year target/outcome measurement: 5

Second-year target/outcome measurement: 7

Data Source:

Michigan TIP Project

Description of Data:

Cumulative number of TIP sites per fiscal year

Data issues/caveats that affect outcome measures:

None

Priority #: 10

Priority Area: Underage Drinking

Priority Type: SAP

Population(s): PP

Goal of the priority area:

To reduce childhood and underage drinking.

Strategies to attain the goal:

1. Strengthen multi-system collaboration at state, tribal, regional, and local levels to implement strategies identified in the Do Your Part Michigan Strategic Plan to Reduce Underage Drinking.
2. Reduce adult misuse of alcohol by engaging all segments of the community in establishing a recovery-oriented system of care and increase the use of brief intervention.
3. Engage parents and other adults in helping reduce underage drinking.
4. Increase public and provider risk communication regarding the dangers and consequences of underage drinking via the Do Your Part media campaign videos, website, and social media posts.
5. Continue to build and enhance community substance abuse prevention infrastructure and capacity by strengthening collaboration with primary care providers and other community organizations to implement screening, brief intervention, and referral (SBIR) to prevention services.
6. Encourage the use of Communities that Care, Community Trials, or other appropriate coalition models to address underage drinking in communities.

7. Support the use of appropriate evidence-based prevention education curriculums to address underage drinking risk and protective factors.
8. Support the coordination of a statewide underage drinking prevention coalition.
9. Support the coordination of the Michigan Higher Education Network to assist colleges and universities in programming that addresses underage drinking and alcohol misuse.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Alcohol use in past month among individuals aged 12 to 20

Baseline Measurement: 22.0% 2018/2019 NSDUH

First-year target/outcome measurement: 21.5%

Second-year target/outcome measurement: 21.0%

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

NSDUH is an annual survey of the U.S. civilian, noninstitutionalized population ages 12 years or older

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Binge alcohol use in past month among individuals aged 12 to 20

Baseline Measurement: 13.0% 2018/2019 NSDUH

First-year target/outcome measurement: 12.5%

Second-year target/outcome measurement: 12.0%

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

NSDUH is an annual survey of the U.S. civilian, noninstitutionalized population ages 12 years or older

Data issues/caveats that affect outcome measures:

None

Priority #: 11

Priority Area: Youth Access to Tobacco

Priority Type: SAP

Population(s): PP

Goal of the priority area:

To reduce underage access to tobacco, vapor, and alternative nicotine products through retail outlets.

Strategies to attain the goal:

1. Conduct Synar and non-Synar tobacco compliance checks to discourage sales to individuals under the age of 21 during annual Synar required inspection period and non-Synar regionally scheduled phases throughout the year.
2. Support provision of vertical driver's license education (promote "Read the Red" and MI Secretary of State awareness website) as part of tobacco vendor education sessions.
3. Encourage tobacco retailers to comply with Tobacco 21 through positive community recognition via mass media, trade magazine feature articles and

E-blast acknowledgments.
4. Encourage tobacco retailers to engage staff in merchant retailer education via OROSC's ImprovingMIPractices.org free online certificated training.
5. Provide birthdate and legal awareness (YTA) signage to all merchants on the state's tobacco Master Retail List.
6. Encourage participation in environmental efforts, such as "Kick Butts" annual smoking cessation day. Alliance with existing "Do Your Part" campaign using fact sheets, PowerPoints, and video resources for educators, merchants, parents along with research resources for youth.
7. Update the Strategic Tobacco Plan and strengthen multi-system collaboration at the state, tribal, regional, and local level to implement strategies identified during the planning process to address Tobacco 21 federal legislation.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Effect 10% tobacco retailers sell rate to individuals under the age of 21

Baseline Measurement: 15.1% retailer violation rate – SFY2020

First-year target/outcome measurement: 15.0% SFY 2021

Second-year target/outcome measurement: 14.0% SFY 2022

Data Source:

Annual Synar Survey

Description of Data:

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

Data issues/caveats that affect outcome measures:

None

Priority #: 12

Priority Area: Youth Use of Vaping Products

Priority Type: SAP

Population(s): PP

Goal of the priority area:

To reduce the use of Electronic Nicotine Delivery Devices (ENDS) among youth.

Strategies to attain the goal:

1. Develop and disseminate communication material regarding the risk and consequences of using vaping products to educate youth, parents, schools, higher education, the general public, etc.
2. Use of research-based practices and classroom curriculum to delay the initiation of ENDS use among children, youth, and young adults.
3. Encourage participation in environmental efforts, such as "Kick Butts" annual smoking cessation day. Alliance with existing "Do Your Part" campaign using fact sheets, PowerPoint and video resources by developing an attention getting website for educators, merchants, and parents along with research resources for youth.
4. Partner with the MDHHS Tobacco Section to provide ENDS train-the-trainer sessions for prevention professionals and other key stakeholders.
5. Support communities in conducting town hall meetings to disseminate information about ENDS products.
6. Update the Strategic Tobacco Plan and strengthen multi-system collaboration at the state, tribal, regional, and local level to implement strategies identified during the planning process.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Past 30-day electronic vapor products use

Baseline Measurement: 20.8% 2019 YRBSS

First-year target/outcome measurement: 20.5%

Second-year target/outcome measurement: 20.2%

Data Source:

Michigan Youth Risk Behavior Surveillance System (YRBSS)

Description of Data:

The national survey, conducted every two years by CDC, provides data representative of 9th through 12th grade students in public and private schools in the United States.

Data issues/caveats that affect outcome measures:

Data available in every two years.

Priority #: 13

Priority Area: Health Disparities

Priority Type: SAP

Population(s): Other (LGBTQ)

Goal of the priority area:

To decrease identified behavioral health disparities among LGBT youth and adults.

Strategies to attain the goal:

1. Review and share data from existing sources to gain additional knowledge on substance use and mental health issues among target population.
2. Provide funding to include question on sexual orientation on the BRFSS; identify other mechanisms to increase sources for data.
3. Disseminate LGBT materials and information to the statewide prevention provider network.
4. Evaluate effective evidence-based prevention programs and practices for this target population in anticipation of future pilot projects.
5. Identify training and TA needs to help prevention providers and coalitions address this population.
6. Support implementation of evidence-based prevention practices and programs to address behavioral health issues among LGBTQ population.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Tobacco use in past month among LGBT individuals aged 18 and older

Baseline Measurement: 21.3% use in last month 2018 BRFSS

First-year target/outcome measurement: 21.0%

Second-year target/outcome measurement: 20.7%

Data Source:

Michigan Behavioral Risk Factor Surveillance System (BRFSS

Description of Data:

BRFSS is an annual national health-related telephone survey.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Binge alcohol use in past month among LGBT persons aged 18 or older

Baseline Measurement: 20.9% 2018 BRFSS

First-year target/outcome measurement: 24.5%

Second-year target/outcome measurement: 24.0%

Data Source:

Michigan Behavioral Risk Factor Surveillance System (BRFSS)

Description of Data:

BRFSS is an annual national health-related telephone survey.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Tobacco products use in past month among LGBT high school students

Baseline Measurement: 31.5% 2019 YRBSS

First-year target/outcome measurement: 31.0%

Second-year target/outcome measurement: 30.5%

Data Source:

Michigan Youth Risk Behavior Surveillance System (YRBSS)

Description of Data:

The national survey, conducted every two years by CDC, provides data representative of 9th through 12th grade students in public and private schools in the United States.

Data issues/caveats that affect outcome measures:

Data are available in every two years.

Indicator #: 4

Indicator: Binge alcohol use in past month among LGBT high school students

Baseline Measurement: 14.8% 2019 YRBSS

First-year target/outcome measurement: 14.5%

Second-year target/outcome measurement: 14.0%

Data Source:

Michigan Youth Risk Behavior Surveillance System (YRBSS)

Description of Data:

The national survey, conducted every two years by CDC, provides data representative of 9th through 12th grade students in public and private schools in the United States.

Data issues/caveats that affect outcome measures:

Data are available in every two years

Priority #: 14

Priority Area: Marijuana Use

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Use among youth and young adults will decrease and perception of harm will increase.

Strategies to attain the goal:

1. Strengthen multi-system collaboration at the state, tribal, regional, and local level to implement strategies to prevent youth marijuana use identified in the MDHHS Marijuana Prevention Workgroup Strategic Plan.
2. Support the use of appropriate evidence-based prevention education curriculums to address cannabis use, consequences, and risk and protective factors.
3. Use fact sheets and infographics as a prevention tool to increase awareness of impact of marijuana use.
4. Continue to implement a statewide media campaign focusing on individuals 12-20 via traditional, digital, and social media.
5. Develop and maintain a resource website to house public health information regarding cannabis use health impact.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Perceived great risk of smoking marijuana once a month among 12 to 17 years old

Baseline Measurement: 20.3% 2018-2019 NSDUH

First-year target/outcome measurement: 20.8%

Second-year target/outcome measurement: 21.3%

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

NSDUH is an annual survey of the U.S. civilian, noninstitutionalized population ages 12 years or older

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Marijuana use in past month among 12 to 17 years old

Baseline Measurement: 7.4% 2018-2019 NSDUH

First-year target/outcome measurement: 7.0%

Second-year target/outcome measurement: 6.5%

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

NSDUH is an annual survey of the U.S. civilian, noninstitutionalized population ages 12 years or older

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Marijuana use in past month among 18 to 25 years old

Baseline Measurement: 29.3% 2018-2019 NSDUH

First-year target/outcome measurement: 29.0%

Second-year target/outcome measurement: 28.7%

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

NSDUH is an annual survey of the U.S. civilian, noninstitutionalized population ages 12 years or older

Data issues/caveats that affect outcome measures:

None

Priority #: 15

Priority Area: Opiate Use

Priority Type: SAP

Population(s): PP

Goal of the priority area:

To reduce non-medical use of prescription drugs.

Strategies to attain the goal:

1. Strengthen multi-system collaboration at state, tribal, regional, and community levels to address community identified concerns regarding the non-medical use of prescription drugs.
2. Develop leadership structure combining relevant agencies and organizations that oversee surveillance, intervention, education, and enforcement.
3. Update and promote the use of the statewide media campaign, Do your Part: Be the Solution to Prevent Prescription Drug Abuse, via website material, digital media, social media posts, etc.
4. Broaden the use of brief screenings in behavioral and primary health care settings.
5. Promote increased access to and use of prescription drug monitoring program.
6. Support implementation of activities identified in the Michigan Older Adult Wellbeing Initiative Strategic Plan: Focusing on Our Future around older adults (55+) and opioid issues / problem behaviors as well as relationship to alcohol.
7. Support implementation of prevention programs that address individual and family risk and protective factors related to the non-medical use of prescription drugs.
8. Develop and disseminate educational materials and science-based messaging to educate the public about not sharing medications, safe storage of medications, and safe disposal of

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Pain reliever misuse in past year among individuals aged 12 and older

Baseline Measurement: 3.8% 2018-2019 NSDUH

First-year target/outcome measurement: 3.5%

Second-year target/outcome measurement: 3.2%

Data Source:

National Survey on Drug Use and Health (NSDUH

Description of Data:

NSDUH is an annual survey of the U.S. civilian, non-institutionalized population ages 12 years or older

Data issues/caveats that affect outcome measures:

None

Priority #: 16

Priority Area: Tribal Partnership

Priority Type: SAP

Population(s): Other

Goal of the priority area:

To strengthen relationships with tribal organizations in order to build capacity for prevention practices, programs, and policies.

Strategies to attain the goal:

1. Offer training and technical assistance to tribes for development of tribal action plans.
2. Collaborate with tribes and PIHPs to provide culturally appropriate prevention services.
3. Offer a Native American Substance Abuse Prevention Skills Training course.
4. Identify and provide training on evidence-based practices and programs for Native American population.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of trainings and participating tribes.

Baseline Measurement: FY2021 – New indicator

First-year target/outcome measurement: FY2022 – 2 trainings, 4 tribes

Second-year target/outcome measurement: FY2023 – 4 trainings, 8 tribes

Data Source:

OROSC training log

Description of Data:

OROSC tracking of number of trainings and tribes participating

Data issues/caveats that affect outcome measures:

None

Priority #: 17

Priority Area: SAMHSA Established

Priority Type: SAT

Population(s): Other (Adolescents w/SA and/or MH)

Goal of the priority area:

To promote long term recovery beginning in adolescence

Strategies to attain the goal:

1.Youth community centers to promote substance free life choices and interact with other youth working towards same goal.
2. Youth peer curriculum – Work with a Youth Peer to support substance free choices.
3. After care counseling for a continued substance free life.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the percent of Adolescents receiving Recovery Support Services by 10%

Baseline Measurement: 5.23% of Adolescents received Recovery Support Services in FY2020

First-year target/outcome measurement: 5.5% of Adolescents receive Recovery Support Services

Second-year target/outcome measurement: 5.75% of Adolescents receive Recovery Support Services

Data Source:

Encounter data for youth ages 12-17 years old.

Description of Data:

Encounters will show the number of youth ages 12-17 who received an H0038 or a T1012 service. This will be used to show a rate, when

compared to the number of 12–17-year-old individuals receiving SUD services.

Data issues/caveats that affect outcome measures:

Relies on error-free reporting and correct identification of the population by age.

Priority #: 18

Priority Area: Increased Access to Extended Case Management

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Access to Enhanced Women's Specialty Services (EWSS) treatment will be increased for parents with dependent children

Strategies to attain the goal:

1. Outreach to individuals who did not report a substance free birth
2. Offer services to those with a substance exposed birth
3. Provide resources to all agencies for individuals who are pregnant to become familiar with EWSS and refer to EWSS when appropriate
4. Encourage the use of recovery support services to extend engagement and support retention following treatment

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of eligible individuals participating in EWSS services

Baseline Measurement: FY21 Baseline = 99 individuals participated in EWSS

First-year target/outcome measurement: FY22 Target = 103 individuals participating in EWSS

Second-year target/outcome measurement: FY23 Target = 107 individuals participating in EWSS

Data Source:

Regional annual admissions data

Description of Data:

PIHPs submit annual reports for WSS and EWSS

Data issues/caveats that affect outcome measures:

Self-report data regarding substance free births

Priority #: 19

Priority Area: Increase identification of individuals with co-occurring MH and SUD diagnosis

Priority Type: SAT

Population(s): Other (Persons with co-occurring disorders)

Goal of the priority area:

Increase the accuracy of identification of co-occurring disorders to ensure proper service delivery

Strategies to attain the goal:

1. Provide ASAM Continuum trainings to clinicians statewide
2. Promote accurate assessment of needs and delivery of services to meet those needs
3. Review clinical records to ensure accurate level of care, and service deliver is appropriate to identified need
4. Provide feedback and technical assistance to clinicians for continuous quality improvement

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Accuracy of identification of co-occurring disorders

Baseline Measurement: FY20 Baseline = Newly implemented 10/01/2021

First-year target/outcome measurement: FY22 Target = 70%

Second-year target/outcome measurement: FY23 Target = 75%

Data Source:

ASAM continuum/WITS reporting and annual clinical record reviews

Description of Data:

Assessment database connected to the PIHP EHRs and managed by FEI, Inc.

Data issues/caveats that affect outcome measures:

None; new contract requirement and 1115 waiver

Priority #: 20

Priority Area: Promote Healthy Births

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Promote the percentage of substance-free births

Strategies to attain the goal:

1. Increase outreach to pregnant individuals to increase the population's access to treatment.
2. Increase the number of medication assisted treatment providers in the state who treat pregnant individuals
3. Provide extended care management to pregnant individuals to provide support after the treatment episode in order to promote a healthy birth.
4. Promote recovery support services to extend engagement and support retention.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of reported drug free births

Baseline Measurement: 15.4% of births in FY20 were drug free

First-year target/outcome measurement: 16% of births are drug free in FY 2021

Second-year target/outcome measurement: 17% of births are drug free in FY 2022

Data Source:

Women's Specialty Services Report and BHTEDS

Description of Data:

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

Data issues/caveats that affect outcome measures:

Number of overall births in Michigan have been decreasing, which decreases the overall number of drug free births. The number of providers who prescribe MAT to pregnant individuals varies between PIHP regions thus limiting access to some individuals. An increase in the amount of MAT providers will increase access, decrease barriers to ongoing treatment and eventually increase the amount of substance free births. This measure must be tracked by hand and, if an individual leaves treatment unexpectedly, a program may never know if she has a healthy birth. MDHHS works diligently to ensure numbers are reported accurately and continues to encourage case

management and recovery supports for pregnant individuals as they exit formal treatment. MDHHS has piloted NAS projects in each PIHP region to help connect individuals with an opioid use disorder with all the services she and the baby need for a successful deliver and postpartum period, and this allows for better tracking of healthy pregnancies as well.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023.
ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (SABG)[b]
1. Substance Abuse Prevention[c] and Treatment	$84,085,550.00		$126,000,000.00	$31,913,052.00	$42,742,020.00	$0.00	$38,611,854.00		$0.00	$0.00
a. Pregnant Women and Women with Dependent Children[c]	$11,208,604.00				$25,937,525.00					
b. All Other	$72,876,946.00		$126,000,000.00	$31,913,052.00	$16,804,495.00		$38,611,854.00			
2. Primary Prevention[d]	$22,422,813.00		$0.00	$3,030,006.00	$2,685,200.00	$0.00	$11,300,000.00		$0.00	$0.00
a. Substance Abuse Primary Prevention	$22,422,813.00			$3,030,006.00	$2,685,200.00		$11,300,000.00			
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program/provider level) MHBG and SABG must be reported separately	$5,605,703.00				$2,000,000.00		$2,626,940.00			
10. Crisis Services (5 percent set-aside)										
11. Total	**$112,114,066.00**	**$0.00**	**$126,000,000.00**	**$34,943,058.00**	**$47,427,220.00**	**$0.00**	**$52,538,794.00**	**$0.00**	**$0.00**	**$0.00**

[a] The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

[c] Prevention other than primary prevention

[d] The 20 percent set aside funds in the SABG must be used for activities designed to prevent substance misuse.

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Footnotes:
Estimated expenditures are for the period 10/1/2021 - 9/30/2023 to coincide with State Fiscal Year.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023.
Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)	J. ARP Funds (MHBG)[b]
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention[e]										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[d]		$2,111,463.00						$2,426,582.00		
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital			$79,457,651.00		$497,454,420.00	$37,706,235.00	$46,783,672.00			
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care					$188,459.00					
9. Administration (excluding program/provider level)[f] MHBG and SABG must be reported separately		$1,055,731.00						$1,213,291.00		
10. Crisis Services (5 percent set-aside)[g]		$1,055,731.00						$1,213,291.00		
11. Total	**$0.00**	**$4,222,925.00**	**$79,457,651.00**	**$0.00**	**$497,642,879.00**	**$37,706,235.00**	**$46,783,672.00**	**$4,853,164.00**	**$0.00**	**$0.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025,** which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states

[d] Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

[e] While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

[f] Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

[g] Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	22,699	873
2. Women with Dependent Children	171,448	24,228
3. Individuals with a co-occurring M/SUD	196,200	32,689
4. Persons who inject drugs	156,536	14,794
5. Persons experiencing homelessness	9,315	15,745

Please provide an explanation for any data cells for which the state does not have a data source.

9,315 count are an average daily count for all persons homeless in Michigan. The Number in Treatment reporting homelessness is a yearly count. All other estimates use census data and NSDUH prevalence estimates to derive an estimate of need. The treatment counts are obtained via Michigan internal TEDS data collection system

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Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
1 . Substance Use Disorder Prevention and Treatment[3]	$42,043,638.00	$38,611,854.00	$36,149,529.00
2 . Primary Substance Use Disorder Prevention	$11,211,637.00	$11,300,000.00	$9,224,884.00
3 . Early Intervention Services for HIV[4]			
4 . Tuberculosis Services			
5 . Administration (SSA Level Only)	$2,802,909.00	$2,626,940.00	
6. Total	**$56,058,184.00**	**$52,538,794.00**	**$45,374,413.00**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant (SABG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

A		B		
Strategy	IOM Target	FFY 2022		
		SA Block Grant Award	COVID-19[1]	ARP[2]
1. Information Dissemination	Universal	$1,547,648	$1,537,341	$1,255,025
	Selective	$17,570	$10,977	$8,961
	Indicated	$3,300	$65,967	$53,853
	Unspecified			
	Total	**$1,568,518**	**$1,614,285**	**$1,317,839**
2. Education	Universal	$806,029	$827,995	$675,943
	Selective	$662,533	$552,034	$450,659
	Indicated	$99,958	$234,257	$191,238
	Unspecified			
	Total	**$1,568,520**	**$1,614,286**	**$1,317,840**
3. Alternatives	Universal	$947,450	$1,177,522	$961,284
	Selective	$509,895	$342,451	$279,564
	Indicated	$111,175	$94,313	$76,993
	Unspecified			
	Total	**$1,568,520**	**$1,614,286**	**$1,317,841**
4. Problem Identification and Referral	Universal	$285,788	$165,031	$134,725
	Selective	$934,941	$661,043	$539,650
	Indicated	$347,790	$788,212	$643,466
	Unspecified			
	Total	**$1,568,519**	**$1,614,286**	**$1,317,841**
	Universal	$1,560,478	$1,607,365	$1,312,191

	Selective	$6,804	$5,855	$4,780
5. Community-Based Process	Indicated	$1,238	$1,065	$870
	Unspecified			
	Total	**$1,568,520**	**$1,614,285**	**$1,317,841**
6. Environmental	Universal	$1,568,520	$1,614,286	$1,317,841
	Selective			
	Indicated			
	Unspecified			
	Total	**$1,568,520**	**$1,614,286**	**$1,317,841**
7. Section 1926 Tobacco	Universal	$1,568,520	$1,614,286	$1,317,841
	Selective			
	Indicated			
	Unspecified			
	Total	**$1,568,520**	**$1,614,286**	**$1,317,841**
8. Other	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$10,979,637**	**$11,300,000**	**$9,224,884**
Total SABG Award[3]		**$56,058,184**	**$52,538,794**	**$45,374,413**
Planned Primary Prevention Percentage		**56.20 %**	**59.96 %**	**69.43 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
Universal Direct	$3,167,764	$2,916,191	$2,380,666
Universal Indirect	$5,116,670	$5,627,635	$4,594,184
Selective	$2,131,743	$1,572,380	$1,283,614
Indicated	$568,460	$1,183,814	$966,420
Column Total	**$10,984,637**	**$11,300,020**	**$9,224,884**
Total SABG Award[3]	**$56,058,184**	**$52,538,794**	**$45,374,413**
Planned Primary Prevention Percentage	**19.60 %**	**21.51 %**	**20.33 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award[1]	ARP Award[2]
Targeted Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☐	☑	☐
Heroin	☐	☑	☑
Inhalants	☐	☐	☐
Methamphetamine	☐	☐	☑
Bath salts, Spice, K2)	☐	☐	☐
Targeted Populations			
Students in College	☑	☑	☑
Military Families	☐	☑	☑
LGBTQ	☑	☑	☑
American Indians/Alaska Natives	☑	☑	☑
African American	☑	☑	☑
Hispanic	☑	☑	☑
Homeless	☐	☑	☑
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☐	☐	☐
Rural	☐	☑	☑

Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

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Footnotes:

ARP Award also has an emphasis on targeting Older Adults (adults aged 55+)

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022				
	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems	$40,000.00	$32,000.00	$0.00	$600,000.00	$2,200,000.00
2. Infrastructure Support	$600,000.00	$0.00	$0.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$100,000.00	$0.00	$0.00	$0.00	$0.00
4. Planning Council Activities (MHBG required, SABG optional)	$0.00	$0.00	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$100,000.00	$0.00	$600,000.00	$100,000.00
6. Research and Evaluation	$0.00	$0.00	$0.00	$300,000.00	$660,000.00
7. Training and Education	$0.00	$100,000.00	$300,000.00	$1,750,000.00	$2,000,000.00
8. Total	**$740,000.00**	**$232,000.00**	**$300,000.00**	**$3,250,000.00**	**$4,960,000.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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Footnotes:

Amount of SABG Primary Prevention funds (from Table 4, Row 2) to be used for Non-Direct-Services/System Development Activities for SABG Prevention Column B and/or SABG Combined in Column C = $232,000

Amount of SABG Administration funds (from Table 4, Row 5) to be used for Non-Direct-Services/System Development Activities for SABG Prevention, Column B, and/or SABG Combined, Column C = $0.

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 10/01/2021 MHBG Planning Period End Date: 09/30/2023

Activity	FFY 2022 Block Grant	FFY 2022[1] COVID Funds	FFY 2022[2] ARP Funds	FFY 2023 Block Grant	FFY 2023[1] COVID Funds	FFY 2023[2] ARP Funds
1. Information Systems	$314,500.00			$314,500.00		
2. Infrastructure Support	$12,846,990.00	$9,135,766.00	$8,005,426.00	$12,846,990.00	$9,135,766.00	$8,005,426.00
3. Partnerships, community outreach, and needs assessment	$1,666,075.00			$1,666,075.00		
4. Planning Council Activities (MHBG required, SABG optional)	$12,000.00			$12,000.00		
5. Quality Assurance and Improvement	$916,509.00			$916,509.00		
6. Research and Evaluation	$145,580.00			$145,580.00		
7. Training and Education	$7,866,707.00			$7,866,707.00		
8. Total	**$23,768,361.00**	**$9,135,766.00**	**$8,005,426.00**	**$23,768,361.00**	**$9,135,766.00**	**$8,005,426.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15,2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

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Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds.
The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

Mental health and primary care integration manifests in myriad forms in the State of Michigan. This includes within the practice setting in addition to integration at the payer level. Chief examples include the MI Health Link (Michigan's dual-enrolled Medicare/Medicaid demonstration pilot), Medicaid Health Homes (e.g., Behavioral Health Home for SMI/SED, MI Care Team Health Home for mild-to-moderate behavioral health conditions, and the Opioid Health Home for opioid use disorder), SAMHSA integrated cooperative agreements including the Promoting the Integration of Primary and Behavioral Healthcare (PIPBHC) grant, and the CMS Certified Community Behavioral Health Clinic (CCBHC) Demonstration and SAMHSA CCBHC Expansion Grants.

MI Health Link
The MI Health Link allows dually enrolled Medicare/Medicaid beneficiaries to utilize a single Integrated Care Organization for all their physical and behavioral health care needs. By utilizing a single point of care, beneficiaries receive streamlined services, optimized care coordination, and are relieved of complex cost-sharing arrangements typically associated with the dually enrolled population.

Health Homes
Pursuant to Section 2703 of the Affordable Care Act, Medicaid Health Homes afford states the option to develop innovative, integrative, and sustainable care management/coordination programs for high-need, high-cost Medicaid beneficiaries with chronic health conditions. These conditions must include a diagnosis of either one serious mental illness, two chronic conditions, or one chronic condition and the risk of developing another. Health Homes allow states to develop sustained reimbursement mechanisms for services typically not covered, including community health workers and the gamut of resources needed to affect the social determinants of health (e.g., housing, transportation, food assistance, employment assistance, etc.). The goal of Health Homes is to increase outcomes and decrease costs by transcending barriers to care through enhanced access and coordination.

Health Homes are predicated on the integration of behavioral, physical, and social aspects of care to effectuate all facets of health and wellness. States have significant latitude in designing programs, including provider types, care teams, delivery systems, payment models, information technology/data sharing, and metrics. That said, states are required to submit a State Plan Amendment to the US Centers for Medicare & Medicaid Services (CMS) for approval. Moreover, there are core services that must be delivered under the Health Home authority, including:
• Comprehensive care management;
• Care coordination;
• Health promotion;

• Comprehensive transitional care and follow-up;
• Individual and family support; and
• Referral to community and social services

Finally, states are financially incentivized to participate through an enhanced 90 percent Federal Matching Assistance Percentage (FMAP) for 8 quarters of Health Home services (10 quarters for Substance Use Disorder programs). As of January 2019, 22 states and DC have a total of 37 approved Health Home models. Michigan is a leader in Health Home implementation and currently operates 3 Health Homes—the Opioid Health Home, the MI Care Team Health Home, and the Behavioral Health Home. A summary of each Michigan Health Home and their respective scope follows.

1) The Behavioral Health Home (BHH)
Target Population: Medicaid beneficiaries in a designated county with a Serious Mental Illness/Serious Emotional Disturbance diagnosis

Background
Effective July 1, 2014, the BHH is a health home model that bolsters care management and coordination services for adult Medicaid beneficiaries with SMI and child Medicaid beneficiaries with SED. The BHH is delivered through CMHSPs with payment and certain enrollment tasks provided by PIHPs. Today, the BHH is provided in two counties—Grand Traverse and Manistee (Washtenaw County provided BHH services until 2017). Though small-scale, cost-efficiency studies completed per federal requirements have shown significant positive results both clinically and fiscally.

· Given the growing prevalence of individuals with mental illness and its associated fundamental outcomes like the alarming growth in suicide rates, BHDDA revamped and expanded the BHH. As of October 1, 2020 BHH services were expanded to beneficiaries in 37 Michigan counties including PIHP regions 1 (upper peninsula), 2 (northern lower Michigan), and 8 (Oakland County).
·
· The BHH revamp delegates the operational duties of the BHH to the region's PIHP. Per the approved state plan amendment, the PIHP contracts with state-designated providers (health home partners) to deliver BHH services. Health home partners include CMHs and FQHCs in the three regions mentioned above. The revamp also focuses on more specified diagnoses per identification of high-cost, high-use SMI/SED diagnostic codes.

Enrollment
As of August 2021, Michigan's BHH serves roughly 700 people (age 6-84 years old) through 16 health home partners and 3 PIHPs. All three regions are working to expand health home partners to increase their capacity to serve more beneficiaries.

Notable Links
• Michigan's Behavioral Health Home Website: MDHHS - Behavioral Health Home (michigan.gov)
• Behavioral Health Home Handbook: Behavioral Health Home (BHH) Handbook (michigan.gov)
• Behavioral Health Home Directory: Behavioral Health Home (BHH) - PIHP and Health Home Partner Directory (michigan.gov)
• Behavioral Health Home Brochure: BHH Trifold Brochure (michigan.gov)

2) The Opioid Health Home (OHH)
Target Population: Medicaid beneficiaries living in a designated county with an Opioid Use Disorder (OUD) diagnosis.

Background
On October 1, 2018, MDHHS implemented the OHH to help mitigate Michigan's opioid epidemic in Michigan's Prepaid Inpatient Health Plan (PIHP) Region 2, which is comprised of the 21 northernmost counties in Michigan's lower peninsula. In October 2020, MI expanded OHH services to PIHP Region 1, PIHP Region 9 and Calhoun and Kalamazoo counties within PIHP Region 4. Continuing MI's goal for statewide expansion PIHP Regions 6, 7 and 10 are expected to be OHH eligible October 1, 2021. The OHH provides intensive care management and coordination to Medicaid beneficiaries with OUD to attend to the spectrum of one's needs. Per state plan requirements, providers deliver on-site primary, behavioral, and recovery-centered care services (including Medication Assisted Treatment [MAT]) through an interdisciplinary care team, including peer recovery coaches and community health workers.

MDHHS delegates the operational duties of the OHH to each designated PIHP. Per the approved state plan amendment, the PIHP contracts with state-designated providers to deliver OHH services. These providers include Opioid Treatment Programs and Office-Based Opioid Treatment Providers, the latter of which are currently Community Mental Health Services Programs (CMHSPs) and Federally Qualified Health Centers (FQHCs). Providers are reimbursed by the PIHP via a monthly case rate for enrolled beneficiaries with an OHH service. MDHHS also developed a unique Pay-for-Performance incentive that will reward providers if metrics pertinent to mitigating the opioid epidemic are met (e.g., decrease in related hospitalizations, increase in MAT, etc.). The OHH utilizes an inverse integration approach by enjoining specialty and non-specialty behavioral health providers with the PIHP. This closes the chasm between Michigan's Medicaid delivery systems for beneficiaries with OUD, catalyzing greater access to care regardless of setting.

Enrollment
As of August 2021, the OHH has 1,548 enrolled beneficiaries (note: MDHHS is n the process of updating the State Plan Amendment to activate the OHH benefit plan in three additional PIHPs).

Notable Links
• Michigan's OHH Website: MDHHS - Opioid Health Home (michigan.gov)
• Approved OHH State Plan Amendment (MI-18-5001): MI-20-1501.pdf (medicaid.gov)
• OHH Handbook: OHH_Handbook_717239_7.pdf (michigan.gov)
• OHH Provider Sites: Opioid Health Home (OHH) PIHP and Designated OHH Providers (michigan.gov)
• MSA Policy Bulletin 20-31: Proposed Policy Bulletin (michigan.gov)

3) The MI Care Team (MCT)
Target Population: Medicaid beneficiaries living in a designated county and having a diagnosis of depression and/or anxiety in addition to either diabetes, heart disease, hypertension, chronic obstructive pulmonary disease, and/or asthma.

Background
Operationalized on July 1, 2016, the MCT is a health home model which utilizes an interdisciplinary team of providers that operate in a highly behavioral health integrated primary care setting. The MCT is built on the philosophy of whole-person, team-based care. The care team includes a primary care provider, behavior health consultant, nurse care manager, community health worker, health homes coordinator, and a psychologist/psychiatrist. The MCT participating members receive an array of services consistent with the core services outlined above. This helps ensure seamless transitions of care and connects the beneficiary with needed clinical and social services. In turn, this enhances patient outcomes and quality of care, while simultaneously shifting people from the emergency departments and hospitals to a primary care setting.

The MCT program is currently offered through FQHCs and Tribal Health Centers (THC). Today, 10 FQHCs provide MCT services in 21 counties throughout the upper and lower peninsula. Providers receive a monthly case rate directly from MDHHS for enrolled beneficiaries with an MCT service.

Enrollment
As of March 2019, the MCT has over 3,400 beneficiaries enrolled into the program.

Notable Links
• Approved State Plan Amendment (MI 15-2000): https://www.michigan.gov/documents/mdhhs/MI-15-2000_CMS_Approved_MI_Care_Team_SPA_528217_7.pdf
• MI Care Team Handbook: https://www.michigan.gov/documents/mdhhs/MI_Care_Team_Handbook_528104_7.pdf
• Map of Participating Counties: https://www.michigan.gov/documents/mdhhs/MI_Care_Team_Health_Home_Map_6-2016_526789_7.pdf
• MI Care Team Sites: https://www.michigan.gov/documents/mdhhs/MI_Care_Team_Health_Homes_Sites_527378_7.pdf
• Program Brochure: https://www.michigan.gov/documents/mdhhs/MDHHS_2016_MICARETEAM_brochure_FINAL_526790_7.pdf

SAMHSA PIPBHC Cooperative Agreement Overview
On August 8, 2018, Michigan received a Notice of Award from the US Substance Abuse and Mental Health Services Administration (SAMHSA) to implement a Cooperative Agreement program entitled “Promoting the Integration of Primary and Behavioral Health Care” (or PIPBHC). Providers offer a continuum of prevention, treatment and recovery support services to consumers within the PIPBHC grant program. Michigan’s award totals to $2 million annually for up to five years.

Purpose
The purpose of this cooperative agreement is to:
1) Promote full integration and collaboration in clinical practice between primary and behavioral healthcare;
2) Support the improvement of integrated care models for primary care and behavioral health care to improve the overall wellness and physical health status of adults with a serious mental illness (SMI) or children with a serious emotional disturbance (SED); and
3) Promote and offer integrated care services related to screening, diagnosis, prevention, and treatment of mental and substance use disorders, and co-occurring physical health conditions and chronic diseases.

Partnerships
One of the main provisions of the PIPBHC program is to establish formal partnerships between the state and key community-based providers to facilitate the integration of primary and behavioral healthcare. More specifically, SAMHSA requires that a state partner with a Community Mental Health Services Program (CMHSP) or a Federally Qualified Health Center (FQHC). If the primary partner is a CMHSP, the CMHSP must establish a formal partnership with a FQHC to augment primary care services within the CMHSP setting; if the primary partner is a FQHC, the FQHC must establish a formal partnership with a CMHSP to augment behavioral health services within the FQHC setting.

MDHHS worked with local CMHSP and FQHC organizations and the Community Mental Health Association of Michigan and the Michigan Primary Care Association to select state partnerships that synchronized need and readiness per the terms of the PIPBHC application. As a result, the following providers were selected as partners:

• Cherry Health FQHC (secondary partner with Barry County CMHSP)
• Saginaw County CMHSP (secondary partner with Great Lakes Bay Health Center FQHC)
• Shiawassee County CMHSP (secondary partner with Great Lakes Bay Health Center FQHC)

Through co-located clinics between the CMH and FQHC, consumers have access to an interdisciplinary team of providers that can attend to their behavioral health and physical health needs all under one roof. This partnership has fostered joint COVID-19 vaccination clinics, behavioral health pediatric consultation for primary care, and integrated care team huddles. Additionally, grantees are currently working toward integrating their EHR system to Azara DRVS to share patient data between the CMH and FQHC. This effort should further improve care coordination and integration efforts between the physical health and behavioral health providers.

Certified Community Behavioral Health Clinics (CCBHCs)
CMS CCBHC Demonstration
In 2016, MDHHS applied to the Centers for Medicare & Medicaid Services (CMS) to become a CCBHC Demonstration state under Section 223 of the federal Protecting Access to Medicare Act of 2014 (PAMA). That request was approved on August 5, 2020, when the federal CARES Act of 2020 authorized two additional states—Michigan and Kentucky—to join the demonstration. As a result, MDHHS was approved for a two-year demonstration with an anticipated implementation start date of October 1, 2021. The two-year period begins upon implementation.
Per CMS, only the 14 prospective CCBHC Demonstration Sites named in Michigan's 2016 application are eligible to participate in the state's demonstration. These sites include 11 Community Mental Health Services Programs (CMHSPs) and 3 non-profit behavioral health entities, together serving 18 Michigan counties.
• Centra Wellness Network (Benzie and Manistee Counties)
• Community Mental Health and Substance Abuse Services of St. Joseph County
• Community Mental Health Authority of Clinton, Eaton, and Ingham Counties
• CNS Healthcare (Oakland County)
• Easterseals Michigan (Oakland County)
• HealthWest (Muskegon County)
• Integrated Services of Kalamazoo
• Macomb County Community Mental Health
• Saginaw County Community Mental Health Authority
• St. Clair County Community Mental Health Authority
• The Guidance Center (Wayne County)
• The Right Door for Hope, Recovery, and Wellness (Ionia County)
• Washtenaw County Community Mental Health
• West Michigan Community Mental Health (Lake, Mason, and Oceana Counties)
Under the CMS CCBHC Demonstration, each site must be certified by MDHHS. CCBHCs must adhere to a rigorous set of certification standards and meet requirements for staffing, governance, care coordination practice, integration of physical and behavioral health care, health technology, and quality metric reporting. CCBHCs are supported under the demonstration through a unique funding structure, which utilizes a prospective payment system, which reflects the actual anticipated costs of expanding service lines and serving a broader population. Individual PPS rates are set for each CCBHC clinic and will address historical financial barriers, supporting sustainability of the model. MDHHS will operationalize the payment via the current PIHP network.

The CCBHC model increases access to a comprehensive array of integrated services by serving all individuals with a behavioral health diagnosis, regardless of insurance or ability to pay. CCBHCs are required to provide nine core services: crisis mental health services, including 24/7 mobile crisis response; screening, assessment, and diagnosis, including risk assessment; patient-centered treatment planning; outpatient mental health and substance use services; outpatient clinic primary care screening and monitoring of key health indicators and health risk; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family supports; and intensive, community-based mental health care for members of the armed forces and veterans. The model also emphasizes care coordination and the integration of physical and behavioral health care, and CCBHCs are required to build a comprehensive partnership network with a broad array of health and social service providers which is formalized through care coordination agreements.

SAMHSA CCBHC Expansion Grants
In addition to the CMS CCBHC Demonstration, the CCBHC model is implemented throughout the state using SAMHSA CCBHC Expansion Grants. These grants are available to community treatment providers in every state, and applications for the $2 million, 2 -year grants are accepted annually. Qualified applicants must meet the requirements of a CCBHC within four months of receiving the grant. Clinics self-attest that they meet the baseline CCBHC criteria, and the state authority has no direct involvement in the oversight or implementation of these grants. Grantees who are eligible can participate in both federal CCBHC programs provided they can complete the requirements of both. There are currently 33 organizations in Michigan who have received SAMHSA CCBHC Expansion Grants.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring capability.

In addition to the initiatives mentioned above, Michigan is constantly exploring options to integrate systems of care for

individuals and families with co-occurring mental health and substance use disorders. One project centers on working with the provider community and data security community to find ways to allow medical providers to share health information essential to maximizing care coordination activities for the betterment of the patient population. A standardized consent form was developed within this process, which has already helped patients and providers get the right information at the right time. Additionally, BHDDA has provided and fostered training in Medication Assisted Treatment and Evidence-Based Practices (like SBIRT) in settings outside the typical PIHP/CMHSP structure. Michigan's Federally Qualified Health Centers are one benefactor of such trainings and these providers have augmented their ability to provide Medication Assisted Treatment services as a result, which is critical to help mitigate the opioid crisis. While there are many other integration projects underway, other initiatives designed to integrate systems of care include utilizing community health workers, peer support specialists, and peer recovery coaches to ensure optimal care transitions and coordination. These workers also help bridge the gap between different care disciplines. Finally, Michigan Public Act 107 of 2017 instructs MDHHS to pursue up to 3 financial integration pilots whereby Medicaid Health Plans would receive first-dollar Medicaid monies and be expected to coordinate all physical and behavioral health care for their beneficiaries.

Michigan's 1115 Behavioral Health Demonstration SUD Health IT Plan
MDHHS has made significant progress with Health Information Technology initiatives pertinent to its 1115 Behavioral Health Demonstration SUD Health IT Plan. Within the first year of implementation, MI has been able to modify its Care Coordination platform, CC360, to develop an SUD monitoring dashboard that allows MDHHS staff and Prepaid Inpatient Health Plans (PIHPs) to see Behavioral Health 1115 Waiver data that is collected and reported on to CMS. MDHHS is also developing an e-consent management system for data sharing and will begin piloting with a few PIHP regions in FY21-22. MDHHS will move to statewide implementation in the next few years which will allow data sharing between providers for improved care coordination. The e-consent work is bolstered by the creation of an "SUD Data Role" in CC360 to afford access to PIHPs and providers with consents on file to view Medicaid beneficiary information pertinent to all health, including SUD data, which has been masked up to this point. Moving into FY22, MDHHS will continue to work on capturing data for high need beneficiaries and synchronizing Prescription Drug Monitoring Program data in future years. MDHHS has also created the Michigan Crisis and Access Line (MiCAL) to coordinate crisis services and facilitate connection to local behavioral health providers for needed services. MiCAL will also integrate with a centralized and coordinated registry for behavioral health services being implemented statewide.,

PIPBHC Behavioral and Physical Health Information Sharing
MDHHS is directly working with Azara DRVS and Peter Change Enterprise (PCE) Systems (which is a prominent CMHSP EHR vendor in Michigan) to develop a technology solution that will allow each organization to share real-time, shared patient data. Azara DRVS is a scalable population health management and quality improvement solution that pulls in data from a variety of sources (e.g., EHRs, Health Information Exchanges [HIEs], pharmacy, Admission-Discharge-Transfer [ADT] data, health plans, etc.). In Michigan, the majority of Federally Qualified Health Centers (FQHCs) use Azara DRVS, for visit planning, practice transformation, quality improvement, care transition/care coordination, and population health. Through its SAMHSA Promoting the Integration of Primary and Behavioral Healthcare (PIPBHC) grant, MDHHS is leading the effort to connect three CHMSPs and their partner FQHCs to Azara DRVS so they can: 1) identify consenting, common patients, 2) build an API to allow sharing of data between the CMHSP and FQHC, and 3) build an integrated visit planning report and care management passport.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? (•) Yes ( ) No

b) and Medicaid? (•) Yes ( ) No

4. Who is responsible for monitoring access to M/SUD services provided by the QHP?

The MDHHS Medical Services Administration, Behavioral Health and Developmental Disabilities Administration, and the Michigan Department of Insurance and Financial Services.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? (•) Yes ( ) No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education (•) Yes ( ) No

b) Health risks such as

ii) heart disease (•) Yes ( ) No

iii) hypertension (•) Yes ( ) No

iv) high cholesterol (•) Yes ( ) No

v) diabetes (•) Yes ( ) No

c) Recovery supports (•) Yes ( ) No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? (•) Yes ( ) No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and (•) Yes ( ) No

substance use disorder services?

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

None

10. Does the state have any activities related to this section that you would like to highlight?

None

Please indicate areas of technical assistance needed related to this section

No need for technical assistance at this time.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[45].

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

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

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

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

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

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

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	○ Yes ○ No
b) Ethnicity	○ Yes ○ No
c) Gender	○ Yes ○ No
d) Sexual orientation	○ Yes ○ No
e) Gender identity	○ Yes ○ No
f) Age	○ Yes ○ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ○ Yes ○ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ○ Yes ○ No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ○ Yes ○ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? ○ Yes ○ No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ○ Yes ○ No

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

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

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

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

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

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ○ Yes ○ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☐ Leadership support, including investment of human and financial resources.
- **b)** ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☐ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☐ Provider involvement in planning value-based purchasing.
- **e)** ☐ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☐ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

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

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Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? (●) Yes ( ) No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? (●) Yes ( ) No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

Michigan has implemented the Navigate approach from the RAISE model. (http://navigateconsultants.org/) since this funding became available. We have maintained our commitment to implementing this First Episode Psychosis (FEP) model utilizing the 10% set-aside. Beginning in FY20, block grant funds were also used to support two community mental health pilot sites to treat up to five people experiencing First Episode Psychosis (FEP) using Navigate on existing ACT teams. The pilot ACT teams will receive Navigate training, supportive consultation and information that compares, contrasts, and sensitizes ACT staff to differences in FEP and most traditional ACT consumers. Additional information on these pilots is included in the ACT section of this application.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

Michigan is fortunate to have an extensive array of state plan behavioral health services that can provide individualized treatment to those eligible for services, who may or may not be appropriate for an ESMI approach. There are many opportunities for

integrated mental and physical health treatment available for both adults and youth and many of these projects are also MHBG funded. For those experiencing a first episode of psychosis, block grant funded Navigate projects are available in some communities

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? (●) Yes ( ) No

5. Does the state collect data specifically related to ESMI? (●) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Michigan is implementing the Navigate approach from the RAISE model (http://navigateconsultants.org/). This has not changed since the launch of the project.

8. Please describe the planned activities for FFY 2022 and FFY 2023 for your state's ESMI programs including psychosis?

The following activities will continue to occur in FY22 and 23. All of these activities are dependent upon the continuing availability of funds.

In FY22, we hope to identify 1 to 2 new Navigate Teams.

New implementation team(s) will reach capacity (30 individuals) in FY22.

Enrollment in all implementation teams will be maintained at no more than 3 participants below capacity at any given time, once capacity is initially achieved.

Implementation agencies will maximize reimbursements from sources other than grant funds, including program participant insurance benefits.

Teams will promote the sustainability of FEP treatment programs

All implementation teams' staff will maintain fidelity to the NAVIGATE model of care.

Implementation teams' staff including Project Directors, FE, IRT, SEE and prescribers will individually obtain certification in the NAVIGATE model of care. ETCH, LLC will provide oversite for activities to monitor all implementation teams' staff process, receiving consultation from the National NAVIGATE team as needed.

Outcomes on treatment for first episode psychosis will be available.

Teams will continue to expand knowledge and education of FEP, treatment and resources via the Michigan Minds Empowered web page.

Two ACT pilot sites will receive Navigate training and serve up to 5 individuals each in the model.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

Teams report required data quarterly to the project coordinator. Quarterly and annual reports are provided to MDHHS by the project coordinator. Data collected thus far includes demographic data, Clinical Global Impression (CGI) and the Service Utilization Review Form (SURF) data and COMPASS data. Project coordinator and teams will continue to work with a university researcher to analyze data and get a web-based data collection portal up and running for the teams to enter outcome data and generate reports.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Navigate diagnostic category is psychosis - first episode.

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

Sustainability and planning when funding is variable.

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Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? (•) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

Person Centered Planning (PCP) is a required process for all individuals receiving services in the behavioral health system. The Michigan Mental Health Code requires the PCP process to be utilized: "Person-centered planning" means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. MCL 330.1700(g)

The Michigan Mental Health Code also requires use of PCP for development of an Individual Plan of Services:
"The responsible mental health agency for each recipient shall ensure that a PCP process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The person in charge of implementing the plan of services shall be designated in the plan." MCL 330.1712.

4. Describe the person-centered planning process in your state.

PCP is a way for people to plan their lives in their communities, set the goals that they want to achieve, and develop a plan for how to accomplish them. PCP is required by state law (Michigan Mental Health Code) and federal law (the Home and Community Based Services Final Rule and the Medicaid Managed Care Rules) as the way that people receiving services and supports from the community mental health system plan how those supports are going to enable them to achieve their life goals. The process is used to plan the life that the person aspires to have, considering various options—taking the individual's goals, hopes, strengths, and preferences and weaving them into plans for the future. Through PCP, a person is engaged in decision-making, problem solving, monitoring progress, and making needed adjustments to goals and supports and services provided in a timely manner. PCP is a process that involves support and input from those people who care about the person doing the planning. The PCP process is used any time an individual's goals, desires, circumstances, choices, or needs change. While PCP is the required planning approach for mental health and intellectual/developmental disabilities services provided by the CMHSP system, PCP can include planning for other public supports and privately-funded services chosen by the person.

Through the PCP process, a person and those he/she has selected to support him/her:

a. Focus on the person's life goals, interests, desires, choices, strengths and abilities as the foundation for the PCP process.

b. Identify outcomes based on the person's life goals, interests, strengths, abilities, desires and choices.

c. Make plans for the person to achieve identified outcomes.

d. Determine the services and supports the person needs to work toward or achieve outcomes including, but not limited to, services and supports available through the community mental health system.
e. After the PCP process, develop an Individual Plan of Services that directs the provision of supports and services to be provided

through the CMHSP.

PCP focuses on the person's goals, while still meeting the person's basic needs [the need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation as identified in the Code]. As appropriate for the person, the PCP process may address Recovery, Self-Determination, Positive Behavior Supports, Treatment of Substance Abuse or other Co-Occurring Disorders, and Transition Planning as described in the relevant MDHHS policies and initiatives.

PCP focuses on services and supports needed (including medically necessary services and supports funded by the CMHSP) for the person to work toward and achieve their personal goals.

For children, youth and families, the Person-Centered Planning Policy Guideline states: "The Michigan Department of Health and Human Services (MDHHS) has advocated and supported a family-driven and youth-guided approach to service delivery for children, youth and their families. A family-driven and youth-guided approach recognizes that services and supports impact the entire family, not just the identified child or youth receiving mental health services. In the case of minors, the child, youth and family are the focus of service planning, and family members are integral to a successful planning process. The wants and needs of the child, youth and they/their family are considered in the development of the Individual Plan of Service." As the child or youth matures toward transition age, the focus of the treatment planning, services and supports should be youth/young/adult driven to accommodate the youth as they gain skills towards independence.

Family-driven and youth-guided principles should be implemented at several different levels: the child, youth and family level, programmatic level which includes peer-delivered services the system level (the community or state level). These principles incorporate all levels and will be detailed under section D: Essential Elements of this guideline.

· Families, children and youth as well as providers and administrators share decision-making and responsibility for outcomes.

· Families, children and youth are given accurate, understandable, and complete information necessary to set goals and to make informed decisions and choices about the individualized and potential services and supports for their child or youth and their family as a whole.

· Children, youth and parents or caregivers have the right to invite an external support and/or advocate to participate as part of their planning and treatment team.

· CMHSPs can partner with family-run organizations engage in peer support activities to reduce isolation, gather, and disseminate accurate information, and strengthen the family voice.

· Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports and advocate for families and youth to have choices.

· PIHP/CMHSPs and contract providers will take the initiative to change policy and practice from provider-driven to family-driven and youth-guided by prioritizing family-driven and youth-guided practices by allocating staff, training, support and resources.

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

No technical assistance needed at this time.

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Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

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

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

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

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

No

Please indicate areas of technical assistance needed related to this section

No technical assistance ia needed at this time.

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Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

OROSC staff consult with the Michigan Inter-tribal Council on a monthly basis. MDHHS Policy and Planning Staff meeting with Tribal leaders on a quarterly basis.

2. What specific concerns were raised during the consultation session(s) noted above?

Specific concerns raised included: MISACWIS access, Medicaid work requirements, telemedicine, assorted funding concerns (including Medicaid Administration, grant funding, and behavioral health funding), coverage for traditional medicine, prescription reimbursement rates, federal and state language conflicts, non-emergency medical transportation and Indian Outreach Workers.

3. Does the state have any activities related to this section that you would like to highlight?

The Michigan Department of Health and Human Services (MDHHS) currently has three tribal liaisons charged with maintaining regular, open communication with Michigan's 12 tribes and one Urban Indian Health Center. Two representatives from Michigan tribes currently serve on the Behavioral Health Advisory Council, which is Michigan's planning council. A tribal liaison from the Legislative Affairs and Constituent Services division attends the Michigan Tribal Health Directors Association Meetings to share and receive information that provides the department information on how to assist the Tribes in their efforts at administering population health and social service programs. Additionally, the department hosts quarterly conference calls to discuss any current issues of concern to the tribes, held in between the Tribal Health Directors Association meetings to further open communication between the tribes and MDHHS. Behavioral Health and Developmental Disabilities Administration (BHDDA) staff attend the Michigan Inter-Tribal Council's Behavioral Health Communications Network meetings for the purpose of sharing administrative and programmatic information relevant to tribal implementation of substance use and mental health disorder programs. BHDDA staff also receive value added information from tribal members of the network in issues impacting their ability to serve their constituents. A tribal liaison from the Children's Services Administration conducts quarterly Tribal/State Partnership

meetings.

In addition to the formal consultation noted in response #1 above, MDHHS BHDDA staff members meet with members of the Tribal Behavioral Health Communication Network on a quarterly basis to identify and address areas of interest with regard to public behavioral health service delivery. Some focus has been on ensuring that available payment processes are working properly for I/T/U providers that work with Medicaid eligible Tribal Members.

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

No technical assistance is needed at this time.

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [ ] Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- [ ] Children (under age 12)
- [x] Youth (ages 12-17)
- [x] Young adults/college age (ages 18-26)
- [x] Adults (ages 27-54)
- [x] Older adults (age 55 and above)
- [x] Cultural/ethnic minorities
- [x] Sexual/gender minorities
- [x] Rural communities
- [ ] Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

☑ Archival indicators (Please list)

• Consumption data
• Outcome data
• Consequence data

☑ National survey on Drug Use and Health (NSDUH)

☑ Behavioral Risk Factor Surveillance System (BRFSS)

☑ Youth Risk Behavioral Surveillance System (YRBS)

☐ Monitoring the Future

☐ Communities that Care

☑ State - developed survey instrument

☑ Others (please list)

MiPHY county level data

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? ◉ Yes ○ No

If yes, (please explain)

Regional entities (PIHPs) are encouraged to readjust spending of primary prevention funding by prevention strategy, based on needs assessment.

If no, (please explain) how SABG funds are allocated:

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe

The prevention workforce is certified via the Michigan Certification Board for Addiction Professionals. The credentials are Certified Prevention Specialist and Certified Prevention Consultant.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe mechanism used

The state contracts with a training entity (currently the Community Mental Health Association of Michigan). Training needs and technical assistance is determined by an advisory committee of the training agency and via surveys of the field.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

If yes, please describe mechanism used

The Community Readiness Model (Tri-Ethnic) has been used to assess community readiness. Although not contractually required, OROSC encourages PIHPs and providers to use the Tri-Ethnic Community Readiness Model, if needed. Additionally, the SAPST curriculum makes mention of this community readiness model and is a key training for provider staff.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

The strategic plan is attached.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) (●) Yes ( ) No ( ) N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** ☑ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- **b)** ☑ Timelines
- **c)** ☑ Roles and responsibilities
- **d)** ☑ Process indicators
- **e)** ☑ Outcome indicators
- **f)** ☑ Cultural competence component
- **g)** ☐ Sustainability component
- **h)** ☐ Other (please list):
- **i)** ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? (●) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? (●) Yes ( ) No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

The evidence-based workgroup meets on an as needed basis. The link to the guidelines for selecting evidence-based practices is attached.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☑ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☐ The SSA funds regional entities to provide prevention services.
- **f)** ☑ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☐ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

- **a)** Information Dissemination:

  Distribution of materials at events such as health fairs, community round tables. Speaking engagements (direct) – Presentation about SUD. Speaking engagements (indirect) – Radio or TV interview, print media.
- **b)** Education:

  Classroom curriculum such as Botvin's Life Skills and Project Alert. Teaching Anger Management to students at an alternative high school. Teaching Strengthening Families Program to parents. Other evidence-based curriculums such as Prime for Life for youth and young adults.
- **c)** Alternatives:

  Supervision and guiding ATOD free recreational events. Supervision and guiding community events. Supervision and guiding youth/adult leadership events.
- **d)** Problem Identification and Referral:

  Student assistance programs, case finding, provision or referral. Conducting DUI/DWI/MIP classes. Prevention assessment and referral.
- **e)** Community-Based Processes:

Implementing needs assessment tools. Community coalition building and facilitating including collaboratives, task forces and community planning teams. Coalition technical assistance.

f) Environmental:

Prevention of underage tobacco sales – Synar. Prevention of underage alcohol sales.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

If yes, please describe

SABG spending for primary prevention is monitored via contract and consultation staff. Financial reports are submitted on a monthly basis to contract and consultation staff for review and approval.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

Evaluation Report is attached.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** ☐ Includes evaluation information from sub-recipients
- **c)** ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** ☐ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please list:)
- **g)** ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- **a)** ☑ Numbers served
- **b)** ☐ Implementation fidelity
- **c)** ☐ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☑ Attendance
- **f)** ☑ Demographic information
- **g)** ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☐ Heavy use
- ☐ Binge use
- ☑ Perception of harm

c) ☐ Disapproval of use

d) ☐ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☐ Other (please describe):

Footnotes:

Guidance Document

Selecting, Planning, and Implementing Evidence-Based Interventions for the Prevention of Substance Use Disorders

Michigan Department of Community Health
Bureau of Substance Abuse and Addiction Services
Evidence-Based Workgroup

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The purpose of this guidance document is to increase uniformity in the knowledge and application of evidence-based prevention programs, services, and activities to reduce and prevent substance use disorders in the state of Michigan.

Table of Contents

I. Introduction

The purpose of the "*Guidance Document: Selecting, Planning, and Implementing Evidence-Based Interventions for the Prevention of Substance Use Disorders*" is to increase uniformity in the knowledge, understanding, and implementation of evidence-based substance abuse prevention programs, services, and activities in the state of Michigan.

This document is a compilation of the latest information and research from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP), who provided guidance for the document entitled, *Identifying and Selecting Evidence-Based Interventions*," including additional supporting resources, and input from a panel of prevention professionals in the state of Michigan. The goals of this guide are to:

A. Strengthen local ability to identify and select evidence-based interventions.
B. Provide capacity building tools and resources.
C. Foster the development of sound community prevention systems and strategies as part of comprehensive community planning to establish prevention prepared communities.

The Evidence-Based Workgroup hopes that this document will result in an increased ability for local prevention planners to critically assess prevention interventions based on the strength of evidence that an intervention is effective, to implement evidence-based interventions with a balance between fidelity and necessary local adaptations, and to demonstrate the relationship between evidence and achieving outcomes.

The Bureau of Substance Abuse and Addiction Services (BSAAS) offers a special thank you to the workgroup members who took the time to research and provide the information for this document. Leadership was provided by the chair, Kori White-Bissot, who gathered input and content from the Evidence-Based Workgroup membership in compiling this document.

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II. Evidence-Based Practices – Overview and Background

Definition: A prevention service (program, policy, or practice) that has been proven to positively change the problem being targeted.

In general, there needs to be evidence that the intervention has been effective at achieving outcomes through some form of evaluation. This is done by collecting evidence through an evaluation process when a specific intervention is implemented in a community. The evaluation process monitors outcomes to determine whether the intervention positively impacted the target problem and/or contributing condition. The type of evidence collected during an evaluation process will vary for different types of interventions.

The remainder of this guide will assist in thinking critically about these issues, while identifying interventions appropriate for individual communities.

A. Program: Usually thought of as an intervention that is:

1. Guided by curricula or manuals.
2. Implemented in defined settings or organized contexts.
3. Focused primarily on individuals, families, or defined settings.

Examples: *Strengthening Families Program, Botvin's Life Skills, and Project ALERT.*
Evidence: Evidence is usually collected by tracking participants for a period of time after receiving the intervention and comparing them to a group of similar individuals who did not receive the intervention. The evaluation then determines whether the individuals who received the intervention report having lesser rates of substance abuse than those who did not receive the intervention.

B. Policy: Efforts to influence the courses of action, regulatory measures, laws, and/or funding priorities concerning a given topic. A variety of tactics and tools are used to influence policy, including advocating their positions publicly, attempting to educate supporters and opponents, and mobilizing allies on a particular issue.

Example: Smoke-free laws and regulations.
Evidence: Usually evidence that a policy was effective is collected by looking at communities that have implemented the policy and the impact that was documented when they did so. In some cases, evidence is collected by looking at communities that have historically had the policy and then removed it. The negative outcomes of this change may be appropriate to use in order to document the positive benefits of the policy.

C. Environmental Strategy/Practices: Activities working to establish or change written and unwritten community-focused standards, codes, and attitudes, in order to change behavior in the community. This is done by changing the shared environment through three interrelated factors: norms, availability, and regulations. By changing the shared environment of a community, the desired behavior change is supported by everyone in the community (Arthur, M. D. & Blitz, C., 2000).

Example: Consistent enforcement of *Youth Tobacco Act*.
Evidence: Evidence for an environmental strategy is usually assessed by looking at communities that have implemented the strategy and the impact it has on the local condition (e.g., easy access to tobacco) targeted by the strategy.

It is often difficult to determine how one environmental strategy contributes to the longer-term goal of changing the problem being targeted (e.g., tobacco use). Since it is challenging to document how strategies impact the larger problem being targeted:

1. Environmental strategies must be incorporated into a comprehensive plan addressing multiple contributing conditions that have been shown to positively impact the problem being targeted.

2. Each strategy that makes up the comprehensive plan needs to have been documented to positively impact the contributing condition that each targets, often demonstrated in a logic model. (See Attachment 2.)

Strength of Evidence: The strength of evidence will fall along a continuum from weak to strong. Where an intervention falls on this continuum is determined by the scientific rigor of the evaluation process that was employed to document the intervention's positive impact on the problem and/or contributing condition. It is not determined by how large an impact the intervention has demonstrated on the problem being targeted.

One should not to confuse 'strength of evidence' with the magnitude of an intervention's impact on the targeted problem. There may be evidence-based interventions that have documented small levels of impact on the problem they target. However, they may be rated as having 'very strong' evidence because they used a rigorous evaluation process to document their small impact and have submitted their research for review to experts in the field. In turn, there may be untested interventions that have a large impact on the problem targeted. However, until the outcomes are tested and documented using rigorous evaluation standards, the intervention will not be categorized as 'evidence-based.'

Additional Considerations: When selecting an intervention it is important to assess more than just whether an intervention has been effective. In order for the intervention to be effective in the community, one must also consider a practical and conceptual fit and the framework for the plan must be logical and data-driven throughout. This is especially important for prevention practices that are more effective when they are completed as a component of a comprehensive prevention plan and are unlikely to be included on a federal registry of effective prevention programs due to the nature of the activities.

In summary, when selecting prevention services, consider interventions that have both conceptual and practical fit for the community, that have the strongest level of evidence, and that are effective at addressing the targeted problem and local contributing conditions. For more information, refer to Section IV (B).

III. Evidence-Based Categories

For more in-depth information about the following three categories, please refer to *Identifying and Selecting Evidence-Based Intervention*, (Health and Human Services [HHS], 2009).

Because evidence-based categories fall along a continuum, it can be challenging to determine which evidence-based category an intervention falls within. Interventions will often straddle categories as they work to move up the continuum to a stronger level of evidence category. Local prevention planners should do their best to review the evidence available and determine which category most closely represents the strength of evidence for an intervention.

A. Federal Registries

1. National Registry of Effective Prevention Programs (NREPP): A program that was previously listed on the SAMHSA model program list or currently listed on NREPP with positive outcomes demonstrated. SAMHSA no longer publishes a list of "model" programs. NREPP now posts the results found for each program that they have reviewed, including programs that were found not to be effective. Therefore, being listed on NREPP does not alone provide evidence of effectiveness. It is imperative that agencies critically review the outcomes detailed and the strength of the evaluation described in the NREPP review. For more information about using the NREPP registry, refer to Section IV D.

2. Other Federal Agency: The program/model is listed by another federal agency as an effective prevention program/model. Federal lists or registries are limited in scope since they are geared to interventions most amenable to assessment using traditional research designs and methodologies for evaluation. For more information, refer to Section IV C.

The following should be considered when assessing programs on other federal registries:

- Does the intervention have evidence that it positively impacts the local contributing conditions being targeted? If the intervention is promoting broad outcomes (e.g., reduction in alcohol and tobacco use), it will be necessary to identify the contributing conditions that the intervention targeted in order to reach those broad outcomes. If unable to identify the targeted contributing conditions, it will be challenging to determine whether the intervention is an appropriate fit for the community.

- Is the intervention culturally appropriate for the community and target audience? Has it been tested with a target audience similar to the one selected? If not, is it possible to modify the program to meet the needs of the target audience while maintaining the minimum fidelity standards to achieve the desired outcomes? For more information, see Section V (A).

- What research standards are required to be included on the registry? The level of evidence required varies greatly between federal registries. Review the standards to

ensure confidence that the outcomes are well documented and were documented using rigorous research standards.

B. Peer Review Journal

This category refers to interventions whose research findings have been published in a peer-reviewed journal. It is best if there are multiple studies and look for consistently positive outcomes. This option should only be selected if planned activities are closely replicating the key components of the program described in the peer-reviewed journal.

Please note that the burden for determining the applicability and credibility of the findings falls on the local prevention planners. Even though the research is published, this category still requires local prevention planners to think critically about the evaluation methodology and determine whether the claimed results are warranted based on the evaluation design. Consider the scope of the evaluation, the measures used, and whether the claims of effectiveness exceed what the evaluation actually assessed.

What is a Peer Review Journal?

When researchers submit their research articles to a peer review journal, the journal subjects the research to the scrutiny of other experts in the field. These journals have a panel of experts in the field determine whether the research meets accepted standards for research methods, and has appropriately interpreted the research findings. Only articles that meet both of these standards are published in peer review journals.

It should be noted that the purpose of a peer review journal is scholarly and to further the area of research, which is very different from the purpose of a federal registry. Sometimes research findings that an intervention was not effective can be useful in helping plan future efforts. One may find that there were key components of the intervention that were left out that need to be included, or the findings might indicate that the theory of change was flawed and that it is necessary to explore other intervention options.

When using peer review journals to determine whether an intervention has evidence of effectiveness:

1. Review all relevant articles, not just those with positive results. If there is more than one study that reviews the intervention, there should be consistently positive results found.

2. One can feel more confident about articles written by authors who are not the developers of the program because they do not have a vested interest in the program's success.

3. If available, use meta-analysis and literature review articles:

- Meta Analysis: In these articles, researchers conduct a review of as much research as possible published about an issue and use statistics to analyze and summarize results across multiple research studies. These types of articles can be extremely useful in making sense of multiple research studies about an issue.

- Literature Review: In these articles, researchers analyze and summarize results across multiple research studies and other scientific sources and create a narrative that summarized the research findings across studies.

How to Review a Peer Review Journal Article:

Research findings published in peer review journals are presented in a prescribed format with clearly defined sections. Each section provides information about the research study that can be used to assess the quality and relevance of the research presented.

Do not be intimidated. Breaking an article down into its sections allows one to determine the relevance of an article and to gather the information needed to make informed decisions. First, scan the abstract to determine whether the article is relevant to the planned work. If it seems relevant, skim the introduction and discussion section to further determine the relevance of the research. If the article still seems appropriate to aid in planning, it may warrant a full reading of the article.

A helpful article that provides thorough descriptions of the sections of a peer review journal article and how each section can provide useful information is included as Attachment 1. The following is a brief description of the sections:

1. Abstract: A summary of the key points in the article and the hypothesis being tested. This section is the first step in determining whether the article is relevant to the planned work.
2. Introduction: Provides the context of the study.
3. Methods: Explains how the researchers set about testing their hypothesis.
4. Results: Findings of the researchers are detailed in this section.
5. Discussion: A summary of the results, written in a narrative rather than statistical form. This section explains whether the results support the hypotheses and give suggestions for future research.
6. Bibliography: A listing of all sources cited in the article.

C. Other Sources of Documented Effectiveness:

In this category, the specific intervention has documented proven results impacting the targeted factors (contributing conditions, intervening variables, and/or risk/protective factors) through an evaluation process. In addition, the intervention must meet the following four guidelines:

1. The intervention is based on a theory of change that is documented in a clear logic or conceptual model.

2. The intervention is similar in content and structure to interventions that appear in registries and/or peer-reviewed literature.

3. The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects.

4. The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review, local prevention practitioners, and key community leaders as appropriate (e.g., officials from law enforcement and education sectors or elders within indigenous cultures).

This category of evidence-based criteria recognizes that some complex interventions, which usually include innovations developed locally, look different from most of those listed on federal registries. Because complex interventions exhibit qualities different from those of a discrete nature or interventions using a manual, they often require customized assessment.

When it's Appropriate to Apply

This category should be used if an evidence-based intervention in one of the preceding categories does not exist to meet the identified community needs, and there is not one that can be adapted to do so. Keep in mind that there may not be an exact match within one of the preceding categories but there may be a modifiable intervention that could be adapted to meet needs. Please refer to Section V (A) for more guidance.

It is recognized that there may be prevention initiatives that a community is committed to which have not gone through the process to have documented a stronger level of evidence that it is effective. In addition, many environmental interventions have limited evidence that isolate the impact of the specific intervention components of a community plan.

It may also be necessary to rely on weaker evidence when no appropriate interventions are available in categories with stronger evidence. An appropriate intervention addresses the targeted problem and local contributing condition, and is appropriate for the cultural and community context in which it will be implemented.

Under one of these circumstances it may be appropriate to select or continue to use an intervention that does not meet a stronger category of evidence. The following conditions should be addressed in these situations:

1. Evaluation methodology documenting effectiveness should meet rigorous scientific standards and evaluation of local implementation should work to move the intervention further along the continuum of evidence strength. It may be appropriate

to work with a local university, a researcher, an evaluator, or local epidemiology workgroup in order to strengthen the evaluation plan.

2. The intervention should follow best-practice principles. For more information, refer to Section VI (B).

3. Many interventions that fall within this category are strategies that should be combined to develop a comprehensive community plan to address a community's contributing conditions.

4. Because this category has a weaker level of evidence, there is an additional burden on the local prevention planner to evaluate the intervention. When documenting this local evidence, a summary of local evaluation results indicating effectiveness should be developed. This should include a description of the following:

   - Evaluation methodology.
   - Outcomes tracked as well as the results for each.
   - The scope of the evaluation (e.g. Sample size for surveys, number of series, during what time period, etc.).
   - The research/theory on which the activities/programs are based, including a clearly documented theory of change, which is often communicated through the use of a logic model.

   Note: Addressing risk and protective factors is not adequate; evidence of effectiveness for the specific intervention/set of activities is actually needed.

   <u>Key Elements to Support Documented Effectiveness</u>

   Documentation to justify the inclusion of a particular intervention in a comprehensive community plan is important. Prevention planners are encouraged to provide as many types of documentation as are appropriate and feasible in order to provide strong justification of documented effectiveness.

   The following are elements of documentation that might be provided to demonstrate an intervention has other sources of documented effectiveness and meets the four guidelines established by CSAP (HHS, 2009).

   - Documentation that clarifies and explains how the intervention is similar in theory, content, and structure to interventions that are considered evidence-based by scientific standards.

   - Documentation that the intervention has been used by the community through multiple iterations, and data collected indicating its effectiveness.

   - Documentation that indicates how the intervention adequately addresses elements of evidence usually addressed in peer-reviewed journal articles. These elements

may include the nature and quality of the evaluation research design; the consistency of findings across multiple studies; and the nature and quality of the data collection methods, including attention to missing data and possible sources of bias.

- Documentation that explains how the intervention is based on an established theory that has been tested and empirically supported in multiple studies. This documentation should include an intervention-specific logic model that details how the intervention applies and incorporates the established theory.

- Documentation that explains how the intervention is based on published principles of prevention. This documentation should provide references for the principles cited and should explain how the intervention incorporates and applies these principles.

- Documentation that describes and explains how the intervention is rooted in the indigenous culture and tradition.

D. Community-Based Process Best-Practice

Activities conducted through formal coalitions, task forces, community-planning teams, or collaborative groups are necessary to foster prevention prepared communities. While this type of activity was not separately identified within the guidance from CSAP, it is a key component that Michigan recognizes for the success of comprehensive community plans addressing local conditions and targeting community-level change in risk behaviors.

Community-based process is an approach that enhances the efficacy of prevention efforts by working to breakdown silos, streamline services, and to engage the community in a comprehensive multi-layered plan. Community-based process includes activities such as: coordinating and managing coalitions, task forces, community planning teams, and/or collaborative groups.

1. Community-Based Process – Evidence and Importance

   Because community-based process is designed to assist communities in implementing community-level interventions and to increase the community's ability to provide prevention services, rather than target specific community problems, it does not require the same type of evidence.

   - In order to effectively **implement** prevention practices, it is often necessary to engage in a community-based process. Planners may need to mobilize the community to implement a strategy as a component of a comprehensive, multi-layered prevention plan. For example, environmental interventions must be done through a community-based process in order to **succeed**. These are often efforts to make change to the larger environment through reduced access, changing

community norms, and influencing policy and enforcement. However, these activities do not meet evidence-based criteria in the way that an intervention targeting a certain issue would do so.

"Community Building" is not an intervention, nor is it expected to meet evidence-based criteria at affecting the targeted community problem. Keep in mind that the interventions completed through the community-based process should meet evidence-based criteria.

- Even programs that target individuals (such as a curricula-based program) can be more effective when conducted within a community-based process. By collaborating, a program's reach and sustainability can be enhanced when it is done as a component of a larger community plan.

2. Collaborative activities should be considered under the following criteria:

Leading a collaborative effort:

- The intervention is conducted using community-based process (e.g. coalitions, collaborative, taskforces);
  and
- The collaborative process is compatible with the five-step prevention planning process: assessment, capacity building, planning, implementation, and evaluation, with consideration for sustainability and cultural competency.

Participating in a collaborative effort:

- It is necessary to participate in other groups collaborative efforts in order to effectively conduct prevention in the targeted community;
  and
- Planners are representing substance abuse prevention.

3. In addition to the above criteria, the following should be considered when conducting community-based processes:

- Membership: The collaborative should be inclusive in its membership/make-up and engage key community stakeholders. The coalition should have appreciation for local involvement and authority in choosing and carrying out actions.

- Evidence of Effectiveness: Interventions implemented through the community-based process effort need to show evidence of being effective at improving at least one of the following:

  - Contributing to the identified desirable outcome.

  - Impacting the identified community problem/consequence.

- Improving the ability of the prevention system to deliver substance abuse services.

- Clear Purpose: Interventions implemented through a community-based process effort should begin with a clear understanding of their purpose and should consider the following initiatives:

  - Comprehensive services coordination - improving the nature and delivery of services.

  - Community mobilization - generating community activism to address substance abuse and related problems/consequences.

  - Behavior change - creating both system level change and individual behavior change.

  - Community linkages - creating or connecting resources within a community and/or connecting persons to resources.

For more information about best-practice for community based process, please refer to the Community Anti-Drug Coalitions of America website at www.cadca.org.

IV. Identifying and Selecting Interventions

A. Logical and Data-Driven

It is necessary that the intervention be data-driven, in addition to evidence that an intervention has been documented to positively impact the problem or contributing condition being targeted. This means that 'evidence' or data is required to support the decisions made throughout the planning, implementation and evaluation stages.

When planning an intervention it is imperative to have 'evidence' that supports the problem being addressed as well as data to support the local contributing conditions for that problem. This 'evidence' is typically collected as a part of the needs assessment phase of planning.

There should a logical connection between the intervention and the targeted local conditions and that are selected as an evidence-based practice that has been documented to impact the targeted contributing condition. A logic model can be used to demonstrate the connection between needs assessment findings, the intervention, and the intended short- and long-term outcomes, and can be a key tool in ensuring that the selected interventions are appropriate for the community's needs. An example from the Community Anti-Drug Coalitions of America (CADCA) can be found as Attachment 2 (SAMHSA/NREPP, 2010).

B. "Goodness of Fit"

In addition to whether an intervention has been found to be effective, it is important to consider conceptual and practical fit in order to determine whether the intervention 'fits' well in the community. The following factors should be considered:

1. Conceptual Fit (relevant)
   - Addresses a community's salient risk and protective factors, and contributing conditions.
   - Targets opportunities for intervention in multiple life domains.
   - Drives positive outcomes in one or more substance abuse problems, consumption patterns, or consequences.

2. Practical Fit (appropriate)
   - Feasible given a community's resources, capacities, and readiness to act.
   - Additional/reinforcement of other strategies in the community–synergistic vs. duplicative or stand-alone efforts.
   - Appropriate for the cultural context of your community, or able to be modified as appropriate.

3. Evidence of Effectiveness
   - Adequately supported by theory, empirical data, and the consensus judgment of informed experts and community prevention leaders.

General Guidance Steps to Select a "Best-Fit" Option

1. Review or develop a logic model of the program or practice. Does the candidate intervention target the identified problem and the underlying factors that drive or contribute to changes in the problem or outcomes?

2. Consult with the broader community in which the implementation will take place to ensure that community readiness and capacity are in place.

3. Develop and review a plan of action, the steps that will be followed to implement the program/practice, to identify potential implementation problems.

A worksheet to assist in assessing "goodness of fit" is provided as Attachment 3.

C. Finding Interventions That Meet Evidence-Based Criteria

The following resources are not intended to represent a complete list.

Federal Registry - Various federal agencies have identified youth-related programs that they consider worthy of recommendation based on expert opinion or a review of design and research evidence. These programs focus on different health topics, risk behaviors, and settings including violence:

- Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide at http://www.dsgonline.com/mpg2.5/mpg_index.htm.
- Exemplary and Promising Safe, Disciplined and Drug-Free Schools Programs sponsored by the U.S. Department of Education at http://www.ed.gov/admins/lead/safety/exemplary01/exemplary01.pdf.
- Guide to Clinical Preventive Services sponsored by the Agency for Healthcare Research and Quality (AHRQ) at http://www.uspreventiveservicestaskforce.org/recommendations.htm.
- Guide to Community Preventive Services sponsored by the Centers for Disease Control and Prevention (CDC) at http://www.thecommunityguide.org.
- SAMHSA National Registry of Evidence-Based Programs and Practices (NREPP) at http://www.nrepp.samhsa.gov. For more information about using NREPP, please refer to Section IV (D).
- A list of other registries may be found on SAMHSA's website at http://www.samhsa.gov/ebpWebguide/appendixB.asp.

Additional Web Resources - Information about effective prevention planning and implementation can also be found at the following websites:

- Center for the Study and Prevention of Violence Blueprints for Violence Prevention at www.colorado.edu/cspv/.

- National Institute of Alcohol Abuse and Alcoholism (NIAAA) Alcohol Policy Information System (APIA) at http://alcoholpolicy.niaaa.nih.gov/.
- Stop Underage Drinking portal of federal resources at http://www.stopalcoholabuse.gov.
- NIDA InfoFacts: Lessons from Prevention Research at http://www.nida.nih.gov/DrugPages/Prevention.html.

Peer Review Journal Research Sources - Searchable databases: these databases have a search feature for relevant research.

- Google Scholar at http://scholar.google.com/.
- US National Library of Medicine at http://www.pubmed.gov.
- Peer Review Journals: The following are a few of the peer review journals with published research relevant to prevention. They can be accessed through a university library and the above searchable databases.

    - American Journal of Public Health
    - Journal of Addiction Studies
    - Annual Review of Public Health
    - Journal on Studies of Alcohol
    - Preventive Medicine
    - Journal of School Health
    - Journal of Adolescent Health
    - Journal of the American Medical Association
    - Public Health and Research

D. Using the National Registry of Evidence-Based Programs and Policies (NREPP):

NREPP is a decision support system designed to be a tool for selecting interventions. The NREPP reflects current thinking that states and communities are best positioned to decide what is most appropriate for their needs. Beginning in 2007, SAMHSA's NREPP changed to allow local prevention providers and decision makers to identify interventions that produce specific community outcomes that meet their needs.

Key points about the revised NREPP are as follows:

1. A review posted on the NREPP site is no longer adequate to document evidence-based status. All programs that are reviewed will be posted on the NREPP site regardless of evaluation results, including programs with minimal or no positive outcomes found.

2. NREPP is a voluntary rating and classification system designed to provide the public with reliable information on the scientific basis and practicality of interventions that prevent and/or treat mental and substance use disorders.

3. Outside experts review and rate interventions on two dimensions: strength of evidence and dissemination capability. Strength of evidence and readiness for dissemination are assessed according to pre-defined criteria and are rated numerically on an ordinal scale of zero to four, with four being the highest score and zero being the lowest score.

4. Detailed descriptive information and the overall average rating score on each dimension (regardless of the rating score) is included and posted on the NREPP website, for all interventions reviewed. Average scores achieved on each rating criterion within each dimension are also provided.

A list of questions to ask while exploring the possible use of an intervention that is listed on NREPP has been provided as Attachment 4.

V. Implementing Evidence-Based Interventions

When implementing an evidence-based intervention locally, it is necessary to maintain a balance between adaptation and fidelity, follow best-practice principles, and conduct evaluations to monitor and ensure local effectiveness.

A. Balancing Fidelity and Adaptation

A dynamic process, often evolving over time, by which those involved with implementing an intervention address both the need for fidelity to the original program and the need for local adaptation.

There are typically two places in the implementation process when this occurs: (1) at the front end, with the decision to adopt an evidence-based intervention that needs some modification to fit local circumstances; and (2) during implementation, if the expected outcomes are not being achieved locally.

There are three key terms when discussing the issue:

- Fidelity: The degree to which implementation of an intervention adheres to the original design. Sometimes is referred to as program adherence or integrity in some of the literature on this subject. Medical terms, such as dosage, strength of treatment, intensity, and exposure are sometimes used to discuss the overall degree of fidelity (Boruch & Gomez, 1977), (Pentz, 2001).

- Core Components: The elements of a program that analysis shows are most likely to account for positive outcomes. Some programs contain essentially only their core components. Others have discretionary or optional components which can be deleted without major impact on the program's effectiveness, or which are not essential for the program's main target audience.

- Program Adaptation: Deliberate or accidental modification of the intervention, including: deletions or additions (enhancements) of program components; modifications in the nature of the components that are included; changes in the manner or intensity of administration of program components called for in the program manual, curriculum, or core components analysis; modifications required by cultural and other local circumstances.

1. Examples of Adaptations

    - Cutting the number or length of program sessions.
    - Reducing the number of staff involved in delivering a program.
    - Using volunteers or paraprofessionals who do not have adequate experience or training.
    - Changing the intervention as it is implemented over time; such as when a facilitator adjusts the program to fit their style, eliminates content they don't like,

or adds in pieces from other curricula that may not support the goals of the program.

2. Cultural Adaptation

- Cultural adaptation refers to program modifications that are culturally sensitive and tailored to a cultural group's traditional world views.
- Consider the language used – the visuals, examples, and scenarios – and the activities that participants are asked to engage in. These types of changes, which tailor the existing intervention to a particular group of participants, are unlikely to diminish effectiveness.
- Cultural adaptation should address the core values, beliefs, norms, and other more significant aspects of the cultural group's world views and lifestyles.
- Effective cultural adaptation involves understanding and working effectively with cultural nuances and requires appropriate cultural knowledge and sensitivity among developers, those adapting the intervention, and delivery staff.

3. Strategies for Maintaining Effectiveness

- Select an intervention that meets the community's needs. To the extent possible, find an intervention that will need little to no adaptation for targeted circumstances; if this is not possible select an intervention that has been adapted for other audiences in the past or whose developer is willing to assist in the adaptation process.
- Ensure that staff members are committed to fidelity, as they need to be comfortable with the material and the style of interaction. They also must commit to delivering the intervention as agreed.
- Ensure individuals implementing the intervention have appropriate training and skill sets necessary to assure consistent implementation.
- Contact the program developer to ensure that any adaptations made are appropriate. If they are unavailable, discuss it with supervisor, funder, or other local experts. It may be desirable to discuss adaptations locally and then attempt to contact the developer for feedback.
- Determine the key elements that make the intervention effective. This information is usually obtained from the program developer based on his or her research and experience.
- Stay true to the intensity and duration of the intervention. It is important to follow the guidelines for how often the program meets, the length of each session and how long participants stay involved.
- Monitor the intervention's implementation and address any unintentional variation from the original design.
- Stay up-to-date with overall program revisions.
- Be aware that adding material or sessions to an existing intervention while otherwise maintaining fidelity does not generally seem to have a detrimental effect.

4. Adaptations That Are Likely To Reduce Effectiveness

- Eliminating parts of an intervention's content – a piece may be removed that was critical to effectiveness.
- Shortening the duration or intensity of an intervention – there may not be enough time for participants to develop a key skill or to build the relationships that are critical to the change process. Sufficient dosage and the opportunity to form positive relationships with well-trained staff have been identified as important principles of effective prevention programs.
- Making adaptations to the intervention's targeted risk and protective factors, or intervening variable, should not be attempted unless it is done in collaboration with the program's developer.

B. Best-Practice Principles

Even when using an evidence-based intervention it is important to ensure that implementation follows best-practice principles. Most programs that have been found to be effective have been based on these principles. However, it is important that these be well understood by those implementing an intervention, since attention to these principles will likely enhance the success of the intervention. For a detailed description of these principles, refer to Section VI (B).

C. Evaluation of Evidence-Based Interventions

Evaluation is an important part of all prevention services, even when that intervention is evidence-based. Some program developers have been known to promote to purchasers that an outcome evaluation is not necessary if the model program is implemented with fidelity. **This is never the case.**

A local outcome evaluation should still be conducted in order to ensure that the implementation done locally is acquiring positive results. There are many reasons why local implementation of an intervention may alter the expected results: staff delivery, program adaptations, community fit, and cultural context to name a few.

For evidence-based programs that have been rigorously evaluated and consistently shown to have positive results by the developers, a less rigorous local evaluation methodology may be warranted. For example, if doing an intervention that has been shown to reduce substance abuse initiation over time, the local evaluation could focus on ensuring that the intervention has met the immediate outcomes that were documented by the evaluation of the developers (e.g. Botvin Life Skills: decision making, goal setting, etc.). ***The weaker the strength of evidence for an intervention the more rigorous the local evaluation should be.***

It should be noted that SAMHSA's Strategic Planning Framework (SPF) has established evaluation as an integral component of a comprehensive community approach. In a comprehensive community approach using the SPF model, it is important to track progress toward completing the strategic plan, impact of specific strategies on targeted

community conditions, and changes in the targeted contributing conditions. The findings should provide important information to drive future coalition planning and implementation, as well as communicate the benefit of efforts to the community.

VI. Non Evidence-Based Interventions

A. When might it be appropriate to use interventions that are non-evidence-based?

Use of non-evidence based strategies for prevention should be a rare occurrence. There may be instances when a strategy that is not evidence-based is necessary to include as part of using a multi-layered comprehensive prevention approach. These interventions should be used judiciously and considered a last resort. Every attempt should be made to use interventions that meet evidence-based criteria. Instances in which to consider use of evidence-based interventions include:

1. Complex Community Plans
   When using a multi-layered comprehensive approach to target a specific community issue, a community will often find that there are specific local conditions that need to be addressed in order to modify the intervening variables. Research on this type of intervention usually evaluates the impact of a **set** of interventions designed to work together to impact the problem.

   In these cases, one should look for evidence that the intervention component was shown to impact the shorter-term outcome that demonstrates its contribution toward solving the local conditions that are being targeted for improvement.

2. Community Commitment
   Sometimes a community that has been implementing a prevention program for a long period of time will have established strong buy-in from the schools or the community. If this buy-in would be lost by switching to a program with a stronger level of evidence, it may not be possible to change.

   However, the program should not be used indefinitely without evidence of effectiveness. In this scenario, it would be the responsibility of the prevention providers to evaluate the program in order to document effectiveness through a local evaluation.

   Another option that the community may want to consider is to maintain the name and identity of the current program while replacing the content with that of an evidence-based program. In this option, community support may be maintained while ensuring effective services.

3. Emerging Drug Trends
   In some instances the field of prevention research has not yet caught up with emerging drug trends that need to be addressed. In these cases it may be necessary to consider interventions that have not yet been evaluated for their impact on the issue being targeted. Often these issues are drug specific and require interventions unique to the drug (e.g. prescription drug misuse). In these instances it is important to ensure a comprehensive, multi-layered approach that is logical and data-driven.

There may be interventions that have been shown to be effective in targeting a different drug, based on the intervening variables and community conditions that have been identified for the new drug issue. Looking for research to inform decisions about the new drug issue is a way to increase the likelihood that efforts will be effective.

B. Best-Practice Principles

It is imperative to consider what works in prevention. In the article *What Works in Prevention: Principles of Effective Prevention Programs* (Nation, M., et. al., 2003), the authors used a review-of-reviews approach across four areas (substance abuse, risky sexual behavior, school failure, and juvenile delinquency and violence) to identify characteristics consistently associated with effective prevention programs. They are as follows:

1. Comprehensive: Strategies should include multiple components and affect multiple settings to address a wide range of risk and protective factors of the target problem. Consider:

    - Does the program include multiple components?
    - Does the program provide activities in more than one setting?
    - Do the activities happen in settings related to the risk and protective factors associated with the problem?

2. Varied Teaching Methods: Strategies should include multiple teaching methods, including some type of active, skills-based component. Consider:

    - Does the program include more than one teaching method?
    - Does the strategy include interactive instruction, such as role-play and other techniques for practicing new behaviors?
    - Does the strategy provide hands on learning experiences, rather than just presenting information or other forms of passive instruction?

3. Sufficient Dosage: Participants need to be exposed to enough of the activity for it to have an effect. Consider:

    - Does the strategy provide more than one session?
    - Does the strategy provide sessions long enough to present the program content?
    - Does the intensity of the activity match the level of risk/deficits of the participants?
    - Does the strategy include a schedule for follow up or booster sessions?

4. Theory Driven: Preventive strategies should have a scientific justification or logical rationale. Consider:

- Does the program provide (or can one identify) a theory of how the problem behaviors develop?
- Does the program articulate a theory of how and why the intervention is likely to produce change?
- Bring the local model of the problem and model of the solution together to develop a logic model.
- Based on the model of the problem and the model of the solution, is it believable that the program is likely to produce change?

5. Positive Relationships: Programs should foster strong, stable, positive relationships between children and adults. Consider:

   - Does the program provide opportunities for parents and children to strengthen their relationship?
   - For situations where parents are not available or relevant, does the strategy offer opportunities for a participant to develop a strong connection with an adult mentor?
   - Does the strategy provide opportunities for the participant to establish close relationships with people other than professional service providers?

6. Appropriately Timed: Program activities should happen at a time (developmentally) that can have maximal impact in a participant's life. Consider:

   - Does the strategy happen before the problem behavior?
   - Is the strategy timed strategically to have an impact during important developmental milestones related to the problem behavior?
   - Does the activity content seem developmentally (intellectually, cognitively) appropriate for the target population?

7. Socio-Culturally Relevant: Programs should be tailored to fit within cultural beliefs and practices of specific groups, as well as local community norms. Consider:

   - Does the strategy appear to be sensitive to the social and cultural realities of the participants? If not, are planners capable of making the changes that are needed to make it more appropriate?
   - Is the strategy flexible to deal with special circumstances or individual needs of potential participants?
   - Is it possible to consult some potential participants to help evaluate and/or modify the strategy?

8. Outcome Evaluation: A systematic outcome evaluation is necessary to determine whether a program or strategy worked. Consider:

   - Is there a plan for evaluating the program?
   - Does the evaluation plan provide feedback prior to the end of the program?

- Is there a plan for receiving feedback throughout the program development and implementation?

9. Well-Trained Staff: Programs need to be implemented by staff members who are sensitive, competent, and have received sufficient training, support, and supervision. Consider:

   - Is there sufficient staff to implement the program? If so, has the staff received sufficient training, supervision, and support to implement the program properly?
   - Will efforts be made to encourage stability and high morale in the staff members who will provide the program?

C. Evaluation and Gathering Evidence

When using an intervention that does not meet evidence-based criteria, evaluation becomes even more important. An evaluation of interventions that are not evidence-based should be designed based on the theory of change that leads to the decision to implement that intervention. Consider "What is the issue that made planners decide this intervention is necessary?" Then track whether or not the intervention is having an impact on that issue (immediate outcomes).

If it's found that the intervention is successfully improving the immediate outcomes, consider strengthening the evaluation method. In order to move toward collecting evaluation results, document the effectiveness of the intervention so that it will meet evidence-based criteria. This may require that the evaluation move beyond the immediate outcomes and document change at the intervening variable level and possibly the consumption or consequence level.

The goal for non-evidence-based interventions is to move as far along the strength of evidence continuum as possible. However, the initial step of documenting an impact on the most immediate outcomes should be completed as the first step. This will help determine whether the intervention is worth committing the necessary time and resources to conduct a more rigorous evaluation.

If the intervention is found to be effective and a more rigorous evaluation is conducted, consider submitting the findings to a peer review journal. If successful, it may be time to apply to NREPP for review.

VII. Glossary of Key Terms

Contributing/Local Condition: The factors in communities that create and maintain the root causes, or risk factors that contribute to the problem.

Evidence-Based: A prevention service (program, policy, or practice) that has been proven to positively change the problem trying to be impacted.

Interventions: Encompass programs, practices, policies, and strategies that affect individuals, groups of individuals, or entire communities.

Long-term Outcomes: Directly measure changes in the problem. Long-term outcomes show evidence of population-level behavior changes and are potentially influenced in 3 to10 years (e.g. reduction in 30-day use, decrease in alcohol related crashes and fatalities).

Practical Fit: The degree to which an intervention is appropriate for the community's population, cultural context, and local circumstances including its resources, capacities, and readiness to take action.

Problem(s): The risk behavior or consequence it has been decided to address based on the local assessment.

Strength of Evidence: The strength of evidence will fall along a continuum from weak to strong. Where an intervention falls on this continuum is determined by how scientifically rigorous the evaluation process was that documented the intervention's positive impact on the problem and/or contributing condition. It is not determined by how large an impact the intervention demonstrated on the problem targeted.

Short-term Outcomes: Directly measured changes in the local conditions. Short-term outcomes are potentially influenced within 6 to 24 months (e.g., increased retailer compliance).

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CADCA Coalitions Online

July 22, 2004

How to Get the Most Out of Research Articles

Evidence-based. That is the buzz word these days, and it is critical for your coalition to use programs, policies and practices that are (as much as possible) grounded in strong theory and evidence. This is where research comes in. Research is used to test out theories and examine the effectiveness of programs, practices and policies. Coalitions need to use this information to make the best decisions about what strategies they will use to address their local substance abuse issues. It is important to be an informed consumer of research information, and this means reading a research article and assessing the quality of the findings reported and its appropriateness to the work you do. Unfortunately, deciphering these technical articles can be a daunting prospect. However, all hope is not lost!

The following article helps break down the mystery of reading research so that your coalition can get the most out of coalition-relevant research. Research published in peer review journals is typically presented in a very prescribed format, with defined sections. Each section provides you with valuable information about the research study and by linking the pieces together, you can assess the quality and relevance of the research presented. So next time you get a research article, don't toss it aside. Sit down, take a look through the article and make the most of the information in your hand. – Evelyn Yang, MA

"Reading research: Go straight to the source to make science work for you"
By Jessica Campbell

Abstract
This is a summary of the key points in the article and should mention the hypothesis being tested. Read this to determine whether the article is relevant to your work.

Introduction
A context for the study is offered in this section. It should tell you what prompted the researchers to study the question at hand and upon which past research they are building. Ask yourself whether there is a logical connection between the study being introduced and past studies. Note whether the article is a research (reporting the findings of a single study) or review (reporting on a range of related studies) article. Note also whether research is quantitative (dealing with things that can be counted) or qualitative (dealing with interpretation or critique).

Methods
This section, sometimes also called "Methodology," explains how the researchers set about testing their hypothesis. It should include information about the instruments,

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CADCA Calendar

10/19/2004
Audio Teleconference: Coalitions Working with Substance Abuse in the Workplace
TELECONFERENCE

10/27/2004
"Persistently Safe Schoo Conference
Washington, D.C.

11/1/2004
Prevention Ethics Worksl
Las Cruces, New Mexico

11/3/2004
Take the Lead Preventio Conference
Portland, Oregon

11/4/2004
Healthy Communities He

procedures, participants and analysis used by the researchers. Ask yourself whether these seem adequate to answer the question posed by the hypothesis. All of the instruments (questionnaires, surveys, interview protocols, etc.) should be described. Their appropriateness for use in the study should be justified and their quality verified. Then the procedures by which the instruments were applied to the participants should be described. This will help you compare the study to other similar studies. For example, if two studies examined coalition functioning, did one study gather information with a paper/pencil survey and the other with a face-to-face interview? Did one study gather information at just one time point and the other multiple times over the course of five years? How would these factors affect the results? Note not only the number and type of participants included in the study, but also the researchers' reasons for choosing that number and type. Ask yourself whether the participants are demographically similar to the population with which you work and whether any differences in demographics would affect the relevance of the study to your work. The analysis is the final part of the Methods section and will explain how researchers organized and examined the data they collected. Often this takes the form of statistics, but you do not need not be familiar with statistical analysis to understand the study.

Results

The findings of the research are detailed in this section. In addition to raw data, the relationships between variables, as outlined in the introduction, should be explained here. Skim this section and note the subheadings used; they should reflect the questions in the introduction and help you organize your thoughts. The results are often depicted in graphs, tables or other illustrative elements. You might find it helpful to flip to the Discussion section for clarifications of specific findings included in this section.

Discussion

This is a summary of the results, written in narrative rather than statistical or numerical form. This section explains whether the results support the hypothesis and what they mean to previous studies on the topic. Often, suggestions for future research are included in this section. Ask yourself whether the conclusions the researchers draw here are supported by their findings. It can be helpful to read this section before reading the Methods and Results sections to get a better idea of the full scope of the research before delving into its minutiae.

Bibliography

This is a listing of all the sources cited in the article, as well as relevant articles or books that were not cited. Scan this to find other writings relevant to your work.

This article first appeared in the Spring 2004 issue of *Prevention Forum*, published by Prevention First. For more information, please visit www.prevention.org.

Evelyn Yang is the Evaluation and Research Manager at CADCA's National Community Anti-Drug Coalition Institute. If you have any questions, she can be reached at eyang@cadca.org or 703-706-0560, ext. 243.

Youth Conference
St. Paul MN

11/11/2004

CADCA Calendar

This Week in Coalitions Online

- CADCA Hosts 6th Annual Drug-Free Kids Campaign Awards Dinner
- New Legislation Introduced to Reduce Underage Drinking
- Deadline Approaches for CADCA's Mid-Year Training Institute
- Tobacco Prevention Funding Available for Coalitions from RWJF
- SAMHSA Releases Updated Directory of Treatment Programs

SAMPLE LOGIC MODEL

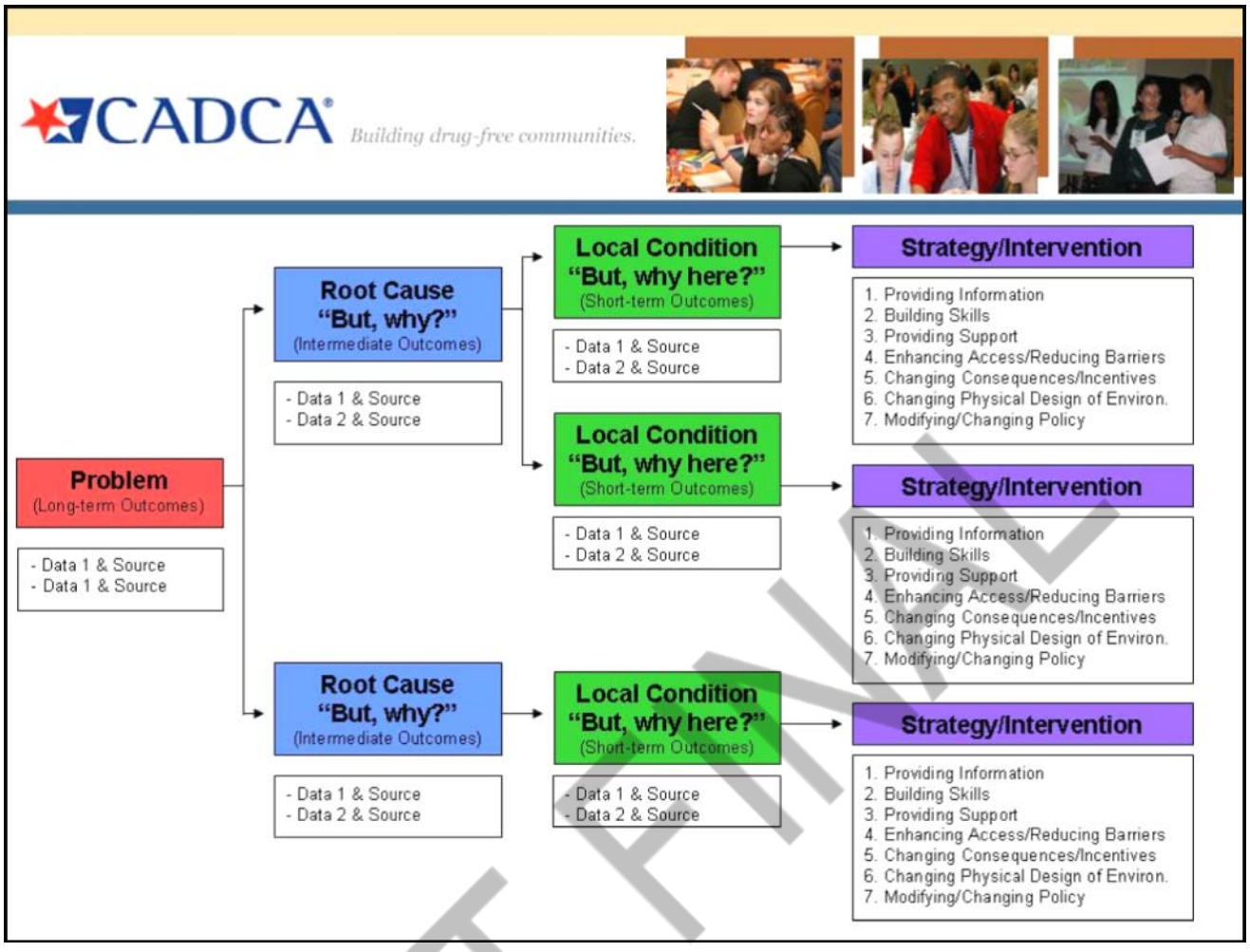
Theory of Change

When a community comes together and implements multiple strategies to address young adult use of methamphetamine drugs in a comprehensive way, young adults will be more likely to use less.

Problem Statement		Strategies		Activities	Outcomes		
Problem	**But why?**	**But why here?**			**Short-Term**	**Intermediate**	**Long-Term [1]**
Young adults Are using meth-amphetamine drugs	Meth is easy to make	Over-the-counter products are sold that contain ephedrine and pseudoephedrine used to make meth	Increase barriers to local meth production by passing a policy to lock up OTC drugs containing precursor chemicals	• Research existing policies • Develop model policy • Educate community and retailers about policy • Identify key decision makers • Mobilize community to support policy • Approach decision-makers to pass policy • Get policy passed • Ensure policy is enforced	50 % of public report support of policy changes % of retailers complying with new policies	Decrease in OTC precursor product sales/thefts Decrease in perceived availability	**Behavioral Outcomes** % of young adults reporting meth use decreases
	Meth is easy to get	Meth is widely sold and given away at bars and parties	Reduce access to meth in the community	Provide information to bar owners & event hosts re: ways to identify & discourage on-site meth use Enhance skills of "hot spot" bar owners & event hosts to counter on-site meth use Increase consequences to bar owners & event hosts who allow meth use on site	% of bar owners/event hosts that say they received mailing and remember key points Percent of bar owners and event hosts that received training and attend to change their practice as a result of training Increased law enforcement presence is documented in problem venues	% bar owners/ event hosts that implement anti-meth practices Increase in perception that meth hot spots are decreasing Decr in perceived availability	**Downstream Consequences (Health and Social Consequences)** % of young adults in treatment for meth addiction decreases
	There is high demand for meth	There is a demand for meth among young adults that feeds the supply Meth users do not have access to treatment in our community	Reduce local demand for meth	Change community practices/systems to engage in comprehensive meth prevention Enhance access and reduce barriers to treatment for meth users Enhance skills of health and social service providers	% of all community members (children, parents, organizations, citizens, etc.) that participate in prevention programs Treatment services are developed/ expanded to address meth use Increased skill in problem identification and referral among health and social service providers	Increase in perceived harm Increase in age of initiation % of young adults referred to treatment for meth decreases	% of meth arrests as a proportion of all drug-related arrests decreases % of meth related ER/Hospital visits decreases

[1] The long-term outcomes are affected not by any single strategy but by ALL of the strategies and activities.

Source: Community Anti-Drug Coalitions of America (CADCA), National Coalition Institute's, Evaluation Primer


CADCA
Building drug-free communities.
Problem
(Long-term Outcomes)
- Data 1 & Source
- Data 1 & Source
Root Cause
"But, why?"
(Intermediate Outcomes)
- Data 1 & Source
- Data 2 & Source
Root Cause
"But, why?"
(Intermediate Outcomes)
- Data 1 & Source
- Data 2 & Source
Local Condition
"But, why here?"
(Short-term Outcomes)
- Data 1 & Source
- Data 2 & Source
Local Condition
"But, why here?"
(Short-term Outcomes)
- Data 1 & Source
- Data 2 & Source
Local Condition
"But, why here?"
(Short-term Outcomes)
- Data 1 & Source
- Data 2 & Source
Strategy/Intervention
1. Providing Information
2. Building Skills
3. Providing Support
4. Enhancing Access/Reducing Barriers
5. Changing Consequences/Incentives
6. Changing Physical Design of Environ.
7. Modifying/Changing Policy
Strategy/Intervention
1. Providing Information
2. Building Skills
3. Providing Support
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Strategy/Intervention
1. Providing Information
2. Building Skills
3. Providing Support
4. Enhancing Access/Reducing Barriers
5. Changing Consequences/Incentives
6. Changing Physical Design of Environ.
7. Modifying/Changing Policy

Assessing "Goodness of Fit" Worksheet

The following questions, provided by the SAMHSA Prevention Platform, can be used to assess "Goodness of Fit."

Note that "community" could be substituted for "organization" if considering a community logic model.

Mission, Goals, Objectives	Yes	No	NA
1. Does this program or practice fit your organization's mission?			
2. Does the program or practice fit with the *values* underlying your organization's mission?			
3. Is the program or practice compatible with the organization's current focus?			
Implementation Capacity	Yes	No	NA
4. Does your organization have the human resources to implement the program or practice?			
5. Does your organization have the material resources to implement the program or practice?			
6. Does your organization have the appropriate funding to implement the program or practice?			
7. Can you implement the program or practice in the manner it was designed?			
8. Does the program or practice take into account the readiness of the community and target population?			
Cultural Relevance	Yes	No	NA
9. Is the program or practice appropriate for the community's values and existing practices?			
10. Is the program or practice appropriate for the culture and characteristics of the community being served?			
11. Does the program or practice take into account the community's values and traditions that affect how its citizens and the targeted group regard health promotion issues?			
12. Has the program or practice shown positive results in areas that are important to your community?			
Evidence Based and Effective	Yes	No	NA
13. Is the program or practice based on a well-fined theory or model?			
14. Is there documented evidence of effectiveness (such as formal evaluation results?			
15. Have the results been replicated successfully by different researchers over time?			
16. Has the program or practice been shown to be effective for areas similar to those you will address?			

National Registry of Evidence-based Programs and Practices

Questions To Ask as You Explore the Possible Use of an Intervention

Implementations

- Where has this intervention been implemented? In what settings? With what populations?
- What are the particular challenges to effective implementation? How might these challenges be overcome?
- What common mistakes have been made, and how can we avoid them?
- Can you provide contact information for two or three directors of implementation sites that are currently in the process of implementing the intervention?

Notes:

Adaptations

- Has your intervention been adapted in any ways that might be relevant to its implementation in a setting like mine (describe your setting) or with a population like mine (describe your population)?
- Have you been able to identify whether there are any "core components" of the intervention—parts of the intervention that must be implemented and/or should not be adapted?

Notes:

Staffing

- What are the staffing requirements (number and type)?
- What are the minimum staff qualifications (degree, experience)?
- What methods are used to select the best candidates (philosophy, skills)?
- Is there a recommended practitioner-to-client ratio?
- Is there a recommended supervisor-to-practitioner ratio?

Notes:

Quality Assurance Mechanisms

- What are the core components that define the essence of the intervention?
- How are supervisors prepared to provide effective support for practitioners?
- What is the supervision protocol for providing effective support for practitioners?
- What practical instruments are available to assess adherence and competence of the practitioner's use of the intervention's core components?
- What tests have been done to ensure the validity and reliability of the fidelity instruments?

Notes:

Training and Technical Assistance

- Is training required before a site can implement this intervention?
- Who conducts the training, and where is it conducted?
- Can staff at implementation sites be certified to conduct the training?
- Who is typically trained (practitioners, staff selection interviewers, staff trainers, staff supervisors/coaches, agency administrators)?
- What is the duration of the training (hours, days)?
- Is retraining required/available?
- What on-site assistance is provided by the developer, if any?
- How long does it usually take for a new implementation site to become a high-fidelity user of the intervention?

Notes:

Costs

- How much does it cost to secure the services of the developer? What is included in that cost?
- If the intervention costs more than my budget allows, is there a way to implement only part of the intervention?
- Do costs include salaried positions? In-kind costs? Special equipment?

Notes:

Partnership for Success: Project Year 5 Summary

October 1, 2019-September 30, 2020

Brianna M. Sabol & Elizabeth Agius
WAYNE STATE UNIVERSITY | SCHOOL OF SOCIAL WORK

Table of Contents

Executive Summary

Michigan's Partnership for Success (PFS) 2015-2020 grant project strives to enhance behavioral health capacity within communities, by strengthening and expanding the Strategic Prevention Framework (SPF) and enhancing community-level infrastructure to link with primary care. In order to do so, the grant project involves three central activities: (1) coalition development, continuation, and/or enhancement; (2) collaboration and capacity building in partnership with primary care providers (PCPs) to implement Screening, Brief Intervention, and Referral to Treatment (SBIRT); and (3) administer individual and family-level intervention programs (Prime for Life [PFL] and Strengthening Families Program [SFP]). Communities targeted through the PFS grant include: Muskegon, Mason, Oceana, St. Joseph, Van Buren, Bay, Eaton, Wayne (Detroit [Empowerment Zone Coalition & Love Detroit Prevention Coalition] & Taylor), Macomb, and Genesee. Assessment criteria of each community is based on evaluation goals required by the Center for Substance Abuse Prevention (CSAP).

Overall, through a combination of implementing the SPF process as well as leveraging resources and funding streams, all communities implementing initiatives that successfully supported the grant's three central activities. In turn, these efforts strengthened prevention capacity and infrastructure at the community level. Communities also took steps to sustaining these efforts, once the grant ends. Furthermore, National Outcomes Measures (NOMs) demonstrate these efforts have contributed to preventing the onset and reducing the progression of underage drinking and prescription drug misuse, as well as reducing alcohol- and prescription drug-related consequences. As a result, communities demonstrated success in meeting CSAP evaluation goals and have accomplished grant objectives by the end of Project Year (PY) 5.

Introduction

Michigan's Partnership for Success (PFS) 2015-2020 grant project strives to enhance behavioral health capacity within communities, by strengthening and expanding the Strategic Prevention Framework (SPF) and enhancing community-level infrastructure to link with primary care. Michigan has chosen to address underage drinking among youth, ages 12-20, and prescription drug misuse and abuse among youth, ages 12-25. In order to do so, the grant project involves three central activities: (1) coalition development, continuation, and/or enhancement; (2) collaboration and capacity building in partnership with primary care providers (PCPs) to implement Screening, Brief Intervention, and Referral to Treatment (SBIRT); and (3) administer individual and family-level intervention programs (Prime for Life [PFL] and Strengthening Families Program [SFP]). Within these central activities, communities are expected to increase Michigan Profile for Healthy Youth (MiPHY) participation and target a portion of their efforts toward a population experiencing behavioral health disparities.

Counties targeted through PFS include: Muskegon, Mason, Oceana, St. Joseph, Van Buren, Bay, Eaton, Wayne (Detroit [Empowerment Zone Coalition & Love Detroit Prevention Coalition] & Taylor), Macomb, and Genesee. The following report outlines how each community accomplished the primary grant objectives and presents trends in National Outcome Measures (NOMS), over the course of the PFS grant. This information provides a holistic picture of efforts in each community and is used to conclude whether communities met PFS evaluation goals required by the Center for Substance Abuse Prevention (CSAP) (table 1).

Table 1. PFS Evaluation Goals
Goal 1. Preventing the onset and reducing the progression of underage drinking and prescription drug misuse.
Goal 2. Reducing alcohol- (ages 12-20) and prescription drug-related (ages 12-25) consequences among adolescents and young adults.
Goal 3. Implementing the SPF process at the State/Jurisdiction/tribal, and community (sub-recipient levels).
Goal 4. Strengthening the prevention capacity and infrastructure at the State/jurisdiction/tribe and community (sub-recipient) levels.
Goal 5. Leveraging, redirecting, and aligning statewide funding streams and resources for prevention.

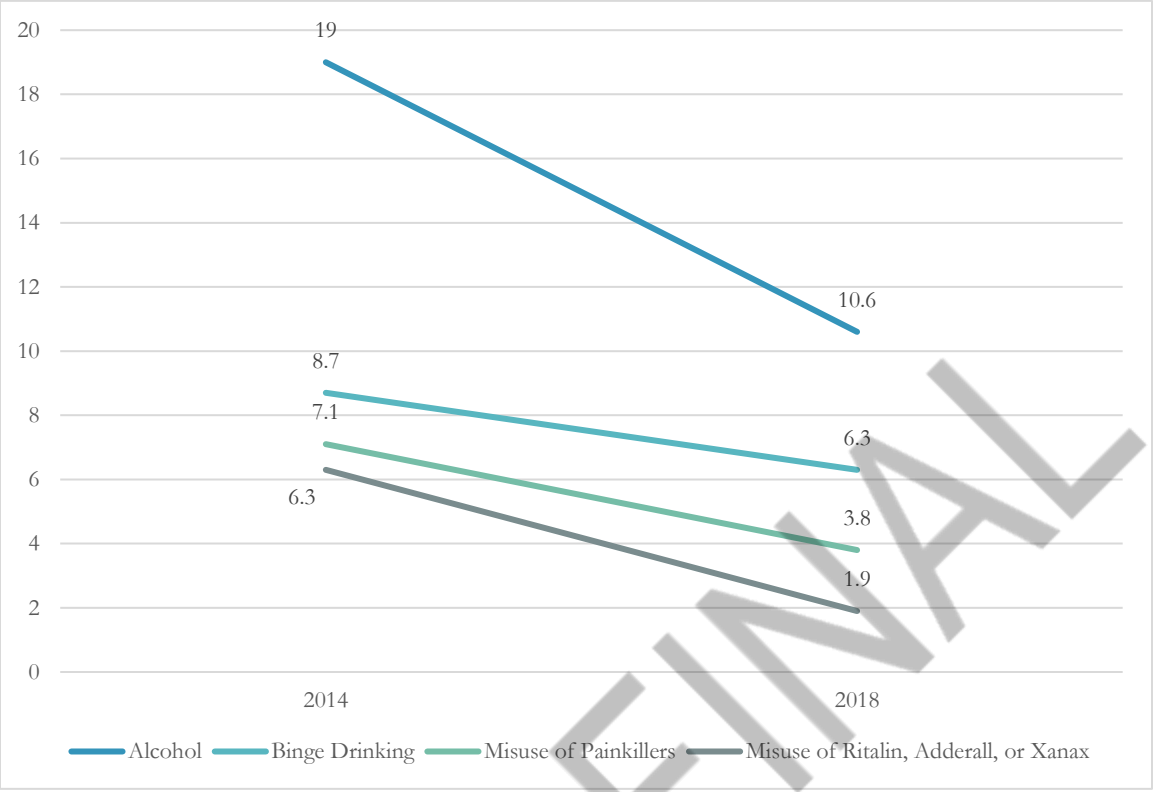
Community Performance Outcomes

Region 3: Mason County

Community Level (PY1)	Coalition Model	Prevention Program(s)	Health Disparity Population
1	CT	PFL & SFP	White, Low SES

In Project Year (PY) 1, Mason County was designated as a level 1 community, as there was no existing coalition and minimal effort in community around prevention. Through the PFS grant, Mason County has developed a fully functioning coalition that has a significant presence in the community. The coalition has grown through extensive recruitment and retention efforts, which are partly accomplished through community initiatives held on a regular basis. These efforts include community presentations, community awareness and outreach events, distributing medication lock boxes, and prescription drug take back events. Coalition meetings have also been reorganized to include an orientation in the second half of the meetings for new attendees. Alongside these initiatives have been efforts to conduct the MiPHY survey in order to receive on-going local data. The coalition has grown the participation of local schools by providing incentives and support for implementation; thereby, leading to more consistent participation. Overall, this groundwork conducted in the community placed Mason County in a strong position to apply for the Drug Free Communities (DFC) grant. Beyond coalition development and enhancement, Mason County conducts prevention programs on a regular basis. Through partnerships with local schools, prevention programming is offered as an alternative to suspension. Although the predominant healthcare system (Spectrum Health) in Mason County already has substance use screening and assessment processes in place, the coalition has partnered with them to collaborate on community events and presentations. The coalition coordinator participates in the local Behavioral Health Collaborative, chaired by Spectrum Health, which also includes other primary care representatives from the community. In turn, representatives from Spectrum Health serve on the coalition as a Mental Health Liaison and Executive Committee member. As the coalition maintains a list of community resources around local substance use treatment and recovery agencies, this partnership permits information and resources to be shared on a regular basis among the two entities.

Recent Substance Use (Past 30-Days (%))



Intervening Variables

	Perception of Parental Disapproval or Attitude		Perception of Peer Disapproval or Attitude		Perceived Risk/Harm of Use		Family Communication Around Substance Use
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Parent**
2014	92.9%	96.8%	69.8%	86.4%	71.5%	79.2%	78.6%
2016							
2018	93.0%	96.8%	72.4%	83.4%	56.3%	69.0%	77.6%
2020							

Consequences

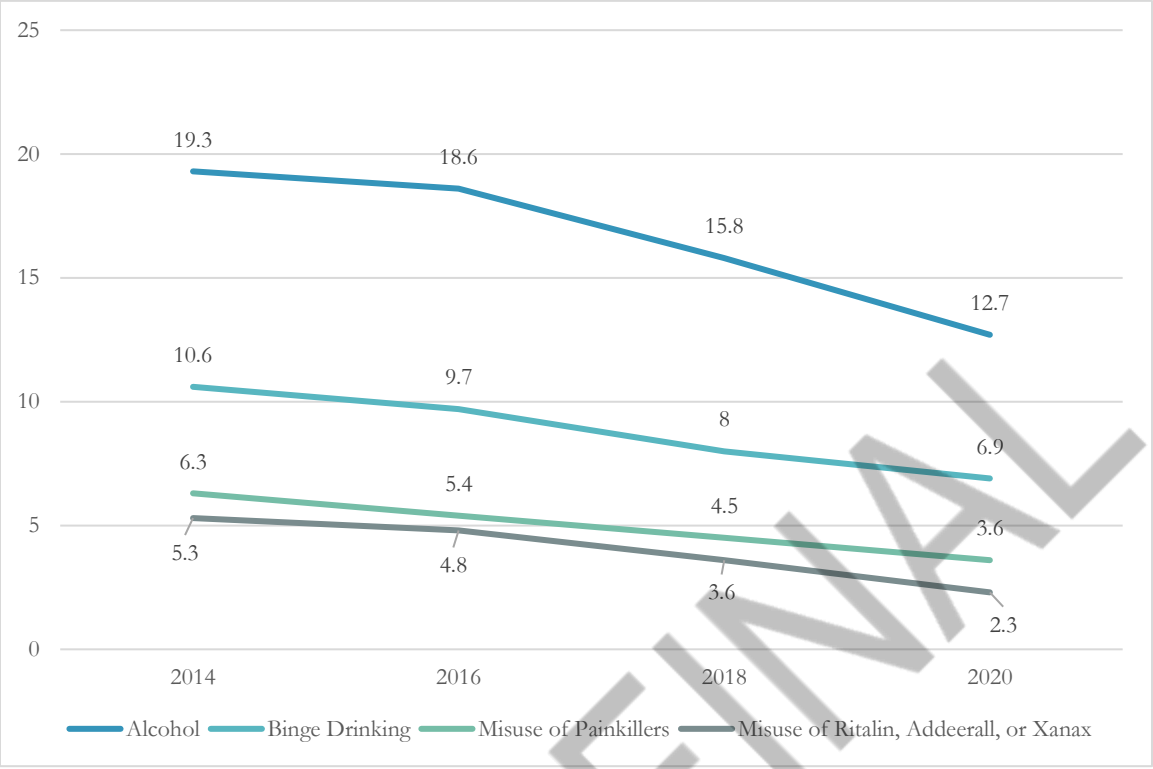
	Substance Related Traffic Crashes		Substance Related Traffic Injuries	
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**
2014	0.6%	0.9%	0.0%	3.2%
2015	2.9%	0.9%	5.3%	0.0%
2016	0.5%	0.3%	0.0%	0.0%
2017	2.4%	2.7%	9.1%	14.5%
2018	2.3%	0.6%	3.7%	4.5%
2019	1.3%	1.3%	5.9%	8.6%

Region 3: Muskegon County

Community Level (PY1)	Coalition Model	Prevention Program(s)	Health Disparity Population
3	N/A	PFL & SFP	White, Low SES

In PY 1, Muskegon County was designated as a level 3 community. Through the PFS grant, Drug Free Muskegon County has enhanced existing community processes and expanded relationships with their priority population. Muskegon County has a strong coalition, that is well-established in the community. The coalition holds quarterly meetings, which regularly include a speaker from a partner agency. Each workgroup meets monthly to plan events that are built around group members' interests. Common community initiatves include alcohol retail education and compliance checks, national take back day, and media campaigns. The coalition routinely consults and updates their strategic plan, and conducts an annual coalition evaluation to identify which areas of the coalition require improvement. Muskegon County regularly has strong MiPHY participation, with generally 100% participation of all 12 public school districts in the county. The coalition has been working with Hackely Community Care Center and Mercy Health. Both of these sites conduct their own screening and have their own referral processes in place. The coalition supports existing screening and referral efforts through regular meetings, where they consult on how to expand and develop their respective Substance Use Disorder (SUD) services. Prevention programming also occurs regularly throughout the community, and relationships with schools have created a sustainable method of maintaining prevention programs. SFP is conducted through Arbor Circle. They contract with several staff to serve as facilitators. Arbor Circle has collaborative partnerships with local churchs, schools, coalitions, and organizations. Partners assist by hosting SFP courses, along with providing referrals as well as advertising and conducting outreach to obtain referrals for the program. PFL programs are held on-site at the local health department agency. They mostly provide programming to middle school and high school youth. This is because PFL is administered to a summer school program, juvenile justice program and is used as an alternate to suspension in local schools. Drug Free Muskegon County partners with the Muskegon Health Disparities Coalition to conduct trainings that largely revolve around raising awareness and understanding of health disparities, which includes sessions on unconscious bias, cultural competency and access to care forums. The coalition also routinely receives data on social determinants of health from a local partner, which is used to inform their community efforts.

Recent Substance Use (Past 30-Days (%))



Intervening Variables

	Perception of Parental Disapproval or Attitude		Perception of Peer Disapproval or Attitude		Perceived Risk/Harm of Use		Family Communication Around Substance Use
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Parent**
2014	93.5%	95.6%	72.2%	81.9%	70.5%	76.6%	77.0%
2016	95.3%	96.5%	75.1%	83.7%	68.4%	74.2%	77.2%
2018	94.6%	96.6%	76.5%	86.9%	69.2%	75.6%	77.3%
2020	95.0%	97.3%	77.9%	88.6%	68.9%	75.7%	77.5%

Consequences

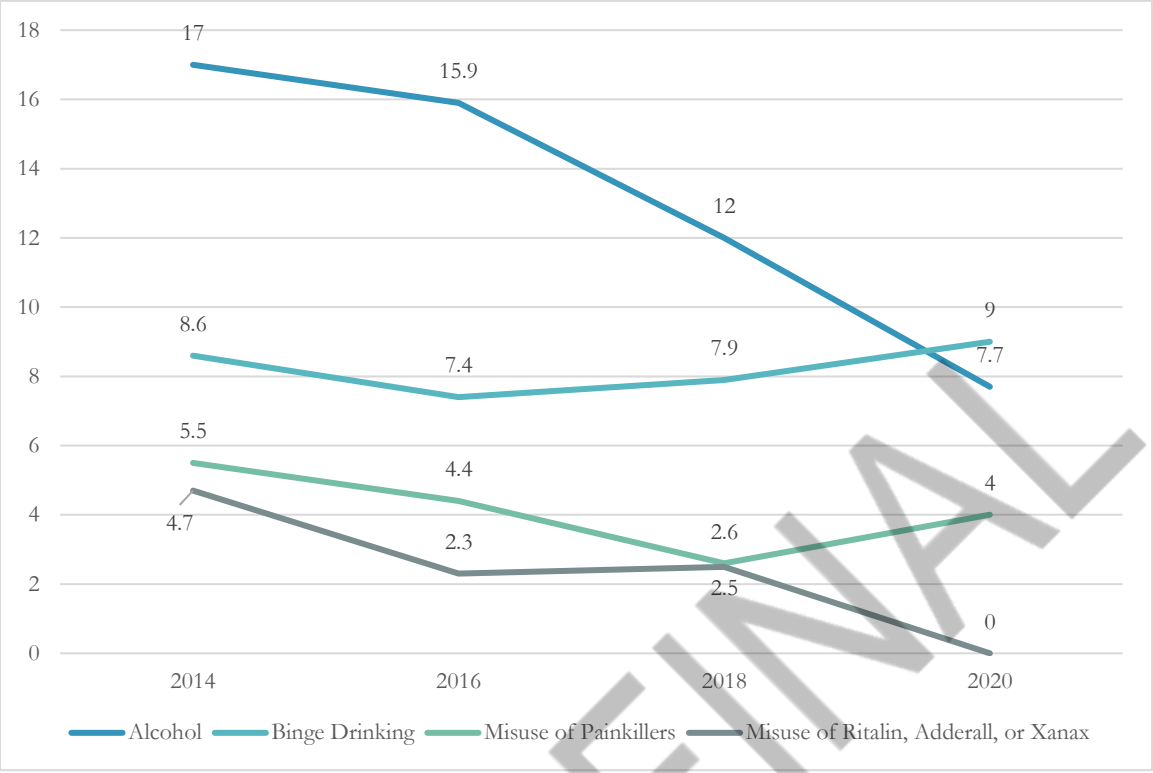
	Substance Related Traffic Crashes		Substance Related Traffic Injuries	
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**
2014	1.0%	0.3%	3.8%	2.5%
2015	1.8%	0.6%	3.8%	2.7%
2016	0.5%	0.7%	1.3%	1.7%
2017	0.9%	0.8%	2.8%	2.5%
2018	1.2%	1.4%	1.9%	4.1%
2019	1.1%	0.9%	4.5%	2.3%

Region 3: Oceana County

Community Level (PY1)	Coalition Model	Prevention Program(s)	Health Disparity Population
1	CT	PFL & SFP	Hispanic/Latino

In PY 1, Oceana County was designated as a level 1 community, as there was no existing coalition and minimal effort in community around prevention. Throughout the PFS grant, Oceana County has developed a fully functioning coalition that has a significant presence in the community. The coalition structure is maintained through established processes and procedures, including: a mission statement, bylaws, annual renewal of Coalition Involvement Agreements (CIAs) with members, regular meetings, and more. The coalition has grown through extensive recruitment and retention efforts, which are partly accomplished through community initiatives held on a regular basis (for example: “Keep Out: Teen Room Project”, distribution of medication lock boxes, sticker shock campaigns, and medication take back events). Alongside these initiatives have been efforts to conduct MiPHY survey implementation in order to receive local data. The coalition has gradually built the number of schools willing to participate in this survey. Overall, this groundwork conducted in the community, placed Oceana County in a strong position to apply for the DFC grant. Beyond coalition development and enhancement, Oceana County conducts prevention programs on a regular basis. Prevention programming is largely offered in schools as an alternative to suspension. This has extended to the target health disparity population, where a partnership with organizations that serve the Hispanic community, assist the coalition in offering PFL in Spanish. The coalition coordinator works with primary care sites, namely Mercy Health and Spectrum Health, who already have their own SBIRT screening and assessment processes in place. However, the coalition includes healthcare representatives that take information and resources back to their organizations, or share using email and other communication.

Recent Substance Use (Past 30-Days (%))



Intervening Variables

	Perception of Parental Disapproval or Attitude		Perception of Peer Disapproval or Attitude		Perceived Risk/Harm of Use		Family Communication Around Substance Use
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Parent**
2014	94.7%	96.0%	71.2%	80.6%	68.8%	81.6%	78.9%
2016	94.6%	97.6%	74.3%	88.0%	73.6%	81.3%	77.9%
2018	92.8%	95.5%	72.1%	86.4%	72.2%	74.8%	73.5%
2020	94.7%	97.3%	71.1%	77.3%	58.7%	76.3%	66.7%

Consequences

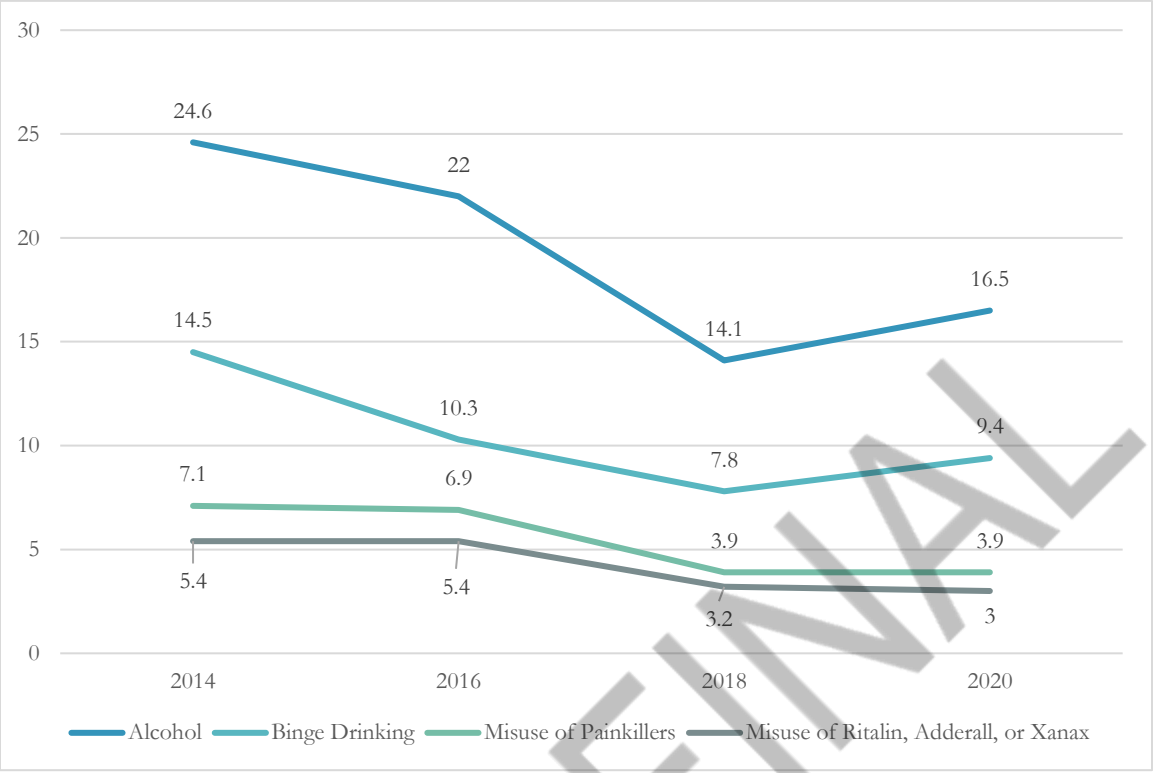
	Substance Related Traffic Crashes		Substance Related Traffic Injuries	
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**
2014	1.7%	1.3%	4.2%	6.7%
2015	2.6%	0.9%	3.4%	2.0%
2016	0.0%	0.4%	0.0%	0.0%
2017	2.4%	3.1%	7.1%	5.6%
2018	0	0.8%	0	1.8%
2019	2.0%	0.9%	7.7%	0

Region 4: St. Joseph County

Community Level (PY1)	Coalition Model	Prevention Program(s)	Health Disparity Population
2	CMCA	PFL & SFP	Hispanic/Latino

In PY1, St. Joseph County was designated as a level 2 community; meaning, there was a coalition in existence but it needed to be enhanced before establishing prevention programming and SBIRT. Since PFS, the coalition has intentionally recruited new members and sectors to fill gaps that existed at the beginning of the project. In particular, they have engaged individuals that represent the Hispanic community. The coalition hopes to solidify these relationships and thereby achieve consistent, meaningful representation from the Hispanic community, in order to serve the needs of their health disparity target population. Coalition members plan and implement community initiatives specific to prescription drug and alcohol use; some specific tasks involve developing messages for e-mail marketing, social media outreach, and e-newsletter distribution. Further, the coalition's involvement in MiPHY survey implementation has resulted in regular participation from local schools. Efforts to enhance MiPHY participation were part of broader coalition efforts to enhance data collection in the community, which led to the creation of an Epidemiological Workgroup. Annually, the Workgroup produces a report of local and statewide data trends, pertinent to substance use in the community. These results are shared with coalition members, and based on the data, the coalition discusses how to target community interventions. Engaging coalition members in the data assessment and planning phase has helped with member retention and involvement. In turn, increased coalition capacity has led to the formation of more community partnerships, and therefore higher levels of PFL implementation. Referrals to PFL programming are received on a consistent basis from community partners—mainly court programs—and there are several host sites throughout the community. Lastly, through a partnership with Indiana University, St. Joseph County assisted in the implementation of SBIRT at a local primary care site (Covered Bridge). The SBIRT planning and implementation phases at Covered Bridge are complete, and SBIRT at Covered Bridge is organized to operate independently after PFS is complete.

Recent Substance Use (Past 30-Days (%))



Intervening Variables

	Perception of Parental Disapproval or Attitude		Perception of Peer Disapproval or Attitude		Perceived Risk/Harm of Use		Family Communication Around Substance Use
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Parent**
2014	92.0%	95.0%	67.2%	79.7%	67.9%	76.5%	76.4%
2016	91.4%	94.4%	75.6%	83.3%	68.1%	74.5%	79.1%
2018	91.6%	95.4%	72.6%	82.6%	67.8%	73.7%	77.8%
2020	91.5%	96.5%	71.3%	84.6%	67.2%	75.0%	78.8%

Consequences

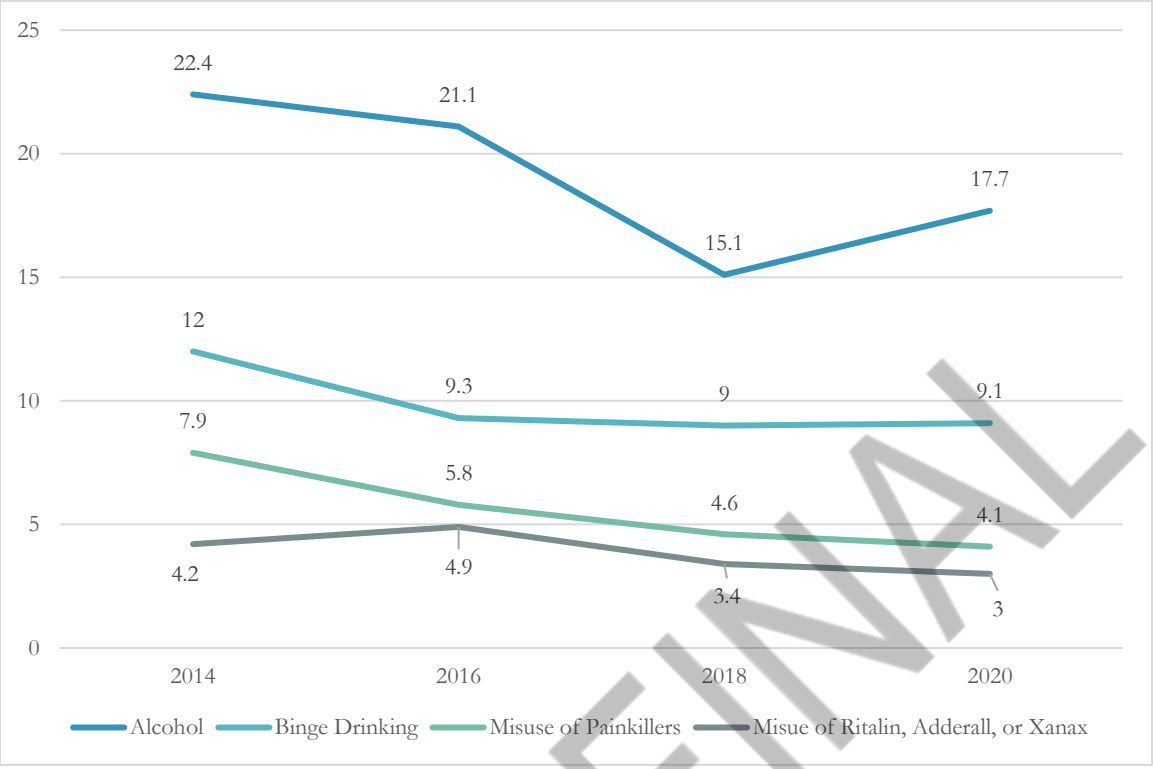
	Substance Related Traffic Crashes		Substance Related Traffic Injuries	
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**
2014	2.0%	0.2%	3.5%	1.0%
2015	3.6%	0.8%	8.1%	0.0%
2016	3.4%	1.4%	11.4%	4.3%
2017	3.0%	1.6%	9.2%	5.3%
2018	2.6%	0.9%	3.0%	1.7%
2019	1.1%	1.0%	0	3.8%

Region 4: Van Buren County

Community Level (PY1)	Coalition Model	Prevention Program(s)	Health Disparity Population
N/A	N/A	PFL	Hispanic/Latino

In PY4, Van Buren County was added to the PFS grant as an expansion community. Although coalition membership was already strong, the PFS grant propelled Van Buren to ensure complete sector representation by adding individuals from sectors including healthcare, law enforcement, and civic groups. In particular, they engaged individuals that represent the Hispanic community, in hopes of having a consistent voice on the coalition to effectively serve the needs of their health disparity target population. Coalition members are actively involved in planning and implementing community initiatives related to PFS efforts. This is largely due to using action-oriented agendas that involve coalition members in relating local-level and statewide data to strategies and activities they wish to prioritize in the community. The newly created Epidemiological Workgroup is responsible for gathering this data and creating an annual report that informs these processes. Part of the data that's gathered is from MiPHY, which has high participation from local schools due to strong partnerships. These school partnerships have also led to widespread PFL implementation in several schools on a regular basis. Lastly, SBIRT has been successfully implemented at a local primary care site, InterCare; where patients are screened and referred to the in-house SUD treatment programs. The coalition is working to connect patients—who are at-risk but not eligible to receive treatment—to necessary prevention services. SBIRT services will operate independently once PFS grant is complete.

Recent Substance Use (Past 30-Days (%))



Intervening Variables

	Perception of Parental Disapproval or Attitude		Perception of Peer Disapproval or Attitude		Perceived Risk/Harm of Use		Family Communication Around Substance Use
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Parent**
2014	92.8%	94.8%	66.0%	79.1%	69.5%	76.8%	76.3%
2016	92.8%	94.4%	70.4%	80.1%	70.7%	75.0%	78.6%
2018	93.5%	96.3%	77.0%	86.9%	69.8%	77.1%	78.6%
2020	93.9%	96.6%	73.0%	87.6%	67.4%	75.4%	79.8%

Consequences

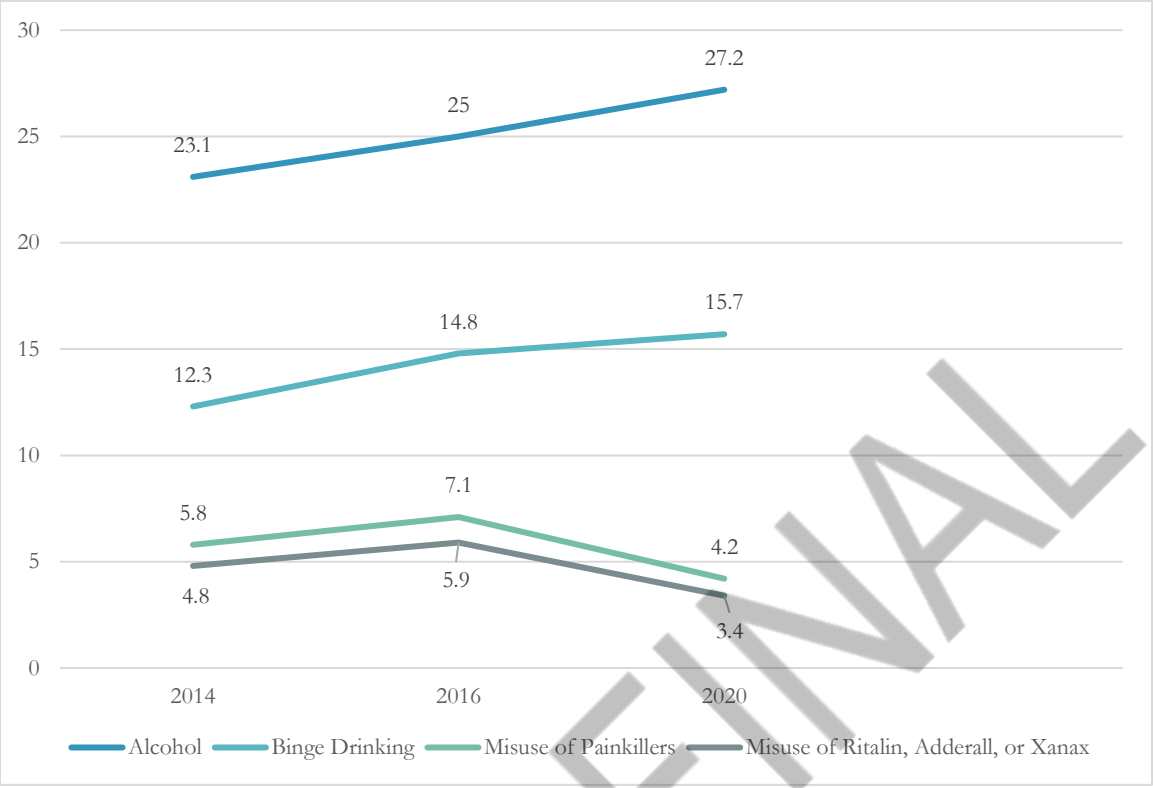
	Substance Related Traffic Crashes		Substance Related Traffic Injuries	
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**
2014	2.3%	1.2%	1.7%	0.7%
2015	1.4%	1.8%	1.0%	4.0%
2016	2.2%	1.6%	4.2%	4.5%
2017	3.8%	3.1%	7.4%	12.0%
2018	3.2%	0.8%	7.7%	2.5%
2019	2.3%	1.7%	8.7%	8.4%

Region 5: Bay County

Community Level (PY1)	Coalition Model	Prevention Program(s)	Health Disparity Population
2	CT	PFL	White, Low SES

In PY1, Bay County was designated as a level 2 community. Before PFS, Bay County had stable coalition membership, but continued to engage in recruitment efforts throughout the grant. Coalition leadership revisits the strategic plan annually to update and review bylaws, guiding principles, and objectives. Coalition subgroups implement activities that align with the objectives; namely, underage drinking and sticker shock campaigns, beverage server training, and vendor education. Bay County has increased MiPHY participation and produces a report of findings to distribute at community meetings. In response to PCP resistance to SBIRT, the PFS coordinator established SBIRT training at Saginaw Valley State University, which has trained over 200 students enrolled in the following healthcare programs: Nurse Practitioner, Occupational Therapy, Social Work, and Pharmacy. The PFS coordinator also established Project Extension for Community Health Care Outcomes (ECHO), which engages PCPs in SUD education using telehealth. Over the course of the project, Project ECHO has reached over 140 clinical sites. Both of these projects will remain in-place once the grant is complete. PFL programs run at through Neighborhood Resource Center are conducted at schools where the majority of students receive free/reduced lunch; thereby, targeting the coalition's health disparity population.

Recent Substance Use (Past 30-Days (%))



Intervening Variables

	Perception of Parental Disapproval or Attitude		Perception of Peer Disapproval or Attitude		Perceived Risk/Harm of Use		Family Communication Around Substance Use
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Parent**
2014	92.4%	94.5%	65.3%	81.4%	68.1%	82.8%	84.0%
2016	93.3%	97.3%	71.3%	85.6%	70.8%	81.3%	79.4%
2018							
2020	87.9%	96.3%	63.5%	85.5%	61.4%	75.6%	76.8%

Consequences

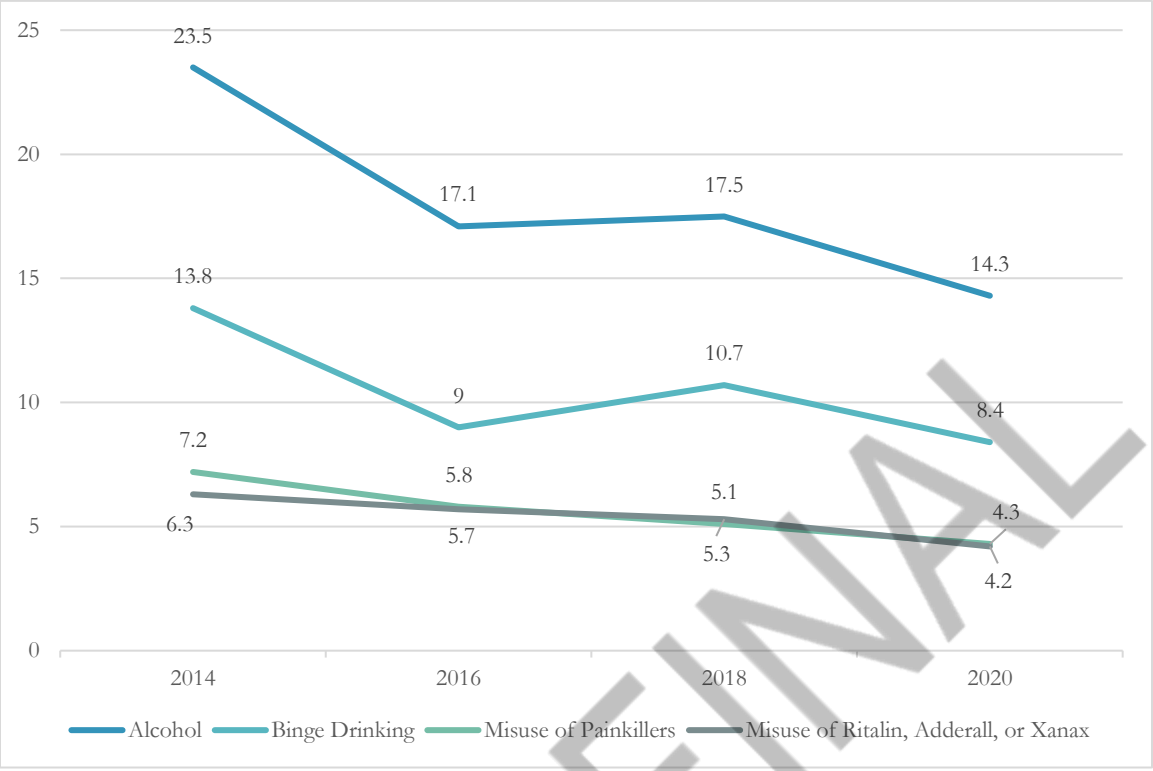
	Substance Related Traffic Crashes		Substance Related Traffic Injuries	
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**
2014	1.6%	0.6%	4.0%	2.0%
2015	1.4%	0.5%	6.5%	0.5%
2016	1.6%	0.3%	4.1%	0.0%
2017	1.3%	1.2%	2.4%	3.9%
2018	2.0%	0.9%	4.9%	2.8%
2019	2.5%	0.7%	4.5%	3.2%

Region 5: Eaton County

Community Level (PY1)	Coalition Model	Prevention Program(s)	Health Disparity Population
N/A	N/A	PFL	LGBTQ

Eaton County joined PFS as an expansion community in PY3. Since receiving the PFS grant, coalition staff met with area leaders to re-engage them in coalition work. They also enhanced partnerships with community coalitions and tri-county groups, which concurrently served to aide recruitment efforts. New members have also been recruited through community events; namely the coalition helped sponsor Eaton County Opioid Summit in March 2020. Discussion of the PFS grant is a standing agenda item at coalition meetings, where staff provide updates and facilitate conversations around strategies and initiatives. The PFS grant has allowed the coalition to bolster existing community initiatives, and thus, member participation has increased by involving them in these initiatives. Further, all schools in the county have participated in MiPHY 2020. This data will inform future strategic initiatives. Following a year of working with school administrators to adapt policies, PFL is now implemented in two schools as an alternative to suspension for students caught using substances. School district staff were trained as facilitators to continue the program once PFS ends. Two trainings were provided to local hospital systems by Indiana University. The coalition also provides referral information for local treatment resources, including an updated the Wellness Guide—with mental health and treatment resources—and Growing Healthy Teens Guide. In the county, there was not a current referral process in-place for adults, however, referral forms have been developed for youth to be referred to mental and behavioral health providers. To target their health disparity population, Eaton County included resources specific to LGBTQ youth, in their Health Resource Guide, and began working with Gay Straight Alliances (GSAs) in high schools to share information about substance use. Each of the above strategies have been integrated into the coalition's work plan and were set-up using existing funding sources, so they will be able to continue once the grant concludes.

Recent Substance Use (Past 30-Days (%))



Intervening Variables

	Perception of Parental Disapproval or Attitude		Perception of Peer Disapproval or Attitude		Perceived Risk/Harm of Use		Family Communication Around Substance Use
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Parent**
2014	92.5%	95.7%	69.4%	79.8%	71.0%	77.7%	77.7%
2016	93.7%	96.4%	75.6%	80.8%	65.1%	77.7%	78.8%
2018	94.3%	96.3%	73.6%	81.8%	69.5%	74.4%	77.7%
2020	93.9%	95.7%	76.4%	85.9%	65.9%	76.0%	76.4%

Consequences

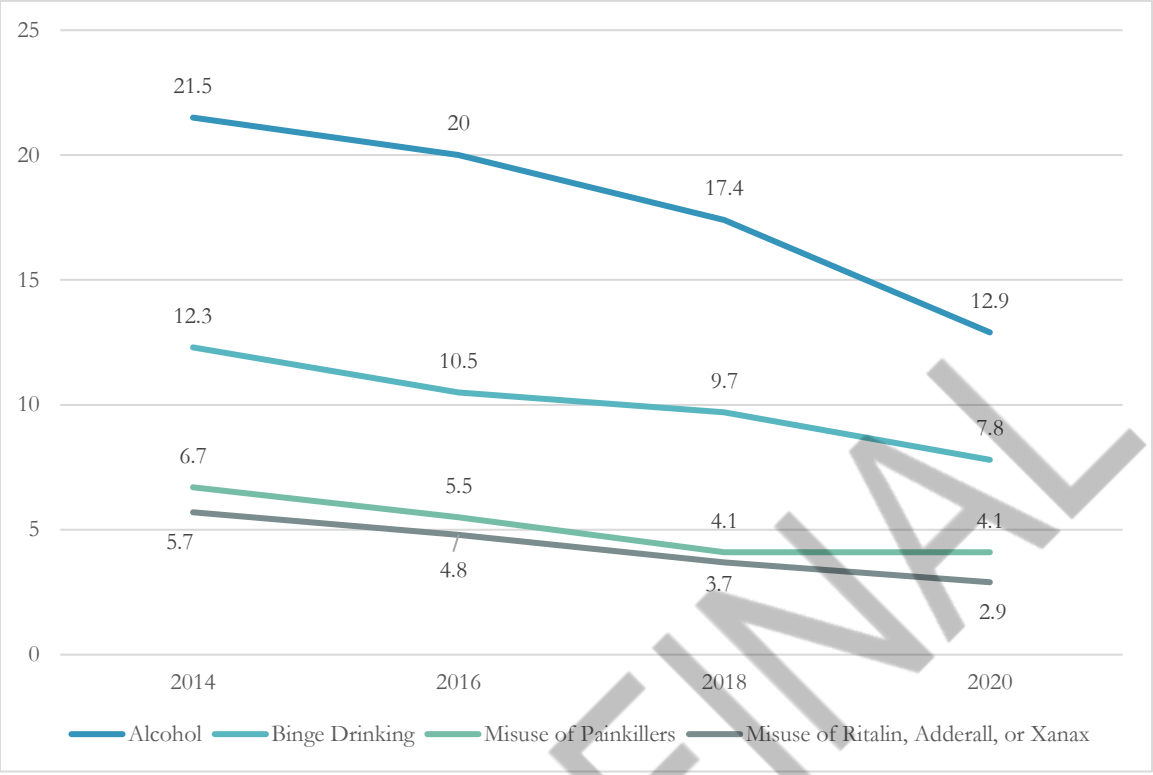
	Substance Related Traffic Crashes		Substance Related Traffic Injuries	
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**
2014	1.3%	0.8%	2.3%	4.6%
2015	1.9%	0.8%	4.0%	3.3%
2016	1.1%	0.8%	6.1%	6.2%
2017	1.9%	1.1%	4.5%	3.5%
2018	1.7%	1.6%	3.6%	4.9%
2019	2.8%	1.4%	7.5%	7.0%

Region 7: Wayne County (Detroit, Empowerment Zone Coalition)

Community Level (PY1)	Coalition Model	Prevention Program(s)	Health Disparity Population
N/A	N/A	SFP	African American, Low SES

The Empowerment Zone Coalition (EZC) joined PFS as an expansion community in PY3. Before joining PFS, EZC had a strong coalition, evidenced by annual coalition assessments that demonstrate high levels of competency and functionality. The coalition conducts targeted training and development, continually seeks to broaden sector representation, and has mechanisms in place to integrate new projects. Recruitment occurs via social media, through local organizations and events. Coalition members participate in PFS by planning and implementing activities, including various community events, such as: an opioid summit, school presentations, town hall meetings, health fairs, prescription drug takeback events, and social norming campaigns. EZC partnered with other local coalitions to advocate for MiPHY participation in Detroit Public Community Schools. Although this has been unsuccessful, EZC implemented their own youth survey containing NOMs to gather local substance use data. EZC also implements SFP at Matrix Human Services and Samaritan Center. The coalition relies on members to facilitate programs. If community residents have difficulty with transportation, the coalition utilizes community partnerships to host SFP at convenient locations. In doing so, EZC has enhanced recruitment, retention, and collaboration among organizations in the community. Activities to target their health disparity priority population are built into existing community initiatives, as EZC focused on African American females. EZC stays in contact with Mercy Primary Care by providing SBIRT resources, including an SBIRT implementation manual, trainings, and community resources.

Recent Substance Use (Past 30-Days (%))



Intervening Variables

	Perception of Parental Disapproval or Attitude		Perception of Peer Disapproval or Attitude		Perceived Risk/Harm of Use		Family Communication Around Substance Use
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Parent**
2014	93.2%	94.6%	70.9%	81.3%	67.3%	70.4%	73.5%
2016	94.4%	95.8%	74.5%	83.8%	67.8%	71.3%	75.6%
2018	94.6%	96.0%	74.9%	84.8%	69.5%	74.2%	78.0%
2020	94.0%	94.8%	76.6%	85.9%	64.0%	68.5%	75.4%

Consequences

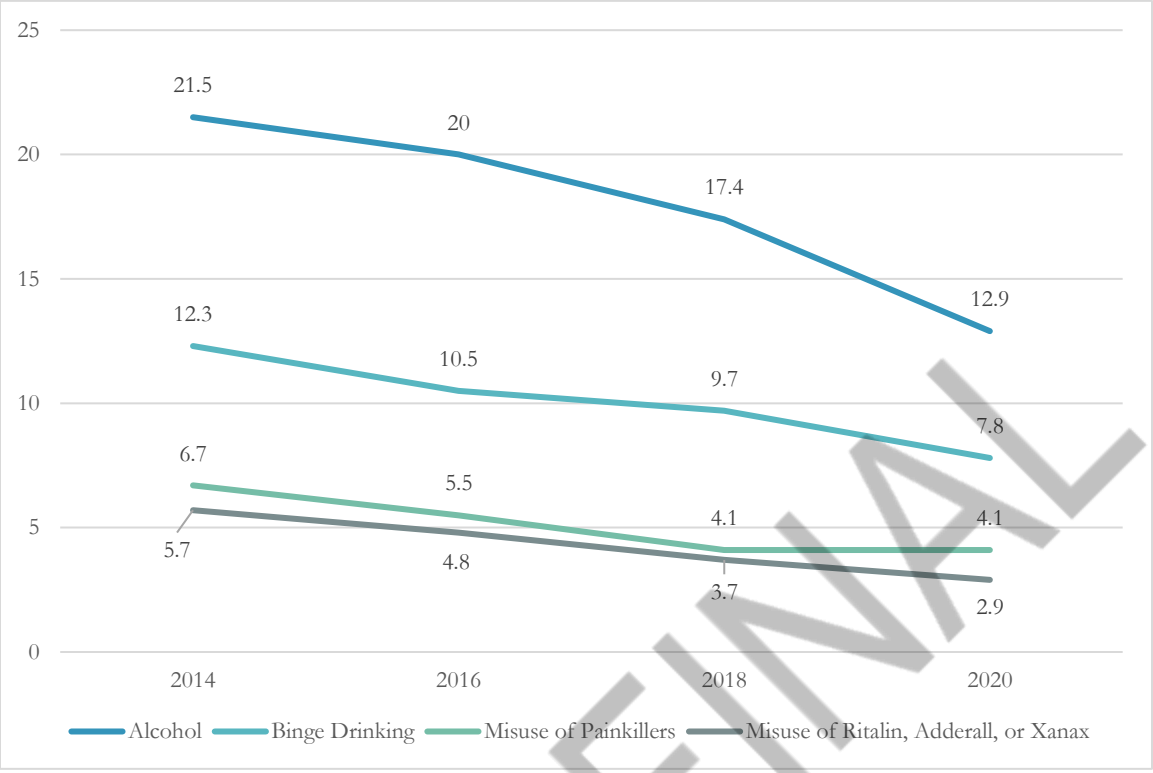
	Substance Related Traffic Crashes		Substance Related Traffic Injuries	
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**
2014	1.7%	0.7%	3.7%	1.8%
2015	1.9%	0.8%	3.9%	2.1%
2016	1.4%	0.9%	2.9%	2.0%
2017	1.4%	0.7%	3.3%	2.0%
2018	1.2%	0.6%	2.6%	1.7%
2019	1.4%	0.7%	3.4%	2.2%

Region 7: Wayne County (Detroit, Love Detroit Prevention Coalition)

Community Level (PY1)	Coalition Model	Prevention Program(s)	Health Disparity Population
3	N/A	SFP & Botvin Life Skills	African American, Low SES

In PY1, Wayne County (Love Detroit Prevention Coalition (LDPC)) was designated as a level 3 community. Since PFS began, LDPC strengthened community partnerships and sector representation among the following groups and individuals: law enforcement, faith-based organizations, local health departments, youth, schools, pharmacists, the Detroit Police Department Drug Enforcement Agency (DEA), Wayne State University Master of Public Health program, and more. The LDPC project coordinator and members participate in community events and activities that allow the coalition to promote their efforts in the community. Notable events include partnering with the DEA on takeback events, Red Ribbon Week, and Narcan training. The coalition conducts several media campaigns focusing on substance use education using geo-fencing, Facebook, and local news channels. Enhanced youth engagement led to the development of a youth subcommittee. Youth are involved in planning events and prevention messages, along with participating in national substance use conferences. Through partnerships established in the community, the coalition has identified more local data sources to inform their prevention efforts and strategic plan, which includes implementing their own youth survey containing questions similar to the MiPHY. LDPC has also expanded SBIRT screenings and referrals by working with Wellness Plan Medical Centers in Detroit, who conduct their own screening and assessment then determine the appropriate referral. LDPC implements SFP and Botvin Life Skills. These programs are implemented in charter schools, churches, and local organizations. Although there is a steady stream of referrals into these programs, coalition members continue to meet with school administration and churches, as well as advertise programs at community resource fairs and partner agencies.

Recent Substance Use (Past 30-Days (%))



Intervening Variables

	Perception of Parental Disapproval or Attitude		Perception of Peer Disapproval or Attitude		Perceived Risk/Harm of Use		Family Communication Around Substance Use
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Parent**
2014	93.2%	94.6%	70.9%	81.3%	67.3%	70.4%	73.5%
2016	94.4%	95.8%	74.5%	83.8%	67.8%	71.3%	75.6%
2018	94.6%	96.0%	74.9%	84.8%	69.5%	74.2%	78.0%
2020	94.0%	94.8%	76.6%	85.9%	64.0%	68.5%	75.4%

Consequences

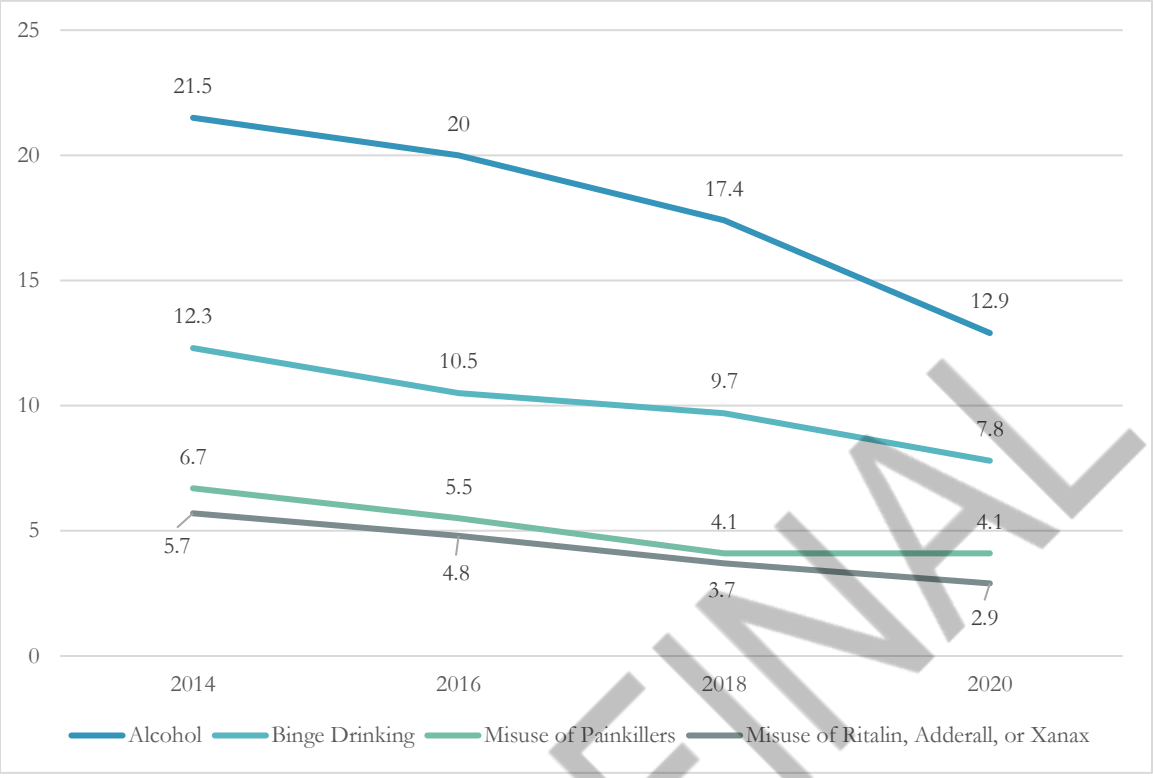
	Substance Related Traffic Crashes		Substance Related Traffic Injuries	
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**
2014	1.7%	0.7%	3.7%	1.8%
2015	1.9%	0.8%	3.9%	2.1%
2016	1.4%	0.9%	2.9%	2.0%
2017	1.4%	0.7%	3.3%	2.0%
2018	1.2%	0.6%	2.6%	1.7%
2019	1.4%	0.7%	3.4%	2.2%

Region 7: Wayne County (Taylor, Taylor Substance Abuse Prevention Task Force)

Community Level (PY1)	Coalition Model	Prevention Program(s)	Health Disparity Population
3	N/A	Teens in Action & Active Parenting	LGBTQ

In PY1, Wayne County (Taylor) was designated as a level 3 community. Since PFS began, the coalition has grown its membership and expanded relationships with their priority population. There are now 64 coalition members and sector representation has increased by adding: a pharmacist, LGBTQ youth, business owners, pastors, a traffic officer, a fire chief and a recovery house director. The expertise and influence of different members allows the coalition to pool resources to enhance the effectiveness of their strategies for drug prevention. The coalition conducts several outreach activities throughout the community, including: annual town halls, safe server training, prescription drug take-back events, community education and presentations, Prom Pledge, Safe Graduation, and other underage drinking and prescription drug campaigns. The campaigns focus on educating the community through Public Service Announcements in movie theaters, news, local radio and Secretary of State branches. During this time, the coalition established the first downriver Families Against Narcotics (FAN) chapter. Its success has led to future plans for developing a youth FAN. Further, Taylor School District has always been compliant with the MiPHY and allowed the Task Force members to assist with the process in all participating schools. Active Parenting, Teens in Action and PFL are held at the teen health center on an ongoing basis; programs have extended to community center locations and multiple Taylor schools, as referrals for programs expanded to different communities. All Beaumont programs utilize the SBIRT process. Prevention staff use a combination of a brief screen and motivational interviewing to determine if a patient could utilize any support programs. Once identified, an established referral process is followed to ensure patient needs are met. There are regular meetings with community partners to discuss services provided from each organization and to ensure the referral process works as seamlessly as possible. Taylor focused on LGBTQ youth as their health disparity population. They have developed partnerships with healthcare systems, such as University of Michigan Comprehensive Gender Services Program, to work on increasing youth access to Hormone Replacement Therapy. The partnership with Beaumont Health resulted in the coalition creating a video, that is an option in their health-stream training, that outlines an ideal office visit for LGBTQ patients. Taylor has also been asked to speak at meetings for incoming residents and interns. Through social media advertisements, Taylor held the first Downriver Pride Prom with 80 youth in attendance. Most notably, Taylor implemented LGBTQ support groups, and use the Remind App to stay in contact with participants. They have also been working with Michigan Department of Health and Human Services (MDHHS) Taking Pride in Prevention to make their curriculum LGBTQ relevant.

Recent Substance Use (Past 30-Days (%))



Intervening Variables

	Perception of Parental Disapproval or Attitude		Perception of Peer Disapproval or Attitude		Perceived Risk/Harm of Use		Family Communication Around Substance Use
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Parent**
2014	93.2%	94.6%	70.9%	81.3%	67.3%	70.4%	73.5%
2016	94.4%	95.8%	74.5%	83.8%	67.8%	71.3%	75.6%
2018	94.6%	96.0%	74.9%	84.8%	69.5%	74.2%	78.0%
2020	94.0%	94.8%	76.6%	85.9%	64.0%	68.5%	75.4%

Consequences

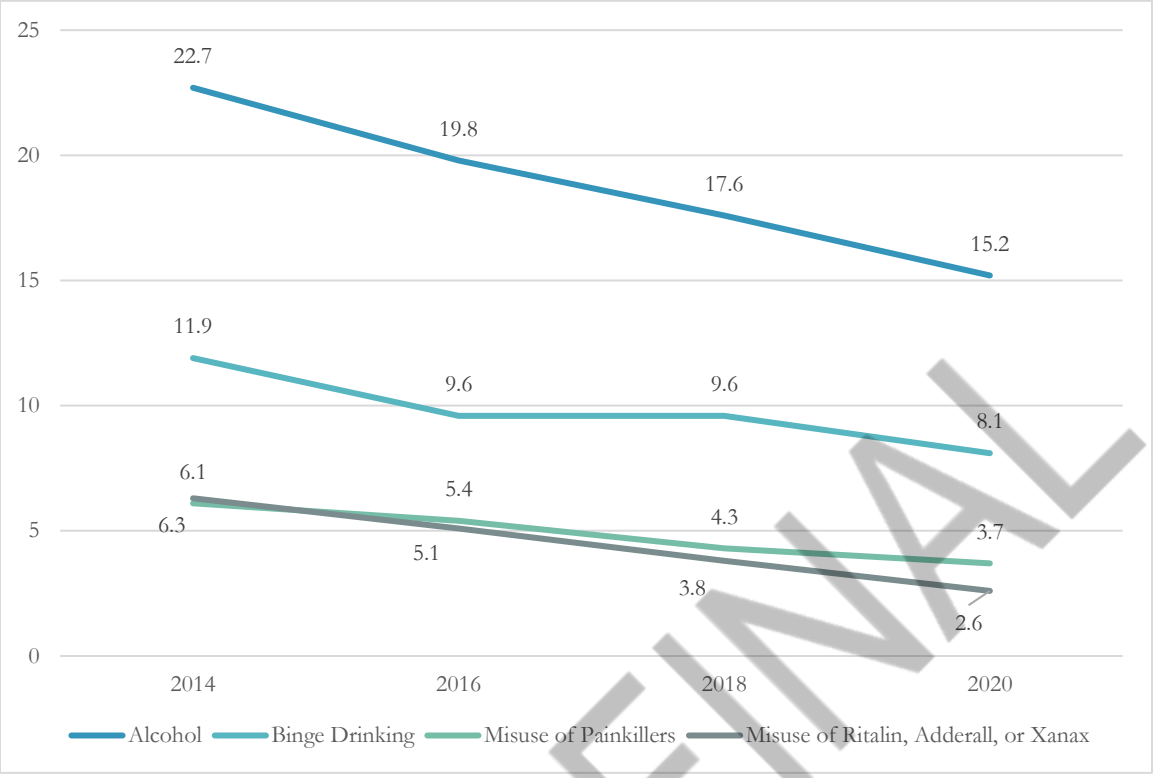
	Substance Related Traffic Crashes		Substance Related Traffic Injuries	
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**
2014	1.7%	0.7%	3.7%	1.8%
2015	1.9%	0.8%	3.9%	2.1%
2016	1.4%	0.9%	2.9%	2.0%
2017	1.4%	0.7%	3.3%	2.0%
2018	1.2%	0.6%	2.6%	1.7%
2019	1.4%	0.7%	3.4%	2.2%

Region 9: Macomb County

Community Level (PY1)	Coalition Model	Prevention Program(s)	Health Disparity Population
2	CT	PFL, SFP, & Active Parenting	LGBTQ

In PY1, Macomb County was designated as a level 2 community. Since PFS began, the Warren Center Line Prevention Coalition has become more engaged in the community through initiatives, including recruitment events, and increased awareness of the coalition within the community. Notably, the coalition has grown their youth sector. The coalition implements large school-based campaigns, such as Red Ribbon Week, Kindness Week, and Drug Take Back events. The coalition also hosts an annual Leadership Camp and participates in various high school groups related to substance use prevention. To reach older youth, the coalition began a student group with a local community college that is maintained by its students. Relationships with schools have enhanced MiPHY participation throughout school districts, as local schools understand the importance of gathering data relevant to their community. To maintain the overall effectiveness of the coalition, leadership ensures they periodically re-assess the SPF, attend trainings, and work to diversify coalition sector representation. These above efforts have helped prepare the coalition to apply for DFC grant funding. In addition to community-level prevention programming (PFL, SFP, & Active Parenting), program implementation has expanded to five school districts throughout Warren and Center Line. Regarding SBIRT, the coalition meets with local primary care sites to ensure screening is occurring and they have the proper resources for patients. The coalition is updating an existing document of available community resources, which is available in paper form and on the coalition website. Part of the resource lists includes organizations that serve LGBTQ youth. In addition to connecting with organizations and attending trainings to develop a list resources specific to the LGBTQ community, the coalition also connected with GSAs in local schools and is working on gathering data specific to substance use on their health disparity target population.

Recent Substance Use (Past 30-Days (%))



Intervening Variables

	Perception of Parental Disapproval or Attitude		Perception of Peer Disapproval or Attitude		Perceived Risk/Harm of Use		Family Communication Around Substance Use
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Parent**
2014	94.2%	95.9%	72.7%	81.3%	73.3%	77.3%	77.5%
2016	95.3%	96.5%	77.8%	84.8%	70.8%	74.1%	77.7%
2018	95.0%	96.5%	77.4%	85.9%	71.7%	75.8%	79.0%
2020	95.4%	96.6%	80.7%	88.3%	72.3%	77.1%	79.4%

Consequences

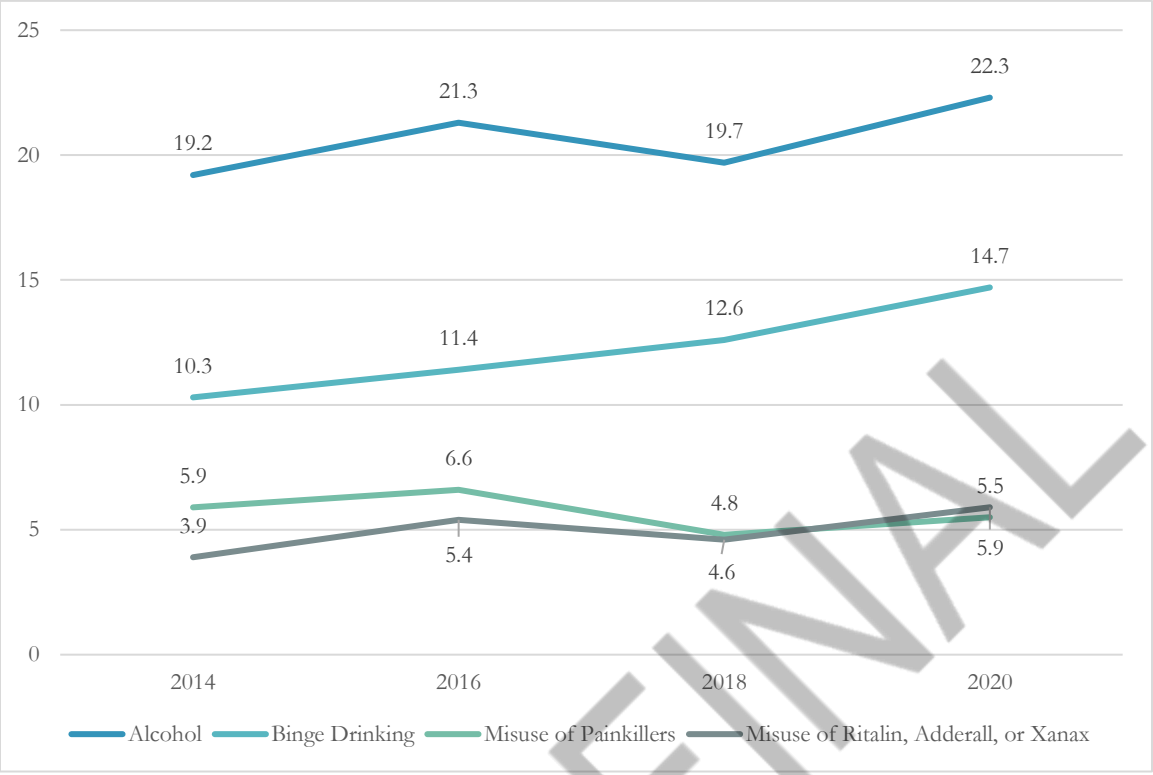
	Substance Related Traffic Crashes		Substance Related Traffic Injuries	
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**
2014	1.9%	0.8%	5.3%	2.3%
2015	1.5%	0.9%	5.6%	3.4%
2016	1.4%	0.9%	5.6%	3.3%
2017	1.3%	0.9%	2.6%	3.3%
2018	1.3%	0.8%	3.3%	2.6%
2019	1.2%	0.8%	4.6%	2.5%

Region 10: Genesee County

Community Level (PY1)	Coalition Model	Prevention Program(s)	Health Disparity Population
3	N/A	PFL	Hispanic/Latino

In PY1, Genesee County was designated as a level 3 community. Over the course of PFS, Genesee County enhanced their coalition by formalizing its structure through the formation of bylaws, developing a 5-year strategic plan, and forming CIAs. These structural enhancements set-up the coalition to receive the DFC grant, which also led to it obtaining 501-3c status and a prevention license from Licensing and Regulatory Affairs. In the past few years, the coalition implemented a community readiness survey and a community norms survey. Results are directed to the appropriate workgroup, so they can be applied to community strategies. The surveys have also provided new opportunities for enhancing community partnerships and increasing community engagement; through health fairs, meetings, and social media efforts. Further, the coalition has recently implemented geo-fencing technology to plan outreach efforts based on marijuana dispensary location, alcohol outlet density, and prescription drug drop-box locations. There is a formal process for implementing PFL programs by designating certain locations and community partners as "host" and "referral" sties. The coalition serves as a host site for individuals referred to the program from Genesee County Juvenile Probation and other community partners. The coalition works with Genesee Health Plan and Mott Children's Health Center by routinely sharing community resources, as both locations have their own internal behavioral health component and follow their own established process for conducting assessments and referrals. To target their health disparity population (Hispanic/Latino), the coalition has built a relationship with the Executive Director of LatinX. They are working on developing a CIA and an action plan to strategically identify and address health disparities that exist among Hispanic youth, specifically as it relates to substance use attitudes, perceptions and behaviors.

Recent Substance Use (Past 30-Days (%))



Intervening Variables

	Perception of Parental Disapproval or Attitude		Perception of Peer Disapproval or Attitude		Perceived Risk/Harm of Use		Family Communication Around Substance Use
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**	**Parent**
2014	92.1%	95.2%	68.8%	80.4%	62.9%	70.6%	74.7%
2016	93.1%	95.2%	73.3%	83.6%	65.4%	71.7%	77.0%
2018	94.3%	95.9%	72.2%	84.8%	69.8%	76.1%	78.4%
2020	91.9%	94.5%	71.3%	80.6%	66.7%	75.7%	79.4%

Consequences

	Substance Related Traffic Crashes		Substance Related Traffic Injuries	
Year	**Alcohol**	**Prescription Drugs**	**Alcohol**	**Prescription Drugs**
2014	1.8%	1.1%	4.4%	2.0%
2015	1.8%	0.9%	5.6%	2.6%
2016	1.6%	1.2%	2.6%	2.7%
2017	1.5%	0.9%	2.9%	1.9%
2018	1.5%	1.1%	2.7%	4.3%
2019	1.7%	1.0%	4.2%	3.1%

Conclusion

PFS target communities include: Muskegon, Mason, Oceana, St. Joseph, Van Buren, Bay, Eaton, Wayne (Detroit [Empowerment Zone Coalition & Love Detroit Prevention Coalition] & Taylor), Macomb, and Genesee. This report served as an overview of PFS community successes and data trends over the past five years. This overview was compared to the evaluation goals set by CSAP. Overall, communities exhibited successful implementation of the SPF process and made significant progress in strengthening the prevention capacity and infrastructure of the community. Data further demonstrated these efforts contributed to preventing and reducing substance use and its related consequences. Overall, there was a decrease among substance use variables in most communities. Intervening variables have remained stable, and although percentages were generally low, consequence variables have also largely remained stable. As a result, PFS communities demonstrated success in meeting CSAP evaluation goals and accomplished grant objectives by the end of PY5.

Appendix A: Sub-recipient Feedback

Feedback surveys were distributed separately to Prepaid Inpatient Health Plan (PIHP) and community sub-recipients, via Qualtrics, near the end of PY5. Surveys assessed sub-recipients' perceptions of the PFS grant, administration, and progress. There were 27 responses from target communities, and six responses from PIHPs. Close-ended responses ranged from "strongly disagree" to "strongly agree". The following tables demonstrate respondents' level of agreement with each statement/question, as well as the distribution of those responses among participants, expressed as the percentage and frequency (%(*n*)).

Perceptions of PFS Grant

Community Feedback (%(*n*))				
	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
The goals of the PFS grant are clear.	3.7(1)		51.9(14)	44.4(12)
The PFS grant promotes system integration.	3.7(1)	7.4(2)	37.0(10)	51.9(14)
The PFS grant encourages us to collect data more routinely.	3.7(1)		48.1(13)	48.1(13)
The PFS grant has focused our efforts on coalition building.	3.7(1)	3.7(1)	33.3(9)	59.3(16)
The PFS grant has increased our efforts to target prescription drugs.	3.7(1)		37.0(10)	59.3(16)
Funding for the grant is appropriate for the goals.	25.9(7)	18.5(5)	37.0(10)	18.5(5)
The face-to-face meetings provide ability to network and learn from others.	3.7(1)	3.7(1)	48.1(13)	44.4(12)
PIHP Feedback (%(*n*))				
	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
The goals of the PFS grant are clear.			33.3(2)	66.7(4)
The PFS grant promotes system integration.			50.0(3)	50.0(3)
The PFS grant encourages us to collect data more routinely.			16.7(1)	83.3(5)
The PFS grant has focused our efforts on coalition building.			16.7(1)	83.3(5)
The PFS grant has increased our efforts to target prescription drugs.			33.3(2)	66.7(4)
Funding for the grant is appropriate for the goals.			33.3(2)	66.7(4)
The face-to-face meetings provide ability to network and learn from others.			33.3(2)	66.7(4)

Perceptions of PFS Administration

Community Feedback (%(*n*))				
	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
Communication from PIHP staff is timely.	7.4(2)	11.1(3)	44.4(12)	37.0(10)
Communication from PIHP staff is clear.	7.4(2)	22.2(6)	25.9(7)	44.4(12)
PIHP leadership is able to keep our work on track.	3.7(1)	18.5(5)	29.6(8)	48.1(13)
PIHP Feedback (%(*n*))				
	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
Communication from OROSC* staff is timely.			33.3(2)	66.7(4)
Communication from OROSC staff is clear.			16.7(1)	83.3(5)
OROSC leadership is able to keep our work on track.			16.7(1)	83.3(5)
*Office of Recovery Oriented Systems of Care				

Perceptions of PFS Grant Progress

Community Feedback (%(*n*))				
	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
Our grant plans are feasible.	3.7(1)	7.4(2)	48.1(13)	40.7(11)
I feel satisfied in our grant progress to date.	3.7(1)	3.7(1)	37.0(10)	55.6(15)
	Very Unproductive	**Unproductive**	**Productive**	**Very Productive**
How would you assess the productivity of the PFS grant?			59.3(16)	40.7(11)
PIHP Feedback (%(*n*))				
	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
Our grant plans are feasible.			33.3(2)	66.7(4)
I feel satisfied in our grant progress to date.		16.7(1)	16.7(1)	66.7(4)
	Very Unproductive	**Unproductive**	**Productive**	**Very Productive**
How would you assess the productivity of the PFS grant?			16.7(1)	83.3(5)

Appendix B: Acronym Guide

Acronym	Definition
CIA	Coalition Involvement Agreement
CMCA	Communities Mobilizing for Change
CSAP	Center for Substance Abuse Prevention
CT	Community Trials
DEA	Drug Enforcement Agency
DFC	Drug Free Communities
ECHO	Extension for Community Health Care Outcomes
EZC	Empowerment Zone Coalition
FAN	Families Against Narcotics
GSA	Gay Straight Alliance
LDPC	Love Detroit Prevention Coalition
MiPHY	Michigan Profile for Healthy Youth
MDHHS	Michigan Department of Health and Human Services
NOMs	National Outcome Measures
OROSC	Office of Recovery Oriented Systems of Care
PFL	Prime for Life
PCP	Primary Care Provider
PFS	Partnership for Success
PIHP	Prepaid Inpatient Health Plan
PY	Project Year
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SFP	Strengthening Families Program
SPF	Strategic Prevention Framework
SUD	Substance Use Disorder

Michigan Department of Health and Human Services
Behavioral Health and Developmental Disabilities Admin.

Office of Recovery Oriented Systems of Care
Strategic Plan FY 2021 – FY 2023

The Office of Recovery Oriented Systems of Care (OROSC) aligns services and priorities consistent with the Michigan Department of Health and Human Services (MDHHS) Core Values:

- Opportunity - Offering all Michigan residents the tools to achieve health, stability, success, and championing equity; and
- Perseverance – Meeting needs and solving problems with innovation

OROSC implements a recovery-oriented system of care in which specialty behavioral health services are delivered within a full continuum of care. In addition, we have identified strategic priorities that target the prevention and treatment of substance use, trauma, and mental health disorders across the lifespan of individuals and families in Michigan. OROSC will continue the process of building a healthier Michigan, serving as a leader in recovery-oriented services and health innovation.

Mission

MDHHS provides opportunities, services and program that promote a healthy, safe, and stable environment for residents to be self-sufficient.

Vision

Develop and encourage measurable health, safety and self-sufficiency outcomes that reduce and prevent risks, promote equity, foster healthy habits, and transform the health and human services system to improve the lives of Michigan families.

Purpose

By promoting wellness, strengthening communities, and facilitating recovery for the people of Michigan, Behavioral Health and Developmental Disabilities Administration (BHDDA) serves citizens by diminishing the impact and incidence of addiction, emotional disturbance, mental illness, and developmental disability.

Guiding Principles

Promote and strengthen OROSC's delivery of specialty behavioral health services including behavioral health promotion, prevention, treatment, and recovery efforts across the lifespan of individuals and families.

- *Further enhance an interagency collaborative approach aimed to improve behavioral health through services that include prevention, treatment, and recovery*

- *Promote behavioral health wellness and recovery for individuals across the lifespan with dignity and respect*
- *Develop innovative practices to improve behavioral health outcomes that result in the reduction of the misuse of alcohol and other drugs*
- *Promote an interagency collaborative approach to Gambling Disorder prevention and treatment using evidence-based practices and recovery support services to increase abstinence and improve overall health and wellness*
- *Increase access to all behavioral health services for persons residing in communities with significant health disparities*
- *Increase access to integrated health care for persons receiving services*
- *Support safe and healthy behavioral health services to Michiganders across the lifespan in a culturally and developmentally competent manner*
- *Promote the use of a Strategic Planning Framework to address behavioral health needs and reduce preventable substance use and mental health disorders across all service systems (e.g. primary care settings, criminal justice, and child welfare)*
- *Implement evidence-based, promising, and best practices that support a recovery-oriented system of care*
- *Promote emotional health and reduce the impact of mental health and substance use and gambling disorders*
- *Implement a trauma informed system of care that includes evidence-based and promising practice*
- *Collect, analyze, and report on behavioral health trends and emerging issues*

Strategic Priorities

Children: Improve Outcomes for Children (youth and families)

Goal 1: Reduce Childhood and Underage Drinking

Performance Indicator: Reduce past month use of alcohol among individuals aged 12-20 by FY 23 Target: 20% (Source: National Survey on Drug Use and Health [NSDUH])

Performance Indicator: Reduce binge alcohol use in past month among individuals aged 12 to 20

Objective 1.1: Conduct Epidemiological (EPI) profile to track prevalence, mortality, and trend data

Objective 1.2: Increase visibility of anti-use campaign (Do Your Part, Talk. They Hear You, etc.)

Objective 1.3: Convene Michigan Higher Education Network (MIHEN) and the Michigan Coalition to Reduce Underage Drinking (MCRUD)

Objective 1.4: Convene State Epidemiological Outcomes Workgroup (SEOW) to address data

Objective 1.5: Impaired Driving Action Team participation

Objective 1.6: Convene Recovery Oriented Systems of Care, Transformation Steering Committee (ROSC/TSC) Prevention Workgroup

Objective 1.7: Maintain prevention programming and partnership with adolescent health centers

Objective 1.8: Establish and increase peer recovery community for adolescents

Objective 1.9: Promote utilization of the Michigan Model statewide

Objective 1.10: Secure training and technical assistance

Objective 1.11: Encourage and support the use of evidence-based programs, practices and strategies shown to impact underage drinking

Objective 1.12: Coordinate multi-system collaboration to implement strategies identified in the Underage Drinking Strategic Plan

Goal 2: Reduce Youth Access to Tobacco and Illegal Sales to Minors

Performance Indicator: Effect a 10% tobacco sales rate to minors by FY 23 (Source: SYNAR Survey Results)

Objective 2.1: Conduct an EPI Profile

Objective 2.2: Provide training and technical assistance (TA) to Designated Youth Tobacco Use Representative (DYTUR) on SYNAR regulations and policy

Objective 2.3: Convene Youth Access to Tobacco Workgroup (YATTW)

Objective 2.4: Continue collaboration with Tobacco Section

Objective 2.5: Continue collaboration with Attorney General

Objective 2.6: Continue implementation of the Federal Drug Administration (FDA) retailer inspection program throughout the state in accordance with Tobacco 21 federal law

Objective 2.7: Continue implementation of the SYNAR retailer inspection program in the state

Objective 2.8: Track and report on legislation regarding youth access to tobacco

Objective 2.9: Develop and submit the annual SYNAR report to Substance Abuse and Mental Health Administration (SAMHSA)

Objective 2.10: Update Do Your Part campaign

Objective 2.11: Improving MI Practices campaign for retailer education

Objective 2.12: Coordinate multi-system collaboration to implement strategies identified in the Strategic Tobacco Plan

Goal 3: Reduce Substance Exposed Births

Performance Indicator: Increase number of drug-free births by FY 21 - Target: 200

Objective 3.1: Review analysis of Women's Specialty Services report

Objective 3.2: Review data related to impact of substance use provided by Population Health and Children's Protective Services

Objective 3.3: Increase access to treatment for pregnant women

Objective 3.4: Increase stigma awareness and trainings for providers and partners

Objective 3.5: Outreach to other agencies that serve children and families to improve education

Objective 3.6: Align policies regarding substance exposed births across the state

Objective 3.7: Reduce the impact of substance use in families by enhancing and improving access to treatment

Objective 3.8: Establish and increase community support to families with children in recovery

Objective 3.9: Secure federal grants to reduce the impact of substance abuse in families

Goal 4: Increase Youth Awareness of Gambling Disorder

Performance Indicator: Reduce past 30-day gambling activity among youth (Source: Michigan Profile for Healthy Youth [MiPHY])

Objective 4.1: Use existing infrastructure to expand Gambling Disorder prevention efforts to youth and adolescents

Objective 4.2: Continue to provide training opportunities and technical assistance for continued Gambling Disorder prevention
Objective 4.3: Distribute redesigned youth media campaign to target youth and adolescents
Objective 4.4: Continue to promote parent utilization of Gambling Disorder helpline
Objective 4.5: Continue participation with ROSC/TSC workgroup
Objective 4.6: Establish and convene gambling disorder youth tax steering committee

Goal 5: Reduce the effects of parental substance use on youth

Performance Indicator: Increase the number of students and children receiving indicated services

Objective 5.1: Improve screening of youth whose parents are served in pregnant and parenting women's programs
Objective 5.2: Provide training and technical assistance to pregnant and parenting women's programs, regarding Adverse Childhood Experiences (ACEs), resiliency factors and evidence-based practices (EBPs) that can be enhanced by the treatment provider
Objective 5.3: Review pregnant and parenting women's programing referral process to ensure that children are receiving the services indicated by screening

Adults and Family Support: Promote and Protect Health, Wellness, and Safety (across the lifespan within communities)

Goal 1: Build community assets to address behavioral health needs

Performance Indicator: Increase number of consumer-run drop-in centers in the state

Performance Indicator: Increase number of naloxone kits distributed through FY 23 (Source: Reported by Prepaid Inpatient Health Plans [PIHPs])

Performance Indicator: Increase number of environmental and community-based prevention strategies by FY23 (Source: Michigan Prevention Data System)

Performance Indicator: Increase support to existing or newly established syringe service programs (SSP)

Objective 1.1: Create and develop drop-in recovery support pilots to provide resources and movement of peers back to the community
Objective 1.2: Promote consumer-run drop-in center locations in the community
Objective 1.3: Conduct and implement the Anti-Stigma Educational Day, which promotes anti-stigma initiatives in the community
Objective 1.4: Involvement of community interactions, outings, and connectedness by the implementation of the Federal Block Grant, Health and Wellness Grant to consumer-run drop-in centers
Objective 1.5: Implement training of trauma informed care in Community Mental Health Service Providers (CMHSPs) and their communities with adults
Objective 1.6: Promote community-wide overdose education and training on use of naloxone
Objective 1.7: Promote purchase and distribution of naloxone statewide
Objective 1.8: Track distribution of naloxone kits
Objective 1.9: Promote utilization of Naloxone Standing Order
Objective 1.10: Creation and distribution of statewide language regarding definition of and Frequently Asked Questions (FAQs) regarding behavioral health needs

Objective 1.11: Encourage multi-system collaboration to implement prevention and mental health promotion strategies

Objective 1.12: Continue to build and enhance community prevention infrastructure and capacity

Objective 1.13: Coordinate multi-system collaboration to implement strategies and support services for SSP programs

Goal 2: Reduce prescription and over-the-counter drug misuse and abuse

Performance Indicator: Reduce non-medical use of prescription drugs, including opiates

Performance Indicator: Increase the number of prescription drug collection sites

Objective 2.1: Collaborate with community programs, organizations, health centers and law enforcement to be area specific when planning permanent collection sites or take-back day events

Objective 2.2: Encourage multi-system collaboration at state and community levels, including leadership development to oversee surveillance, intervention, education, and enforcement

Objective 2.3: Broaden the use of brief screenings in behavioral and primary care settings

Objective 2.4: Promote increased access to and use of prescription drug monitoring program

Objective 2.5: Provide training and technical assistance for communities to address emerging issue of unprecedented increases in opioid use among adults age 55 and older

Goal 3: Reduce misuse and abuse of alcohol, opioid medications, and illicit drugs.

Performance Indicator: Decrease in overdose deaths due to any opioid, heroin, synthetic or non-synthetic non-heroin opioids - rate and number (Source: Michigan Death Certificates); Decrease in hospitalizations due to opioid overdose (Source: Michigan Inpatient Database)

Performance Indicator: Decrease in past 30-day use of alcohol, opioids and illicit drugs among young adults (18 to 25 years), adults (26 to 54 years) and older adults (age 55+) by FY23

Objective 3.1: Promote the utilization of best practice guidelines for opioid prescribing

Objective 3.2: Promote alternative pain management strategies to patients and medical providers

Objective 3.3: Increase visibility of the stopoverdose website

Objective 3.4: Increase utilization of the state prescription drug monitoring program (PDMP) to reduce overprescribing of prescription opioids

Objective 3.5: Develop and promote campaign to increase awareness of opioid misuse and abuse

Objective 3.6: Support the development and distribution of culturally competent messaging for tribal communities on opioid misuse and abuse

Objective 3.7: Implement evidence-based primary prevention practices to reduce opioid misuse and abuse

Objective 3.8: Outreach and collaborate with other agencies that implement educational initiatives

Objective 3.9: Implement and distribute evidence-based alcohol misuse/abuse prevention strategies specific to young adults and older adults

Objective 3.10: Engage all segments of the community in establishing a recovery-oriented system of care and increase the use of brief intervention

Objective 3.11: Provide technical assistance and resources to the Higher Education Network, to address problem drinking and other drug use among college students

Objective 3.12: Build relationships and partnerships with MDHHS communicable disease divisions (hepatitis, TB, and HIV/AIDS) to assure issues of opioid and illicit drug misuse and abuse are addressed

Objective 3.13: Coordinate multi-system collaboration to implement strategies identified in the Marijuana Prevention Strategic Plan

Goal 4: Reduce barriers to accessing treatment for opioid use disorders

Performance Indicator: Increase the number of individuals accessing treatment, by county, by FY22 (Source: Encounter Database and Behavioral Health Treatment Episode Data Set [BH TEDS])

Performance Indicator: Expansion and collaboration with community partners

Objective 4.1: Review BH TEDS and other data sources for identification of gaps in treatment

Objective 4.2: Expand use of peers in healthcare settings, to increase early referral to treatment

Objective 4.3: Increase TA to treatment providers for persons with opioid use disorder

Objective 4.4: Increase transportation resources for persons seeking treatment for opioid use disorder

Objective 4.5: Promote expansion of treatment options for incarcerated populations

Objective 4.6: Increase coverage of uninsured and underinsured persons seeking various treatment and recovery support options for opioid use disorder

Objective 4.7: Identify and share community resources to support recovery

Objective 4.8: Train program employees in evidence-based programs, such as Motivational Interviewing and Trauma Focused Cognitive Behavioral Therapy

Objective 4.9: Disseminate information and training to the field for a statewide assessment

Objective 4.10: Increase collaboration between programs, including sharing of assessments

Objective 4.11: Provide health disparity reports, regarding gaps in services to Michiganders, to continue creation of services to underserved areas

Objective 4.12: Creation of financial map of the state, to evaluate current trends and influence future financial priorities

Goal 5: Increase longevity and quality of life, by reducing health disparities and improving self-management

Performance Indicator: Increase in treatment usage; decrease in injuries and deaths related to substance use disorders

Performance Indicator: Increase medication assisted treatment services to specialty populations, such as expectant mothers and adolescents

Performance Indicator: Reduce past 30-day gambling activity (Source: Behavioral Risk Factors Surveillance System [BRFSS])

Objective 5.1: Develop statewide activities during Gambling Disorder Awareness Month

Objective 5.2: Support and participate in workgroups tasked with further developing Gambling Disorder prevention services

Objective 5.3: Promote utilization of peer-led recovery support services within populations receiving treatment for opioid use disorder

Objective 5.4: Yearly disparity reports, regarding gaps in services to Michiganders, to continue creation of services to underserved areas

Objective 5.5: Delay initiation of first use of drugs or alcohol

Objective 5.6: Increase exposure of behavioral health resources

Objective 5.7: Distribute Information to medical providers highlighting recommended practices of Medication Assisted Treatment (MAT) for Pregnant and Parenting Women (PPW)

Objective 5.8: Coordinate efforts with other State of Michigan offices regarding causes and resolution of health disparities with PPW

Health Services: Align Behavioral and Physical Healthcare

Goal 1: Continue the implementation of a recovery-oriented system of care across the lifespan

Performance Indicator: Provide increased services to adolescent and transitional aged youth

Performance Indicator: Increase services to adults and older adults (Source: BH TEDS)

Objective 1.1: Enhance prevention services to youth and older adults

Objective 1.2: Increase recovery and outpatient services for adolescents and transitional aged youth

Objective 1.3: Develop community-based recovery opportunities (e.g. support groups, youth peer mentors) for youth and families

Objective 1.4: Collaborate with primary care and the behavioral health field to identify gaps in resources for adults/older adults

Objective 1.5: Offer trainings and technical assistance around the Self-Healing Communities model and how a community's Adverse Childhood Experience score influences all aspects of health

Objective 1.6: Collaborate with providers to develop and provide recovery high schools to adolescents

Objective 1.7: Train workforce in evidence-based programming for adolescents and transitional age youth

Objective 1.8: Create workforce of peer mentors through training and additional services

Goal 2: Expand integrated behavioral health and primary care services for persons at risk for and with substance use and mental health disorders

Performance Indicator: Number of consumer-run drop-in center members participating in health activities (per location and statewide)

Performance Indicator: Increase number of resources for co-occurring (MH and SUD) disorders

Objective 2.1: Implement the Health and Wellness Federal Block Grant to 37 consumer-run drop-in centers

Objective 2.2: Promote health care to peers at drop-in centers, support groups, workshops, and conferences

Objective 2.3: Identify, recognize, and acknowledge drop-in centers and peers who are achieving their new health goals

Objective 2.4: Provide training opportunities to programs regarding co-occurring behavioral health and physical disorders

Objective 2.5: Increase number of health homes that include mental health and substance use disorder services onsite
Objective 2.6: Increase the capacity for a community specific prevention referral system, to engage Michigan residents in prevention services
Objective 2.7: Increase number of coordinated care plans

Goal 3: Promote opportunities for individuals with mental health disorders to self-direct their services and supports

Performance Indicator: Increase number of persons involved in Self-Directed Care (SDC) as a part of the Robert Wood Johnson (RWJ) study – Target: 50 by FY23

Objective 3.1: Continue to provide a curriculum for 2-day trainings to Certified Peer Support Specialists (CPSS) on Person-Centered Planning (PCP)
Objective 3.2: Develop and provide Train the Trainer class on PCP curriculum
Objective 3.3: Select CPSS trainers and provide ongoing mentoring
Objective 3.4: Continue to provide technical assistance for SDC to Bay Arenac Behavioral Health (BABH) and other CMHSPs
Objective 3.5: Develop up to two additional CMHSPs to expand the SDC project
Objective 3.6: Develop and implement a curriculum of the role of CPSS and independent support brokers and disseminate to the field

Goal 4: Promote and strengthen the role of consumer-run programs

Performance Indicators: Number of activities, contacts of the technical assistance center of Justice in Mental Health Organization (JIMHO) contracted with the State of Michigan

Objective 4.1: Support, oversee, provide technical assistance to the 47 consumer-run drop-in centers
Objective 4.2: Implement statewide two self-help support conferences
Objective 4.3: Provide technical assistance to the drop-in center for the Health & Wellness Grant, and Transportation Grant through Federal Block Grant
Objective 4.4: Promote the creation of new consumer-run initiatives
Objective 4.5: Trauma informed implementation of all drop-in centers
Objective 4.6: Promote recovery with drop-in members

Goal 5: Treat addiction as a chronic disease

Performance Indicator: Increase client retention in recovery-based services

Objective 5.1: Creation of continuum of care for individuals that begins with prevention and follows through to recovery
Objective 5.2: Increase education to partners and communities to reduce stigma
Objective 5.3: Increase provider use of MAT
Objective 5.4: Increase client use of MAT services

Goal 6: Improve behavioral health outcomes while leveraging efficiencies in cost and societal consequence

Performance Indicators: Decreased cost of behavioral health

Objective 6.1: Increase length of time in recovery

Objective 6.2: Collect data from access centers and programs for admitted individuals, through BH TEDS and evidence-based assessment tool

Objective 6.3: Gather data from outreach/follow-up services

Objective 6.4: Explore connection between completion of follow-up services and length of recovery (include MAT data)

Objective 6.5: Augment relationship between recovery and prevention providers

Goal 7: Implement Trauma Informed Care throughout the Systems of Care for all populations in Michigan

Performance Indicator: Increase the services, programs, and environment to promote Trauma Informed Care throughout each of the CMHSPs in Michigan, including their provider system

Objective 7.1: Implement the State Trauma Policy

Objective 7.2: Survey the depth of trauma implementation in the system of care

Objective 7.3: Conduct the Trauma Subcommittee at the state level to create further trauma resilience initiatives

Objective 7.4: Promote new initiatives on trauma

Objective 7.5: Conduct trauma-specific trainings for clinicians of CMHSPs

Objective 7.6: Incorporate Michigan Fidelity Assistance Support Team (MIFAST) findings in the promotion of training needs

Workforce: Strengthen Workforce and Economic Development

Goal 1: Provide statewide training in best-practice behavioral health services including prevention, treatment, and recovery technology

Performance Indicator: Creation of a workforce development plan

Performance Indicator: Increase number of certified individuals providing services to individuals in treatment for mental health and substance use disorders

Performance Indicator: Increase number of clinicians trained in best-practice psychosocial techniques (Source: reported by PIHPs and State Training Coordinators [CMHAM])

Objective 1.1: Promote utilization of best-practice psychosocial techniques for clinicians treating individuals with opioid use disorder

Objective 1.2: Update and dissemination of a workforce development ladder for prevention specialists

Objective 1.3: Update and dissemination of a workforce development ladder for treatment specialists

Objective 1.4: Update and dissemination of a workforce development ladder for recovery specialists

Objective 1.5: Provide education opportunities that target the components of certification

Objective 1.6: Work with credentialing body to develop a mechanism to effectively assist those with development plans, to ensure they successfully complete the requirements and pass exams

Objective 1.7: Ensure that learning opportunities are available to the field related to evidence-based and promising practices and emerging issues impacting the field

Objective 1.8: Revise the substance use disorder (SUD) communicable disease training for SUD practitioners

Goal 2: Increase the number of individuals certified as peer support specialist and recovery coaches

Performance Indicator: Increase number of individuals certified in each workforce area – Target: 240 CPSS and 300 Certified Peer Recovery Coach (CPRC) for FY 21-23

Performance Indicator: Increase number of training opportunities offered/available to CPSS and CPRC

Objective 2.1: Compile, interview and approve each CPRC who meet the requirements submitted for grand parenting

Objective 2.2: Organize, plan, and implement statewide and regional CPRC trainings

Objective 2.3: Organize, plan, and implement statewide and regional CPSS trainings

Objective 2.4: Provide ongoing oversight, technical assistance and mentoring with statewide trainers

Goal 3: Provide training and continuing education to strengthen skills of CPSS and CPRC

Performance Indicator: Increase number of CPSS/CPRC trainings offered – Target: 70 for FY 21-23

Objective 3.1: Secure training sites and develop a calendar of training dates to send out to stakeholders

Objective 3.2: Develop and provide classes based on promising, best, and evidence-based practices

Objective 3.3: Review evaluations and participate in networking during trainings to add new and additional trainings recommended by the workforce

Objective 3.4: Request information from peer liaisons on training topics beneficial to peers in their agencies

Objective 3.5: Track and review data for CPRC and CPSS after each training

Goal 4: Expand employment opportunities for Certified Peer Recovery Coaches and Certified Peer Support Specialists in primary and integrated care settings

Performance Indicator: Number of peers trained and certified in the areas of Wellness Recovery Action Planning (WRAP), Whole Health Action Management (WHAM), tobacco recovery and as certified Community Health Workers (CHW) - Target: 15% of the workforce FY 21-23

Objective 4.1: Organize, plan, and implement 2-day and 5-day WRAP trainings

Objective 4.2: Organize, plan, and implement WHAM trainings

Objective 4.3: Organize, plan, and implement tobacco recovery/smoking cessation trainings

Objective 4.4: Continue to work in partnerships with the Michigan Community Health Worker Alliance (MICHWA) to expand CHW certification training

Objective 4.5: Provide CHW certification training

Goal 5: Increase the capacity of prevention efforts to address Gambling Disorder

Performance Indicator: Increase number of Gambling Disorder trained individuals in each workforce area

Objective 5.1: Assist with the development of job descriptions, guidelines, recruitment and retention for peer specialists and peer recovery coaches to provide services for persons with Gambling Disorders

Objective 5.2: Convene Gambling Disorder youth workgroup

Objective 5.3: Continue to implement North American Training Institute (NATI) Gambling Disorder training

Objective 5.4: Educate the prevention workforce about comorbidities, overlapping risk, and protective factors between SUD, MH, and Gambling Disorder

Objective 5.5: Host annual Gambling Disorder Symposium

Objective 5.6: Continue participating in Gambling Disorder TSC workgroup

Objective 5.7: Continue to expand Gambling Disorder prevention efforts

Objective 5.8: Provide training opportunities and technical assistance for effective prevention service development and implementation

Objective 5.9: Enhance Gambling Disorder prevention efforts to underserved populations

Office of Recovery Oriented System of Care Website Development:

Goal 1: Information Dissemination

Performance Indicator: Increase visits on OROSC website

Objective 1.1: Promote OROSC website and ease of access to program information

Objective 1.2: Continue to update OROSC website on annual basis

Office of Recovery Oriented Systems of Care
Strategic Plan FY2021-FY2023
Updated 3/24/2020

Guidance Document

Selecting, Planning, and Implementing Evidence-Based Interventions for the Prevention of Substance Use Disorders

Michigan Department of Community Health
Bureau of Substance Abuse and Addiction Services
Evidence-Based Workgroup

January 2012

The purpose of this guidance document is to increase uniformity in the knowledge and application of evidence-based prevention programs, services, and activities to reduce and prevent substance use disorders in the state of Michigan.

Table of Contents

I. Introduction

The purpose of the "*Guidance Document: Selecting, Planning, and Implementing Evidence-Based Interventions for the Prevention of Substance Use Disorders*" is to increase uniformity in the knowledge, understanding, and implementation of evidence-based substance abuse prevention programs, services, and activities in the state of Michigan.

This document is a compilation of the latest information and research from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP), who provided guidance for the document entitled, *Identifying and Selecting Evidence-Based Interventions*," including additional supporting resources, and input from a panel of prevention professionals in the state of Michigan. The goals of this guide are to:

A. Strengthen local ability to identify and select evidence-based interventions.
B. Provide capacity building tools and resources.
C. Foster the development of sound community prevention systems and strategies as part of comprehensive community planning to establish prevention prepared communities.

The Evidence-Based Workgroup hopes that this document will result in an increased ability for local prevention planners to critically assess prevention interventions based on the strength of evidence that an intervention is effective, to implement evidence-based interventions with a balance between fidelity and necessary local adaptations, and to demonstrate the relationship between evidence and achieving outcomes.

The Bureau of Substance Abuse and Addiction Services (BSAAS) offers a special thank you to the workgroup members who took the time to research and provide the information for this document. Leadership was provided by the chair, Kori White-Bissot, who gathered input and content from the Evidence-Based Workgroup membership in compiling this document.

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II. Evidence-Based Practices – Overview and Background

Definition: A prevention service (program, policy, or practice) that has been proven to positively change the problem being targeted.

In general, there needs to be evidence that the intervention has been effective at achieving outcomes through some form of evaluation. This is done by collecting evidence through an evaluation process when a specific intervention is implemented in a community. The evaluation process monitors outcomes to determine whether the intervention positively impacted the target problem and/or contributing condition. The type of evidence collected during an evaluation process will vary for different types of interventions.

The remainder of this guide will assist in thinking critically about these issues, while identifying interventions appropriate for individual communities.

A. Program: Usually thought of as an intervention that is:

1. Guided by curricula or manuals.
2. Implemented in defined settings or organized contexts.
3. Focused primarily on individuals, families, or defined settings.

Examples: *Strengthening Families Program, Botvin's Life Skills, and Project ALERT.*
Evidence: Evidence is usually collected by tracking participants for a period of time after receiving the intervention and comparing them to a group of similar individuals who did not receive the intervention. The evaluation then determines whether the individuals who received the intervention report having lesser rates of substance abuse than those who did not receive the intervention.

B. Policy: Efforts to influence the courses of action, regulatory measures, laws, and/or funding priorities concerning a given topic. A variety of tactics and tools are used to influence policy, including advocating their positions publicly, attempting to educate supporters and opponents, and mobilizing allies on a particular issue.

Example: Smoke-free laws and regulations.
Evidence: Usually evidence that a policy was effective is collected by looking at communities that have implemented the policy and the impact that was documented when they did so. In some cases, evidence is collected by looking at communities that have historically had the policy and then removed it. The negative outcomes of this change may be appropriate to use in order to document the positive benefits of the policy.

C. Environmental Strategy/Practices: Activities working to establish or change written and unwritten community-focused standards, codes, and attitudes, in order to change behavior in the community. This is done by changing the shared environment through three interrelated factors: norms, availability, and regulations. By changing the shared environment of a community, the desired behavior change is supported by everyone in the community (Arthur, M. D. & Blitz, C., 2000).

Example: Consistent enforcement of *Youth Tobacco Act*.
Evidence: Evidence for an environmental strategy is usually assessed by looking at communities that have implemented the strategy and the impact it has on the local condition (e.g., easy access to tobacco) targeted by the strategy.

It is often difficult to determine how one environmental strategy contributes to the longer-term goal of changing the problem being targeted (e.g., tobacco use). Since it is challenging to document how strategies impact the larger problem being targeted:

1. Environmental strategies must be incorporated into a comprehensive plan addressing multiple contributing conditions that have been shown to positively impact the problem being targeted.

2. Each strategy that makes up the comprehensive plan needs to have been documented to positively impact the contributing condition that each targets, often demonstrated in a logic model. (See Attachment 2.)

Strength of Evidence: The strength of evidence will fall along a continuum from weak to strong. Where an intervention falls on this continuum is determined by the scientific rigor of the evaluation process that was employed to document the intervention's positive impact on the problem and/or contributing condition. It is not determined by how large an impact the intervention has demonstrated on the problem being targeted.

One should not to confuse 'strength of evidence' with the magnitude of an intervention's impact on the targeted problem. There may be evidence-based interventions that have documented small levels of impact on the problem they target. However, they may be rated as having 'very strong' evidence because they used a rigorous evaluation process to document their small impact and have submitted their research for review to experts in the field. In turn, there may be untested interventions that have a large impact on the problem targeted. However, until the outcomes are tested and documented using rigorous evaluation standards, the intervention will not be categorized as 'evidence-based.'

Additional Considerations: When selecting an intervention it is important to assess more than just whether an intervention has been effective. In order for the intervention to be effective in the community, one must also consider a practical and conceptual fit and the framework for the plan must be logical and data-driven throughout. This is especially important for prevention practices that are more effective when they are completed as a component of a comprehensive prevention plan and are unlikely to be included on a federal registry of effective prevention programs due to the nature of the activities.

In summary, when selecting prevention services, consider interventions that have both conceptual and practical fit for the community, that have the strongest level of evidence, and that are effective at addressing the targeted problem and local contributing conditions. For more information, refer to Section IV (B).

III. Evidence-Based Categories

For more in-depth information about the following three categories, please refer to *Identifying and Selecting Evidence-Based Intervention*, (Health and Human Services [HHS], 2009).

Because evidence-based categories fall along a continuum, it can be challenging to determine which evidence-based category an intervention falls within. Interventions will often straddle categories as they work to move up the continuum to a stronger level of evidence category. Local prevention planners should do their best to review the evidence available and determine which category most closely represents the strength of evidence for an intervention.

A. Federal Registries

1. National Registry of Effective Prevention Programs (NREPP): A program that was previously listed on the SAMHSA model program list or currently listed on NREPP with positive outcomes demonstrated. SAMHSA no longer publishes a list of "model" programs. NREPP now posts the results found for each program that they have reviewed, including programs that were found not to be effective. Therefore, being listed on NREPP does not alone provide evidence of effectiveness. It is imperative that agencies critically review the outcomes detailed and the strength of the evaluation described in the NREPP review. For more information about using the NREPP registry, refer to Section IV D.

2. Other Federal Agency: The program/model is listed by another federal agency as an effective prevention program/model. Federal lists or registries are limited in scope since they are geared to interventions most amenable to assessment using traditional research designs and methodologies for evaluation. For more information, refer to Section IV C.

The following should be considered when assessing programs on other federal registries:

- Does the intervention have evidence that it positively impacts the local contributing conditions being targeted? If the intervention is promoting broad outcomes (e.g., reduction in alcohol and tobacco use), it will be necessary to identify the contributing conditions that the intervention targeted in order to reach those broad outcomes. If unable to identify the targeted contributing conditions, it will be challenging to determine whether the intervention is an appropriate fit for the community.

- Is the intervention culturally appropriate for the community and target audience? Has it been tested with a target audience similar to the one selected? If not, is it possible to modify the program to meet the needs of the target audience while maintaining the minimum fidelity standards to achieve the desired outcomes? For more information, see Section V (A).

- What research standards are required to be included on the registry? The level of evidence required varies greatly between federal registries. Review the standards to

ensure confidence that the outcomes are well documented and were documented using rigorous research standards.

B. Peer Review Journal

This category refers to interventions whose research findings have been published in a peer-reviewed journal. It is best if there are multiple studies and look for consistently positive outcomes. This option should only be selected if planned activities are closely replicating the key components of the program described in the peer-reviewed journal.

Please note that the burden for determining the applicability and credibility of the findings falls on the local prevention planners. Even though the research is published, this category still requires local prevention planners to think critically about the evaluation methodology and determine whether the claimed results are warranted based on the evaluation design. Consider the scope of the evaluation, the measures used, and whether the claims of effectiveness exceed what the evaluation actually assessed.

What is a Peer Review Journal?

When researchers submit their research articles to a peer review journal, the journal subjects the research to the scrutiny of other experts in the field. These journals have a panel of experts in the field determine whether the research meets accepted standards for research methods, and has appropriately interpreted the research findings. Only articles that meet both of these standards are published in peer review journals.

It should be noted that the purpose of a peer review journal is scholarly and to further the area of research, which is very different from the purpose of a federal registry. Sometimes research findings that an intervention was not effective can be useful in helping plan future efforts. One may find that there were key components of the intervention that were left out that need to be included, or the findings might indicate that the theory of change was flawed and that it is necessary to explore other intervention options.

When using peer review journals to determine whether an intervention has evidence of effectiveness:

1. Review all relevant articles, not just those with positive results. If there is more than one study that reviews the intervention, there should be consistently positive results found.

2. One can feel more confident about articles written by authors who are not the developers of the program because they do not have a vested interest in the program's success.

3. If available, use meta-analysis and literature review articles:

- Meta Analysis: In these articles, researchers conduct a review of as much research as possible published about an issue and use statistics to analyze and summarize results across multiple research studies. These types of articles can be extremely useful in making sense of multiple research studies about an issue.

- Literature Review: In these articles, researchers analyze and summarize results across multiple research studies and other scientific sources and create a narrative that summarized the research findings across studies.

How to Review a Peer Review Journal Article:

Research findings published in peer review journals are presented in a prescribed format with clearly defined sections. Each section provides information about the research study that can be used to assess the quality and relevance of the research presented.

Do not be intimidated. Breaking an article down into its sections allows one to determine the relevance of an article and to gather the information needed to make informed decisions. First, scan the abstract to determine whether the article is relevant to the planned work. If it seems relevant, skim the introduction and discussion section to further determine the relevance of the research. If the article still seems appropriate to aid in planning, it may warrant a full reading of the article.

A helpful article that provides thorough descriptions of the sections of a peer review journal article and how each section can provide useful information is included as Attachment 1. The following is a brief description of the sections:

1. Abstract: A summary of the key points in the article and the hypothesis being tested. This section is the first step in determining whether the article is relevant to the planned work.
2. Introduction: Provides the context of the study.
3. Methods: Explains how the researchers set about testing their hypothesis.
4. Results: Findings of the researchers are detailed in this section.
5. Discussion: A summary of the results, written in a narrative rather than statistical form. This section explains whether the results support the hypotheses and give suggestions for future research.
6. Bibliography: A listing of all sources cited in the article.

C. Other Sources of Documented Effectiveness:

In this category, the specific intervention has documented proven results impacting the targeted factors (contributing conditions, intervening variables, and/or risk/protective factors) through an evaluation process. In addition, the intervention must meet the following four guidelines:

1. The intervention is based on a theory of change that is documented in a clear logic or conceptual model.

2. The intervention is similar in content and structure to interventions that appear in registries and/or peer-reviewed literature.

3. The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects.

4. The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review, local prevention practitioners, and key community leaders as appropriate (e.g., officials from law enforcement and education sectors or elders within indigenous cultures).

This category of evidence-based criteria recognizes that some complex interventions, which usually include innovations developed locally, look different from most of those listed on federal registries. Because complex interventions exhibit qualities different from those of a discrete nature or interventions using a manual, they often require customized assessment.

When it's Appropriate to Apply

This category should be used if an evidence-based intervention in one of the preceding categories does not exist to meet the identified community needs, and there is not one that can be adapted to do so. Keep in mind that there may not be an exact match within one of the preceding categories but there may be a modifiable intervention that could be adapted to meet needs. Please refer to Section V (A) for more guidance.

It is recognized that there may be prevention initiatives that a community is committed to which have not gone through the process to have documented a stronger level of evidence that it is effective. In addition, many environmental interventions have limited evidence that isolate the impact of the specific intervention components of a community plan.

It may also be necessary to rely on weaker evidence when no appropriate interventions are available in categories with stronger evidence. An appropriate intervention addresses the targeted problem and local contributing condition, and is appropriate for the cultural and community context in which it will be implemented.

Under one of these circumstances it may be appropriate to select or continue to use an intervention that does not meet a stronger category of evidence. The following conditions should be addressed in these situations:

1. Evaluation methodology documenting effectiveness should meet rigorous scientific standards and evaluation of local implementation should work to move the intervention further along the continuum of evidence strength. It may be appropriate

to work with a local university, a researcher, an evaluator, or local epidemiology workgroup in order to strengthen the evaluation plan.

2. The intervention should follow best-practice principles. For more information, refer to Section VI (B).

3. Many interventions that fall within this category are strategies that should be combined to develop a comprehensive community plan to address a community's contributing conditions.

4. Because this category has a weaker level of evidence, there is an additional burden on the local prevention planner to evaluate the intervention. When documenting this local evidence, a summary of local evaluation results indicating effectiveness should be developed. This should include a description of the following:

   - Evaluation methodology.
   - Outcomes tracked as well as the results for each.
   - The scope of the evaluation (e.g. Sample size for surveys, number of series, during what time period, etc.).
   - The research/theory on which the activities/programs are based, including a clearly documented theory of change, which is often communicated through the use of a logic model.

   Note: Addressing risk and protective factors is not adequate; evidence of effectiveness for the specific intervention/set of activities is actually needed.

   <u>Key Elements to Support Documented Effectiveness</u>

   Documentation to justify the inclusion of a particular intervention in a comprehensive community plan is important. Prevention planners are encouraged to provide as many types of documentation as are appropriate and feasible in order to provide strong justification of documented effectiveness.

   The following are elements of documentation that might be provided to demonstrate an intervention has other sources of documented effectiveness and meets the four guidelines established by CSAP (HHS, 2009).

   - Documentation that clarifies and explains how the intervention is similar in theory, content, and structure to interventions that are considered evidence-based by scientific standards.

   - Documentation that the intervention has been used by the community through multiple iterations, and data collected indicating its effectiveness.

   - Documentation that indicates how the intervention adequately addresses elements of evidence usually addressed in peer-reviewed journal articles. These elements

may include the nature and quality of the evaluation research design; the consistency of findings across multiple studies; and the nature and quality of the data collection methods, including attention to missing data and possible sources of bias.

- Documentation that explains how the intervention is based on an established theory that has been tested and empirically supported in multiple studies. This documentation should include an intervention-specific logic model that details how the intervention applies and incorporates the established theory.

- Documentation that explains how the intervention is based on published principles of prevention. This documentation should provide references for the principles cited and should explain how the intervention incorporates and applies these principles.

- Documentation that describes and explains how the intervention is rooted in the indigenous culture and tradition.

D. Community-Based Process Best-Practice

Activities conducted through formal coalitions, task forces, community-planning teams, or collaborative groups are necessary to foster prevention prepared communities. While this type of activity was not separately identified within the guidance from CSAP, it is a key component that Michigan recognizes for the success of comprehensive community plans addressing local conditions and targeting community-level change in risk behaviors.

Community-based process is an approach that enhances the efficacy of prevention efforts by working to breakdown silos, streamline services, and to engage the community in a comprehensive multi-layered plan. Community-based process includes activities such as: coordinating and managing coalitions, task forces, community planning teams, and/or collaborative groups.

1. Community-Based Process – Evidence and Importance

   Because community-based process is designed to assist communities in implementing community-level interventions and to increase the community's ability to provide prevention services, rather than target specific community problems, it does not require the same type of evidence.

   - In order to effectively **implement** prevention practices, it is often necessary to engage in a community-based process. Planners may need to mobilize the community to implement a strategy as a component of a comprehensive, multi-layered prevention plan. For example, environmental interventions must be done through a community-based process in order to **succeed**. These are often efforts to make change to the larger environment through reduced access, changing

community norms, and influencing policy and enforcement. However, these activities do not meet evidence-based criteria in the way that an intervention targeting a certain issue would do so.

"Community Building" is not an intervention, nor is it expected to meet evidence-based criteria at affecting the targeted community problem. Keep in mind that the interventions completed through the community-based process should meet evidence-based criteria.

- Even programs that target individuals (such as a curricula-based program) can be more effective when conducted within a community-based process. By collaborating, a program's reach and sustainability can be enhanced when it is done as a component of a larger community plan.

2. Collaborative activities should be considered under the following criteria:

Leading a collaborative effort:

- The intervention is conducted using community-based process (e.g. coalitions, collaborative, taskforces);
  and
- The collaborative process is compatible with the five-step prevention planning process: assessment, capacity building, planning, implementation, and evaluation, with consideration for sustainability and cultural competency.

Participating in a collaborative effort:

- It is necessary to participate in other groups collaborative efforts in order to effectively conduct prevention in the targeted community;
  and
- Planners are representing substance abuse prevention.

3. In addition to the above criteria, the following should be considered when conducting community-based processes:

- Membership: The collaborative should be inclusive in its membership/make-up and engage key community stakeholders. The coalition should have appreciation for local involvement and authority in choosing and carrying out actions.

- Evidence of Effectiveness: Interventions implemented through the community-based process effort need to show evidence of being effective at improving at least one of the following:

  - Contributing to the identified desirable outcome.

  - Impacting the identified community problem/consequence.

- Improving the ability of the prevention system to deliver substance abuse services.

- Clear Purpose: Interventions implemented through a community-based process effort should begin with a clear understanding of their purpose and should consider the following initiatives:

  - Comprehensive services coordination - improving the nature and delivery of services.

  - Community mobilization - generating community activism to address substance abuse and related problems/consequences.

  - Behavior change - creating both system level change and individual behavior change.

  - Community linkages - creating or connecting resources within a community and/or connecting persons to resources.

For more information about best-practice for community based process, please refer to the Community Anti-Drug Coalitions of America website at www.cadca.org.

IV. Identifying and Selecting Interventions

A. Logical and Data-Driven

It is necessary that the intervention be data-driven, in addition to evidence that an intervention has been documented to positively impact the problem or contributing condition being targeted. This means that 'evidence' or data is required to support the decisions made throughout the planning, implementation and evaluation stages.

When planning an intervention it is imperative to have 'evidence' that supports the problem being addressed as well as data to support the local contributing conditions for that problem. This 'evidence' is typically collected as a part of the needs assessment phase of planning.

There should a logical connection between the intervention and the targeted local conditions and that are selected as an evidence-based practice that has been documented to impact the targeted contributing condition. A logic model can be used to demonstrate the connection between needs assessment findings, the intervention, and the intended short- and long-term outcomes, and can be a key tool in ensuring that the selected interventions are appropriate for the community's needs. An example from the Community Anti-Drug Coalitions of America (CADCA) can be found as Attachment 2 (SAMHSA/NREPP, 2010).

B. "Goodness of Fit"

In addition to whether an intervention has been found to be effective, it is important to consider conceptual and practical fit in order to determine whether the intervention 'fits' well in the community. The following factors should be considered:

1. Conceptual Fit (relevant)
   - Addresses a community's salient risk and protective factors, and contributing conditions.
   - Targets opportunities for intervention in multiple life domains.
   - Drives positive outcomes in one or more substance abuse problems, consumption patterns, or consequences.

2. Practical Fit (appropriate)
   - Feasible given a community's resources, capacities, and readiness to act.
   - Additional/reinforcement of other strategies in the community–synergistic vs. duplicative or stand-alone efforts.
   - Appropriate for the cultural context of your community, or able to be modified as appropriate.

3. Evidence of Effectiveness
   - Adequately supported by theory, empirical data, and the consensus judgment of informed experts and community prevention leaders.

General Guidance Steps to Select a "Best-Fit" Option

1. Review or develop a logic model of the program or practice. Does the candidate intervention target the identified problem and the underlying factors that drive or contribute to changes in the problem or outcomes?

2. Consult with the broader community in which the implementation will take place to ensure that community readiness and capacity are in place.

3. Develop and review a plan of action, the steps that will be followed to implement the program/practice, to identify potential implementation problems.

A worksheet to assist in assessing "goodness of fit" is provided as Attachment 3.

C. Finding Interventions That Meet Evidence-Based Criteria

The following resources are not intended to represent a complete list.

Federal Registry - Various federal agencies have identified youth-related programs that they consider worthy of recommendation based on expert opinion or a review of design and research evidence. These programs focus on different health topics, risk behaviors, and settings including violence:

- Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide at http://www.dsgonline.com/mpg2.5/mpg_index.htm.
- Exemplary and Promising Safe, Disciplined and Drug-Free Schools Programs sponsored by the U.S. Department of Education at http://www.ed.gov/admins/lead/safety/exemplary01/exemplary01.pdf.
- Guide to Clinical Preventive Services sponsored by the Agency for Healthcare Research and Quality (AHRQ) at http://www.uspreventiveservicestaskforce.org/recommendations.htm.
- Guide to Community Preventive Services sponsored by the Centers for Disease Control and Prevention (CDC) at http://www.thecommunityguide.org.
- SAMHSA National Registry of Evidence-Based Programs and Practices (NREPP) at http://www.nrepp.samhsa.gov. For more information about using NREPP, please refer to Section IV (D).
- A list of other registries may be found on SAMHSA's website at http://www.samhsa.gov/ebpWebguide/appendixB.asp.

Additional Web Resources - Information about effective prevention planning and implementation can also be found at the following websites:

- Center for the Study and Prevention of Violence Blueprints for Violence Prevention at www.colorado.edu/cspv/.

- National Institute of Alcohol Abuse and Alcoholism (NIAAA) Alcohol Policy Information System (APIA) at http://alcoholpolicy.niaaa.nih.gov/.
- Stop Underage Drinking portal of federal resources at http://www.stopalcoholabuse.gov.
- NIDA InfoFacts: Lessons from Prevention Research at http://www.nida.nih.gov/DrugPages/Prevention.html.

Peer Review Journal Research Sources - Searchable databases: these databases have a search feature for relevant research.

- Google Scholar at http://scholar.google.com/.
- US National Library of Medicine at http://www.pubmed.gov.
- Peer Review Journals: The following are a few of the peer review journals with published research relevant to prevention. They can be accessed through a university library and the above searchable databases.

    - American Journal of Public Health
    - Journal of Addiction Studies
    - Annual Review of Public Health
    - Journal on Studies of Alcohol
    - Preventive Medicine
    - Journal of School Health
    - Journal of Adolescent Health
    - Journal of the American Medical Association
    - Public Health and Research

D. Using the National Registry of Evidence-Based Programs and Policies (NREPP):

NREPP is a decision support system designed to be a tool for selecting interventions. The NREPP reflects current thinking that states and communities are best positioned to decide what is most appropriate for their needs. Beginning in 2007, SAMHSA's NREPP changed to allow local prevention providers and decision makers to identify interventions that produce specific community outcomes that meet their needs.

Key points about the revised NREPP are as follows:

1. A review posted on the NREPP site is no longer adequate to document evidence-based status. All programs that are reviewed will be posted on the NREPP site regardless of evaluation results, including programs with minimal or no positive outcomes found.

2. NREPP is a voluntary rating and classification system designed to provide the public with reliable information on the scientific basis and practicality of interventions that prevent and/or treat mental and substance use disorders.

3. Outside experts review and rate interventions on two dimensions: strength of evidence and dissemination capability. Strength of evidence and readiness for dissemination are assessed according to pre-defined criteria and are rated numerically on an ordinal scale of zero to four, with four being the highest score and zero being the lowest score.

4. Detailed descriptive information and the overall average rating score on each dimension (regardless of the rating score) is included and posted on the NREPP website, for all interventions reviewed. Average scores achieved on each rating criterion within each dimension are also provided.

A list of questions to ask while exploring the possible use of an intervention that is listed on NREPP has been provided as Attachment 4.

V. Implementing Evidence-Based Interventions

When implementing an evidence-based intervention locally, it is necessary to maintain a balance between adaptation and fidelity, follow best-practice principles, and conduct evaluations to monitor and ensure local effectiveness.

A. Balancing Fidelity and Adaptation

A dynamic process, often evolving over time, by which those involved with implementing an intervention address both the need for fidelity to the original program and the need for local adaptation.

There are typically two places in the implementation process when this occurs: (1) at the front end, with the decision to adopt an evidence-based intervention that needs some modification to fit local circumstances; and (2) during implementation, if the expected outcomes are not being achieved locally.

There are three key terms when discussing the issue:

- Fidelity: The degree to which implementation of an intervention adheres to the original design. Sometimes is referred to as program adherence or integrity in some of the literature on this subject. Medical terms, such as dosage, strength of treatment, intensity, and exposure are sometimes used to discuss the overall degree of fidelity (Boruch & Gomez, 1977), (Pentz, 2001).

- Core Components: The elements of a program that analysis shows are most likely to account for positive outcomes. Some programs contain essentially only their core components. Others have discretionary or optional components which can be deleted without major impact on the program's effectiveness, or which are not essential for the program's main target audience.

- Program Adaptation: Deliberate or accidental modification of the intervention, including: deletions or additions (enhancements) of program components; modifications in the nature of the components that are included; changes in the manner or intensity of administration of program components called for in the program manual, curriculum, or core components analysis; modifications required by cultural and other local circumstances.

1. Examples of Adaptations

    - Cutting the number or length of program sessions.
    - Reducing the number of staff involved in delivering a program.
    - Using volunteers or paraprofessionals who do not have adequate experience or training.
    - Changing the intervention as it is implemented over time; such as when a facilitator adjusts the program to fit their style, eliminates content they don't like,

or adds in pieces from other curricula that may not support the goals of the program.

2. Cultural Adaptation

- Cultural adaptation refers to program modifications that are culturally sensitive and tailored to a cultural group's traditional world views.
- Consider the language used – the visuals, examples, and scenarios – and the activities that participants are asked to engage in. These types of changes, which tailor the existing intervention to a particular group of participants, are unlikely to diminish effectiveness.
- Cultural adaptation should address the core values, beliefs, norms, and other more significant aspects of the cultural group's world views and lifestyles.
- Effective cultural adaptation involves understanding and working effectively with cultural nuances and requires appropriate cultural knowledge and sensitivity among developers, those adapting the intervention, and delivery staff.

3. Strategies for Maintaining Effectiveness

- Select an intervention that meets the community's needs. To the extent possible, find an intervention that will need little to no adaptation for targeted circumstances; if this is not possible select an intervention that has been adapted for other audiences in the past or whose developer is willing to assist in the adaptation process.
- Ensure that staff members are committed to fidelity, as they need to be comfortable with the material and the style of interaction. They also must commit to delivering the intervention as agreed.
- Ensure individuals implementing the intervention have appropriate training and skill sets necessary to assure consistent implementation.
- Contact the program developer to ensure that any adaptations made are appropriate. If they are unavailable, discuss it with supervisor, funder, or other local experts. It may be desirable to discuss adaptations locally and then attempt to contact the developer for feedback.
- Determine the key elements that make the intervention effective. This information is usually obtained from the program developer based on his or her research and experience.
- Stay true to the intensity and duration of the intervention. It is important to follow the guidelines for how often the program meets, the length of each session and how long participants stay involved.
- Monitor the intervention's implementation and address any unintentional variation from the original design.
- Stay up-to-date with overall program revisions.
- Be aware that adding material or sessions to an existing intervention while otherwise maintaining fidelity does not generally seem to have a detrimental effect.

4. Adaptations That Are Likely To Reduce Effectiveness

- Eliminating parts of an intervention's content – a piece may be removed that was critical to effectiveness.
- Shortening the duration or intensity of an intervention – there may not be enough time for participants to develop a key skill or to build the relationships that are critical to the change process. Sufficient dosage and the opportunity to form positive relationships with well-trained staff have been identified as important principles of effective prevention programs.
- Making adaptations to the intervention's targeted risk and protective factors, or intervening variable, should not be attempted unless it is done in collaboration with the program's developer.

B. Best-Practice Principles

Even when using an evidence-based intervention it is important to ensure that implementation follows best-practice principles. Most programs that have been found to be effective have been based on these principles. However, it is important that these be well understood by those implementing an intervention, since attention to these principles will likely enhance the success of the intervention. For a detailed description of these principles, refer to Section VI (B).

C. Evaluation of Evidence-Based Interventions

Evaluation is an important part of all prevention services, even when that intervention is evidence-based. Some program developers have been known to promote to purchasers that an outcome evaluation is not necessary if the model program is implemented with fidelity. **This is never the case.**

A local outcome evaluation should still be conducted in order to ensure that the implementation done locally is acquiring positive results. There are many reasons why local implementation of an intervention may alter the expected results: staff delivery, program adaptations, community fit, and cultural context to name a few.

For evidence-based programs that have been rigorously evaluated and consistently shown to have positive results by the developers, a less rigorous local evaluation methodology may be warranted. For example, if doing an intervention that has been shown to reduce substance abuse initiation over time, the local evaluation could focus on ensuring that the intervention has met the immediate outcomes that were documented by the evaluation of the developers (e.g. Botvin Life Skills: decision making, goal setting, etc.). ***The weaker the strength of evidence for an intervention the more rigorous the local evaluation should be.***

It should be noted that SAMHSA's Strategic Planning Framework (SPF) has established evaluation as an integral component of a comprehensive community approach. In a comprehensive community approach using the SPF model, it is important to track progress toward completing the strategic plan, impact of specific strategies on targeted

community conditions, and changes in the targeted contributing conditions. The findings should provide important information to drive future coalition planning and implementation, as well as communicate the benefit of efforts to the community.

VI. Non Evidence-Based Interventions

A. When might it be appropriate to use interventions that are non-evidence-based?

Use of non-evidence based strategies for prevention should be a rare occurrence. There may be instances when a strategy that is not evidence-based is necessary to include as part of using a multi-layered comprehensive prevention approach. These interventions should be used judiciously and considered a last resort. Every attempt should be made to use interventions that meet evidence-based criteria. Instances in which to consider use of evidence-based interventions include:

1. Complex Community Plans
   When using a multi-layered comprehensive approach to target a specific community issue, a community will often find that there are specific local conditions that need to be addressed in order to modify the intervening variables. Research on this type of intervention usually evaluates the impact of a **set** of interventions designed to work together to impact the problem.

   In these cases, one should look for evidence that the intervention component was shown to impact the shorter-term outcome that demonstrates its contribution toward solving the local conditions that are being targeted for improvement.

2. Community Commitment
   Sometimes a community that has been implementing a prevention program for a long period of time will have established strong buy-in from the schools or the community. If this buy-in would be lost by switching to a program with a stronger level of evidence, it may not be possible to change.

   However, the program should not be used indefinitely without evidence of effectiveness. In this scenario, it would be the responsibility of the prevention providers to evaluate the program in order to document effectiveness through a local evaluation.

   Another option that the community may want to consider is to maintain the name and identity of the current program while replacing the content with that of an evidence-based program. In this option, community support may be maintained while ensuring effective services.

3. Emerging Drug Trends
   In some instances the field of prevention research has not yet caught up with emerging drug trends that need to be addressed. In these cases it may be necessary to consider interventions that have not yet been evaluated for their impact on the issue being targeted. Often these issues are drug specific and require interventions unique to the drug (e.g. prescription drug misuse). In these instances it is important to ensure a comprehensive, multi-layered approach that is logical and data-driven.

There may be interventions that have been shown to be effective in targeting a different drug, based on the intervening variables and community conditions that have been identified for the new drug issue. Looking for research to inform decisions about the new drug issue is a way to increase the likelihood that efforts will be effective.

B. Best-Practice Principles

It is imperative to consider what works in prevention. In the article *What Works in Prevention: Principles of Effective Prevention Programs* (Nation, M., et. al., 2003), the authors used a review-of-reviews approach across four areas (substance abuse, risky sexual behavior, school failure, and juvenile delinquency and violence) to identify characteristics consistently associated with effective prevention programs. They are as follows:

1. Comprehensive: Strategies should include multiple components and affect multiple settings to address a wide range of risk and protective factors of the target problem. Consider:

    - Does the program include multiple components?
    - Does the program provide activities in more than one setting?
    - Do the activities happen in settings related to the risk and protective factors associated with the problem?

2. Varied Teaching Methods: Strategies should include multiple teaching methods, including some type of active, skills-based component. Consider:

    - Does the program include more than one teaching method?
    - Does the strategy include interactive instruction, such as role-play and other techniques for practicing new behaviors?
    - Does the strategy provide hands on learning experiences, rather than just presenting information or other forms of passive instruction?

3. Sufficient Dosage: Participants need to be exposed to enough of the activity for it to have an effect. Consider:

    - Does the strategy provide more than one session?
    - Does the strategy provide sessions long enough to present the program content?
    - Does the intensity of the activity match the level of risk/deficits of the participants?
    - Does the strategy include a schedule for follow up or booster sessions?

4. Theory Driven: Preventive strategies should have a scientific justification or logical rationale. Consider:

- Does the program provide (or can one identify) a theory of how the problem behaviors develop?
- Does the program articulate a theory of how and why the intervention is likely to produce change?
- Bring the local model of the problem and model of the solution together to develop a logic model.
- Based on the model of the problem and the model of the solution, is it believable that the program is likely to produce change?

5. Positive Relationships: Programs should foster strong, stable, positive relationships between children and adults. Consider:

   - Does the program provide opportunities for parents and children to strengthen their relationship?
   - For situations where parents are not available or relevant, does the strategy offer opportunities for a participant to develop a strong connection with an adult mentor?
   - Does the strategy provide opportunities for the participant to establish close relationships with people other than professional service providers?

6. Appropriately Timed: Program activities should happen at a time (developmentally) that can have maximal impact in a participant's life. Consider:

   - Does the strategy happen before the problem behavior?
   - Is the strategy timed strategically to have an impact during important developmental milestones related to the problem behavior?
   - Does the activity content seem developmentally (intellectually, cognitively) appropriate for the target population?

7. Socio-Culturally Relevant: Programs should be tailored to fit within cultural beliefs and practices of specific groups, as well as local community norms. Consider:

   - Does the strategy appear to be sensitive to the social and cultural realities of the participants? If not, are planners capable of making the changes that are needed to make it more appropriate?
   - Is the strategy flexible to deal with special circumstances or individual needs of potential participants?
   - Is it possible to consult some potential participants to help evaluate and/or modify the strategy?

8. Outcome Evaluation: A systematic outcome evaluation is necessary to determine whether a program or strategy worked. Consider:

   - Is there a plan for evaluating the program?
   - Does the evaluation plan provide feedback prior to the end of the program?

- Is there a plan for receiving feedback throughout the program development and implementation?

9. Well-Trained Staff: Programs need to be implemented by staff members who are sensitive, competent, and have received sufficient training, support, and supervision. Consider:

   - Is there sufficient staff to implement the program? If so, has the staff received sufficient training, supervision, and support to implement the program properly?
   - Will efforts be made to encourage stability and high morale in the staff members who will provide the program?

C. Evaluation and Gathering Evidence

When using an intervention that does not meet evidence-based criteria, evaluation becomes even more important. An evaluation of interventions that are not evidence-based should be designed based on the theory of change that leads to the decision to implement that intervention. Consider "What is the issue that made planners decide this intervention is necessary?" Then track whether or not the intervention is having an impact on that issue (immediate outcomes).

If it's found that the intervention is successfully improving the immediate outcomes, consider strengthening the evaluation method. In order to move toward collecting evaluation results, document the effectiveness of the intervention so that it will meet evidence-based criteria. This may require that the evaluation move beyond the immediate outcomes and document change at the intervening variable level and possibly the consumption or consequence level.

The goal for non-evidence-based interventions is to move as far along the strength of evidence continuum as possible. However, the initial step of documenting an impact on the most immediate outcomes should be completed as the first step. This will help determine whether the intervention is worth committing the necessary time and resources to conduct a more rigorous evaluation.

If the intervention is found to be effective and a more rigorous evaluation is conducted, consider submitting the findings to a peer review journal. If successful, it may be time to apply to NREPP for review.

VII. Glossary of Key Terms

Contributing/Local Condition: The factors in communities that create and maintain the root causes, or risk factors that contribute to the problem.

Evidence-Based: A prevention service (program, policy, or practice) that has been proven to positively change the problem trying to be impacted.

Interventions: Encompass programs, practices, policies, and strategies that affect individuals, groups of individuals, or entire communities.

Long-term Outcomes: Directly measure changes in the problem. Long-term outcomes show evidence of population-level behavior changes and are potentially influenced in 3 to10 years (e.g. reduction in 30-day use, decrease in alcohol related crashes and fatalities).

Practical Fit: The degree to which an intervention is appropriate for the community's population, cultural context, and local circumstances including its resources, capacities, and readiness to take action.

Problem(s): The risk behavior or consequence it has been decided to address based on the local assessment.

Strength of Evidence: The strength of evidence will fall along a continuum from weak to strong. Where an intervention falls on this continuum is determined by how scientifically rigorous the evaluation process was that documented the intervention's positive impact on the problem and/or contributing condition. It is not determined by how large an impact the intervention demonstrated on the problem targeted.

Short-term Outcomes: Directly measured changes in the local conditions. Short-term outcomes are potentially influenced within 6 to 24 months (e.g., increased retailer compliance).

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CADCA Coalitions Online

July 22, 2004

How to Get the Most Out of Research Articles

Evidence-based. That is the buzz word these days, and it is critical for your coalition to use programs, policies and practices that are (as much as possible) grounded in strong theory and evidence. This is where research comes in. Research is used to test out theories and examine the effectiveness of programs, practices and policies. Coalitions need to use this information to make the best decisions about what strategies they will use to address their local substance abuse issues. It is important to be an informed consumer of research information, and this means reading a research article and assessing the quality of the findings reported and its appropriateness to the work you do. Unfortunately, deciphering these technical articles can be a daunting prospect. However, all hope is not lost!

The following article helps break down the mystery of reading research so that your coalition can get the most out of coalition-relevant research. Research published in peer review journals is typically presented in a very prescribed format, with defined sections. Each section provides you with valuable information about the research study and by linking the pieces together, you can assess the quality and relevance of the research presented. So next time you get a research article, don't toss it aside. Sit down, take a look through the article and make the most of the information in your hand. – Evelyn Yang, MA

"Reading research: Go straight to the source to make science work for you"
By Jessica Campbell

Abstract
This is a summary of the key points in the article and should mention the hypothesis being tested. Read this to determine whether the article is relevant to your work.

Introduction
A context for the study is offered in this section. It should tell you what prompted the researchers to study the question at hand and upon which past research they are building. Ask yourself whether there is a logical connection between the study being introduced and past studies. Note whether the article is a research (reporting the findings of a single study) or review (reporting on a range of related studies) article. Note also whether research is quantitative (dealing with things that can be counted) or qualitative (dealing with interpretation or critique).

Methods
This section, sometimes also called "Methodology," explains how the researchers set about testing their hypothesis. It should include information about the instruments,

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11/1/2004
Prevention Ethics Worksl
Las Cruces, New Mexico

11/3/2004
Take the Lead Preventio Conference
Portland, Oregon

11/4/2004
Healthy Communities He

Youth Conference
St. Paul MN

11/11/2004

CADCA Calendar

procedures, participants and analysis used by the researchers. Ask yourself whether these seem adequate to answer the question posed by the hypothesis. All of the instruments (questionnaires, surveys, interview protocols, etc.) should be described. Their appropriateness for use in the study should be justified and their quality verified. Then the procedures by which the instruments were applied to the participants should be described. This will help you compare the study to other similar studies. For example, if two studies examined coalition functioning, did one study gather information with a paper/pencil survey and the other with a face-to-face interview? Did one study gather information at just one time point and the other multiple times over the course of five years? How would these factors affect the results? Note not only the number and type of participants included in the study, but also the researchers' reasons for choosing that number and type. Ask yourself whether the participants are demographically similar to the population with which you work and whether any differences in demographics would affect the relevance of the study to your work. The analysis is the final part of the Methods section and will explain how researchers organized and examined the data they collected. Often this takes the form of statistics, but you do not need not be familiar with statistical analysis to understand the study.

Results

The findings of the research are detailed in this section. In addition to raw data, the relationships between variables, as outlined in the introduction, should be explained here. Skim this section and note the subheadings used; they should reflect the questions in the introduction and help you organize your thoughts. The results are often depicted in graphs, tables or other illustrative elements. You might find it helpful to flip to the Discussion section for clarifications of specific findings included in this section.

Discussion

This is a summary of the results, written in narrative rather than statistical or numerical form. This section explains whether the results support the hypothesis and what they mean to previous studies on the topic. Often, suggestions for future research are included in this section. Ask yourself whether the conclusions the researchers draw here are supported by their findings. It can be helpful to read this section before reading the Methods and Results sections to get a better idea of the full scope of the research before delving into its minutiae.

Bibliography

This is a listing of all the sources cited in the article, as well as relevant articles or books that were not cited. Scan this to find other writings relevant to your work.

This article first appeared in the Spring 2004 issue of *Prevention Forum*, published by Prevention First. For more information, please visit www.prevention.org.

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This Week in Coalitions Online

- CADCA Hosts 6th Annual Drug-Free Kids Campaign Awards Dinner
- New Legislation Introduced to Reduce Underage Drinking
- Deadline Approaches for CADCA's Mid-Year Training Institute
- Tobacco Prevention Funding Available for Coalitions from RWJF
- SAMHSA Releases Updated Directory of Treatment Programs

SAMPLE LOGIC MODEL

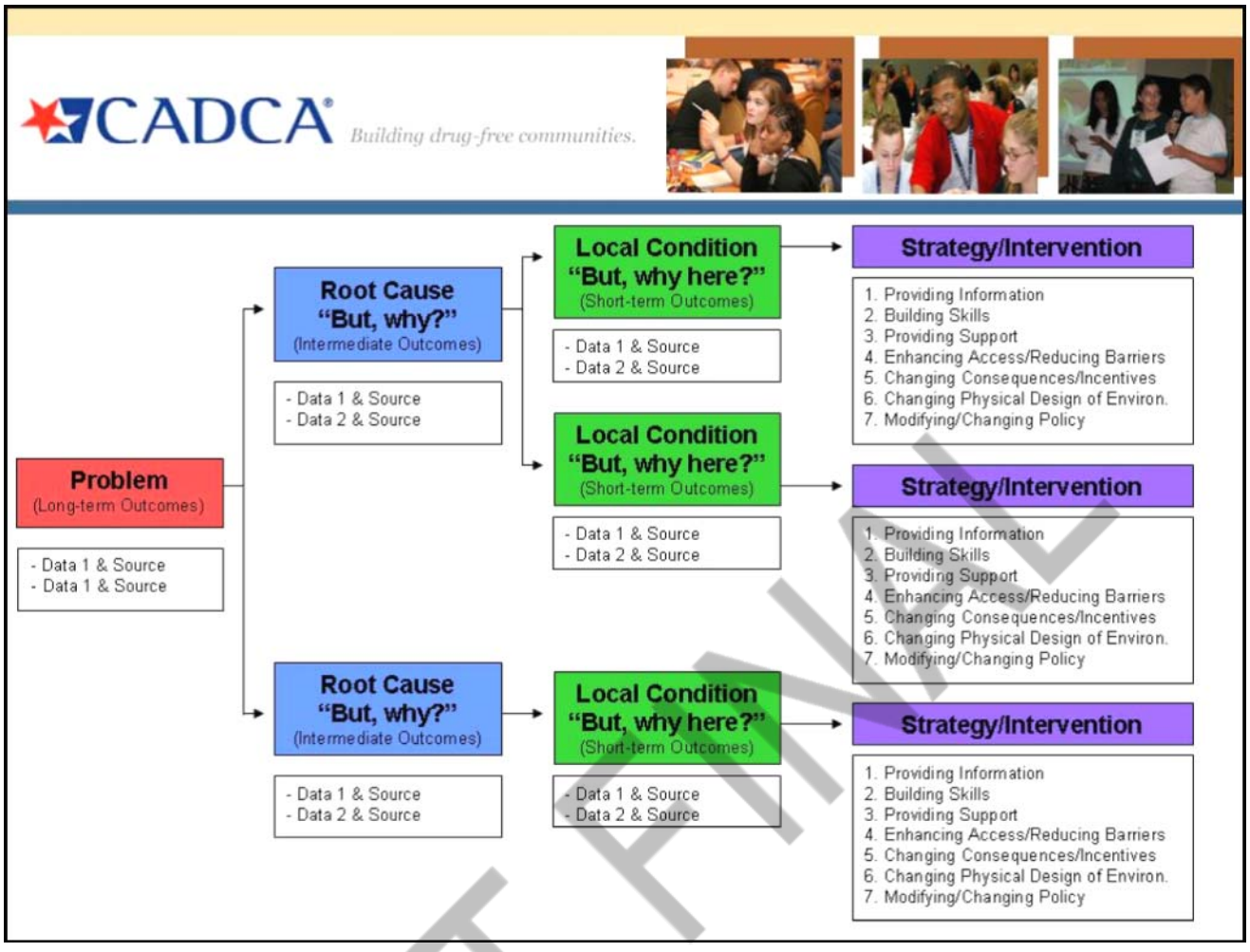
Theory of Change

When a community comes together and implements multiple strategies to address young adult use of methamphetamine drugs in a comprehensive way, young adults will be more likely to use less.

Problem Statement		Strategies		Activities	Outcomes		
Problem	**But why?**	**But why here?**			**Short-Term**	**Intermediate**	**Long-Term** [1]
Young adults Are using meth-amphetamine drugs	Meth is easy to make	Over-the-counter products are sold that contain ephedrine and pseudoephedrine used to make meth	Increase barriers to local meth production by passing a policy to lock up OTC drugs containing precursor chemicals	• Research existing policies • Develop model policy • Educate community and retailers about policy • Identify key decision makers • Mobilize community to support policy • Approach decision-makers to pass policy • Get policy passed • Ensure policy is enforced	50 % of public report support of policy changes % of retailers complying with new policies	Decrease in OTC precursor product sales/thefts Decrease in perceived availability	**Behavioral Outcomes** % of young adults reporting meth use decreases
	Meth is easy to get	Meth is widely sold and given away at bars and parties	Reduce access to meth in the community	Provide information to bar owners & event hosts re: ways to identify & discourage on-site meth use Enhance skills of "hot spot" bar owners & event hosts to counter on-site meth use Increase consequences to bar owners & event hosts who allow meth use on site	% of bar owners/event hosts that say they received mailing and remember key points Percent of bar owners and event hosts that received training and attend to change their practice as a result of training Increased law enforcement presence is documented in problem venues	% bar owners/ event hosts that implement anti-meth practices Increase in perception that meth hot spots are decreasing Decr in perceived availability	**Downstream Consequences (Health and Social Consequences)** % of young adults in treatment for meth addiction decreases
	There is high demand for meth	There is a demand for meth among young adults that feeds the supply Meth users do not have access to treatment in our community	Reduce local demand for meth	Change community practices/systems to engage in comprehensive meth prevention Enhance access and reduce barriers to treatment for meth users Enhance skills of health and social service providers	% of all community members (children, parents, organizations, citizens, etc.) that participate in prevention programs Treatment services are developed/ expanded to address meth use Increased skill in problem identification and referral among health and social service providers	Increase in perceived harm Increase in age of initiation % of young adults referred to treatment for meth decreases	% of meth arrests as a proportion of all drug-related arrests decreases % of meth related ER/Hospital visits decreases

[1] The long-term outcomes are affected not by any single strategy but by ALL of the strategies and activities.

Source: Community Anti-Drug Coalitions of America (CADCA), National Coalition Institute's, Evaluation Primer


CADCA
Building drug-free communities.
Problem
(Long-term Outcomes)
- Data 1 & Source
- Data 1 & Source
Root Cause
"But, why?"
(Intermediate Outcomes)
- Data 1 & Source
- Data 2 & Source
Root Cause
"But, why?"
(Intermediate Outcomes)
- Data 1 & Source
- Data 2 & Source
Local Condition
"But, why here?"
(Short-term Outcomes)
- Data 1 & Source
- Data 2 & Source
Local Condition
"But, why here?"
(Short-term Outcomes)
- Data 1 & Source
- Data 2 & Source
Local Condition
"But, why here?"
(Short-term Outcomes)
- Data 1 & Source
- Data 2 & Source
Strategy/Intervention
1. Providing Information
2. Building Skills
3. Providing Support
4. Enhancing Access/Reducing Barriers
5. Changing Consequences/Incentives
6. Changing Physical Design of Environ.
7. Modifying/Changing Policy
Strategy/Intervention
1. Providing Information
2. Building Skills
3. Providing Support
4. Enhancing Access/Reducing Barriers
5. Changing Consequences/Incentives
6. Changing Physical Design of Environ.
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Strategy/Intervention
1. Providing Information
2. Building Skills
3. Providing Support
4. Enhancing Access/Reducing Barriers
5. Changing Consequences/Incentives
6. Changing Physical Design of Environ.
7. Modifying/Changing Policy

Assessing "Goodness of Fit" Worksheet

The following questions, provided by the SAMHSA Prevention Platform, can be used to assess "Goodness of Fit."

Note that "community" could be substituted for "organization" if considering a community logic model.

Mission, Goals, Objectives	Yes	No	NA
1. Does this program or practice fit your organization's mission?			
2. Does the program or practice fit with the *values* underlying your organization's mission?			
3. Is the program or practice compatible with the organization's current focus?			
Implementation Capacity	Yes	No	NA
4. Does your organization have the human resources to implement the program or practice?			
5. Does your organization have the material resources to implement the program or practice?			
6. Does your organization have the appropriate funding to implement the program or practice?			
7. Can you implement the program or practice in the manner it was designed?			
8. Does the program or practice take into account the readiness of the community and target population?			
Cultural Relevance	Yes	No	NA
9. Is the program or practice appropriate for the community's values and existing practices?			
10. Is the program or practice appropriate for the culture and characteristics of the community being served?			
11. Does the program or practice take into account the community's values and traditions that affect how its citizens and the targeted group regard health promotion issues?			
12. Has the program or practice shown positive results in areas that are important to your community?			
Evidence Based and Effective	Yes	No	NA
13. Is the program or practice based on a well-fined theory or model?			
14. Is there documented evidence of effectiveness (such as formal evaluation results?			
15. Have the results been replicated successfully by different researchers over time?			
16. Has the program or practice been shown to be effective for areas similar to those you will address?			

National Registry of Evidence-based Programs and Practices

Questions To Ask as You Explore the Possible Use of an Intervention

Implementations

- Where has this intervention been implemented? In what settings? With what populations?
- What are the particular challenges to effective implementation? How might these challenges be overcome?
- What common mistakes have been made, and how can we avoid them?
- Can you provide contact information for two or three directors of implementation sites that are currently in the process of implementing the intervention?

Notes:

Adaptations

- Has your intervention been adapted in any ways that might be relevant to its implementation in a setting like mine (describe your setting) or with a population like mine (describe your population)?
- Have you been able to identify whether there are any "core components" of the intervention—parts of the intervention that must be implemented and/or should not be adapted?

Notes:

Staffing

- What are the staffing requirements (number and type)?
- What are the minimum staff qualifications (degree, experience)?
- What methods are used to select the best candidates (philosophy, skills)?
- Is there a recommended practitioner-to-client ratio?
- Is there a recommended supervisor-to-practitioner ratio?

Notes:

Quality Assurance Mechanisms

- What are the core components that define the essence of the intervention?
- How are supervisors prepared to provide effective support for practitioners?
- What is the supervision protocol for providing effective support for practitioners?
- What practical instruments are available to assess adherence and competence of the practitioner's use of the intervention's core components?
- What tests have been done to ensure the validity and reliability of the fidelity instruments?

Notes:

Training and Technical Assistance

- Is training required before a site can implement this intervention?
- Who conducts the training, and where is it conducted?
- Can staff at implementation sites be certified to conduct the training?
- Who is typically trained (practitioners, staff selection interviewers, staff trainers, staff supervisors/coaches, agency administrators)?
- What is the duration of the training (hours, days)?
- Is retraining required/available?
- What on-site assistance is provided by the developer, if any?
- How long does it usually take for a new implementation site to become a high-fidelity user of the intervention?

Notes:

Costs

- How much does it cost to secure the services of the developer? What is included in that cost?
- If the intervention costs more than my budget allows, is there a way to implement only part of the intervention?
- Do costs include salaried positions? In-kind costs? Special equipment?

Notes:

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The array of Medicaid mental health specialty services and supports provided through PIHPs under Michigan's capitated managed care waiver includes: Applied Behavioral Analysis, Assertive Community Treatment, Assessments, Child Therapy, Clubhouse Psychosocial Rehabilitation Programs, Co-occurring Disorders (COD): Integrated Dual Disorders Treatment (IDDT), Crisis Interventions, Crisis Residential Services, Dialectical Behavior Therapy, Family Therapy, Family Psychoeducation, Health Services, Home-Based Services, Individual/Group Therapy, Intensive Crisis Stabilization Services, Medication Administration, Medication Review, Nursing Facility Mental Health Monitoring, Occupational Therapy, Personal Care in Specialized Settings, Physical Therapy, Speech, Hearing and Language, Substance Abuse (including outpatient, approved pharmacological supports, residential and sub-acute detoxification services), Targeted Case Management, Telemedicine, Transportation, Treatment Planning, Partial Hospitalization, and Inpatient Psychiatric Hospitalization. Specialty services and supports included in Medicaid covered services include: Assistive Technology, Community Living Supports, Enhanced Pharmacy, Environmental Modifications, Family Support and Training, Housing Assistance, Peer-Delivered or Operated Support Services, Prevention-Direct Service Models, Respite Care Services, Skill-Building Assistance, Support and Service Coordination, Supported/Integrated Employment Services, Children's Serious Emotional Disturbance Home and Community-Based Services and Fiscal Intermediary Services. MDHHS/BHDDA has been expanding and improving integrated treatment for persons with co-occurring mental health and substance use disorders, and has been an area of focus for improvement over the last several years.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(•) Yes ( ) No
b)	Mental Health	(•) Yes ( ) No
c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No
e)	Housing services	(•) Yes ( ) No
f)	Educational Services	(•) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	( ) Yes (•) No
i)	Support services	(•) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(•) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(•) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

One of the best practices implemented in Michigan that touches many of the items noted above is the implementation and sustainability of the Michigan Fidelity Assistance and Support Team (MIFAST). The MIFAST group reviews programs for the purpose of assisting them in developing and sustaining evidence-based programs with a high level of fidelity. MIFAST does this by conducting a technical assistance training to help agencies become appropriately trained in the models and programs. These are followed by an onsite visit by MIFAST members to determine the degree to which the agency has achieved implementation by fidelity scoring of the scorecard elements, and subsequent provision of technical assistance

to aid in the improvement of areas that are shown to need further development. Currently MIFAST groups address DDCMHT, ACT, IDDT/ACT, DBT, LOCUS, Individual Placement and Support, and Family Psychoeducation.

3. Describe your state's case management services

Targeted case management is a Medicaid covered service that assists beneficiaries 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 other 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 children with serious emotional disturbance, adults with serious mental illness, persons with developmental disability, 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 Prepaid Inpatient Health Plan (PIHP), and/or are unable to independently access and sustain involvement with needed services. Determination of need for case management must occur at the completion of the intake process and through the person-centered planning process. Justification as to whether case management is needed or not must be documented in the individual's record. Monitoring is completed by the case manager determining, on an ongoing basis, if the services and support have been delivered, and if they are adequate to meet the needs/wants of the individual. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the beneficiary's health and welfare needs identified in the individual plan of services.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Through a contract with the PIHPs, it is the expectation effective and efficient operation of various programs and agencies in a manner consistent with all applicable federal and state laws, regulations and policies. As applied to services and supports, this includes assuring appropriate services, quality and the efficient and economic provision of supports and services are assured. Quality is measured by meeting or exceeding a set of outcomes specifications in individual's plan of service, developed through a person-centered planning process. There are to be clear guidelines for decision making and program operations and the provision for monitoring. The PIHP must offer to direct assistance to explore and secure all applicable reimbursements and assist the individual to make the use of other community resources as available and appropriate. MDHHS encourages the use of natural supports to assist in meeting an individual's need to the extent that family or friends who provide natural supports are willing and able to provide this assistance. The use of natural supports must be documented in the individual plan of service. Many of the specialty programs and services provided in Michigan are also intended to reduce hospitalization and hospital stays. For adults, these include Assertive Community Treatment, Clubhouse Psychosocial Rehabilitation, crisis residential programs, consumer run drop-in programs, intensive crisis stabilization, and Family Psychoeducation. Many of the integrated health projects are also focused on work with primary care providers to better coordinate services for individuals to return to the community as soon as medically possible and feasible.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	4.33%	387,000
2.Children with SED	6 -12%	71,046 to 142,092

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Per the 2019 National Survey on Drug Use and Health (NSDUH), 387,000 (5.0%) of Michigan's adult population are estimated to have serious mental illness, and there were 232,945 persons served through the Michigan mental health services system in FY 2019. According to the SAMHSA 2020 Mental Health National Outcome Measures (NOMS) Uniform Reporting System (URS) Report, Michigan's penetration rate per 1000 was 23.33, slightly lower than national rate of 24.58. Nearly 70.8% of these persons served met the federal definition of having a serious mental illness, also slightly below the US average of 71.6%. According to this same data set, 32.3% of adults served were individuals with a co-occurring MH/SUD disorder, significantly higher when compared to the national rate of 28%.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	(•) Yes ( ) No
b)	Educational services, including services provided under IDE	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes ( ) No
e)	Health and mental health services	(•) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such system	(•) Yes ( ) No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

One way in which MDHHS/BHDDA is targeting efforts to reach the rural population in the state is through rural transportation projects with Mental Health Block Grant funding. These grants provide funding for transportation services for the individuals served at critical transitions in their care in rural areas. This ensures that individuals can attend their scheduled behavioral health appointments and reduces the risk of "no-shows".

b. Describe your state's targeted services to the homeless population.

MDHHS Children's Services Agency ensures that Homeless Youth Services are provided to youth ages 16-21 that require support for a longer period of time. Services include crisis management, community education, counseling, placement, and life skills. Services are provided statewide through contracted providers. In addition to the Runaway and Homeless Youth Services, MDHHS supports a transitional living program in the Upper Peninsula, which is funded through a federal Housing and Urban Development (HUD) grant. MDHHS provides a match for the federal funding. The current homeless youth contracted agencies provide crisis call services that are resource-based within their geographical area statewide.

c. Describe your state's targeted services to the older adult population.

Older adults are eligible for the same service array as younger adults within the public behavioral health system. In FY19 over 10,642 older adults (65 and over) received public behavioral health services, which is approximately 3.7% of the total number of adults served. MDHHS continues to partner with Lansing Community College to provide an annual Mental Health and Aging Conference and regional seminars focus on the mental health needs of elders. Other partnerships include collaborative work with the Michigan Assisted Living Association, providing materials, curriculum, and training on dementia care to staff of facilities whose residents include over half persons with dementia.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

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

Assisted by block grant resources, Michigan has continued to make strides in improving our system of care to include the availability and delivery of many programs and practices. Among the strengths demonstrated across our State, efforts have continued to progress in the development and implementation of a range of SAMHSA-endorsed evidence-based practices (EBPs) and cross-cutting initiatives across our CMHSP provider system including training, fidelity review process, and monitoring. Block grant-supported projects targeting various adult service practice areas include: Assertive Community Treatment (ACT); Family Psychoeducation (FPE); Co-occurring Disorders (COD): Integrated Dual Disorders Treatment (IDDT); Motivational Interviewing; Individual Placement and Support; International Accreditation of Clubhouses; Jail Diversion; Veteran and Military Family Members strategic plan implementation; Consumer/Peer-Run Services and Advocacy; Integrated Physical & Behavioral Health; and Trauma-specific and Trauma-informed Services.

Footnotes:

SED State Estimates Algorithms: https://wwwdasis.samhsa.gov/dasis2/urs/adult_smi_child_sed_prev_2

	Level of Functining <=50		Level of Functining <=60	
Poverty Level	Lower Limit	Upper Limit	Lower Limit	Upper Limit
Tier A Lowest percent poverty	5%	7%	9%	11%
Tier B Medium percent poverty	6%	8%	10%	12%
Tier C Highest percent poverty	7%	9%	11%	13%

Michigan, 2019

Popuation 9-17, 2019 1,109,570 https://www.census.gov/data/tables/time-series/d

Children 5-17 in 100% Poverty, 2019 13.9% https://www.census.gov/data/tables/time-series/d

	Level of Functining <=50		Level of Functining <=60	
	Lower Limit	Upper Limit	Lower Limit	Upper Limit
Tier A Lowest percent poverty	55479	77670	99861	122053
Tier B Medium percent poverty	66574	88766	110957	133148

:018.pdf

emo/popest/2010s-state-detail.html Single Year of Age and Sex Population Estimates: April 1,
emo/income-poverty/cps-pov/pov-46.html

2010 to July 1, 2019 - CIVILIAN (SC-EST2019-AGESEX-CIV)

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

Targeted services for veterans?	( ) Yes (•) No
Adolescents?	(•) Yes ( ) No
Other Adults?	( ) Yes (•) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling ( ) Yes (●) No

b) Establishment of an electronic system to identify available treatment slots (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare (●) Yes ( ) No

d) Inclusion of recovery support services (●) Yes ( ) No

e) Health navigators to assist clients with community linkages (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance ( ) Yes (●) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The state level Women's Treatment Specialist works closely with regional Women's Treatment Coordinators to ensure that all programs are meeting the requirements set forth in the state's contract with the regional PIHPs, including the Women's Treatment Policy. The regional coordinators visit each of their contracted PPW programs annually and any issues and concerns are discussed with the Women's Treatment Specialist, as well as the corrective actions needed. Initial visits to programs interested in becoming a PPW program are attended by both the state level Women's Treatment Specialist and the regional Women's Treatment Coordinator(s) to ensure the program meets the requirements to offer the PPW services.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(•) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	(•) Yes ( ) No
c)	Outreach activities	(•) Yes ( ) No
d)	Syringe services programs, if applicable	( ) Yes (•) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	( ) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	( ) Yes (•) No
b)	Automatic reminder system associated with 14-120 day performance requirement	( ) Yes (•) No
c)	Use of peer recovery supports to maintain contact and support	(•) Yes ( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?	(•) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Office of Recovery Oriented Systems of Care monitors compliance for admission via the Priority Population Wait List Deficiency Reports and 90% Capacity Reports. In addition, the State Opioid Treatment Authority (SOTA) works with each regional PIHP to ensure that programs offering medication assisted treatment to PWID are adhering to rules regarding the provision of medications and the services that accompany this level of care. In the event that a program is out of compliance with contractual and federal requirements, a corrective action is issued and monitored by the regional PIHP and SOTA.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers	(•) Yes ( ) No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	(•) Yes ( ) No
c)	Established co-located SUD professionals within FQHCs	(•) Yes ( ) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

All programs are required to conduct a communicable disease screening to identify individuals with high risk for TB and other communicable diseases. If an individual's screening results indicate that they are at risk, they are provided a referral to a health provider for additional services and testing. Residential treatment providers perform TB tests onsite or have arrangements with local health departments to perform and read the tests. During site reviews, MDHHS staff will record compliance of PIHPs with a Communicable Disease policy to include requirements related to appropriate services for persons with or at risk of contracting TB and other communicable disease.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? ( ) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Establishment of EIS-HIV service hubs in rural areas	( ) Yes ( ) No

b)	Establishment or expansion of tele-health and social media support services	○ Yes	○ No
c)	Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS	○ Yes	○ No

Syringe Service Programs

1.	Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)?	◉ Yes	○ No
2.	Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?	◉ Yes	○ No
3.	Do any of the programs use SABG funds to support elements of a Syringe Services Program?	◉ Yes	○ No

If yes, plese provide a brief description of the elements and the arrangement

Programs use Substance Abuse Block Grant funds to provide counseling and care coordination types of services to PWID who use local Syringe Service Programs.

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — ○ Yes ◉ No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — ◉ Yes ○ No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ○ Yes ◉ No
- **c)** Establish a peer recovery support network to assist in filling the gaps — ◉ Yes ○ No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — ◉ Yes ○ No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ◉ Yes ○ No
- **f)** Explore expansion of services for:
  - **i)** MAT — ◉ Yes ○ No
  - **ii)** Tele-Health — ◉ Yes ○ No
  - **iii)** Social Media Outreach — ◉ Yes ○ No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — ○ Yes ◉ No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — ○ Yes ◉ No
- **b)** Establish a program to provide trauma-informed care — ◉ Yes ○ No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — ◉ Yes ○ No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — ◉ Yes ○ No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — ◉ Yes ○ No
- **b)** An organized referral system to identify alternative providers? — ○ Yes ◉ No
- **c)** A system to maintain a list of referrals made by religious organizations? — ○ Yes ◉ No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — ◉ Yes ○ No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — ◉ Yes ○ No
- **b)** Review of current levels of care to determine changes or additions — ◉ Yes ○ No
- **c)** Identify workforce needs to expand service capabilities — ◉ Yes ○ No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — (●) Yes ( ) No

c) Updating written procedures which regulate and control access to records — ( ) Yes (●) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — ( ) Yes (●) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

In Michigan, accreditation is required as a condition of the annual substance abuse licensing process that is conducted by the Department of Licensing and Regulatory Affairs (LARA). All substance abuse treatment providers in Michigan are required to be licensed, which means 100% of the providers have been accredited, with verification of that accreditation reviewed as a condition of the licensing process. LARA posts these licensing reviews online. In addition, the contract between MDHHS and the PIHPs requires the PIHPs to also ensure that their substance abuse service providers meet licensure and accreditation requirements.

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — ( ) Yes (●) No

b) Establishment of policies and procedures related to independent peer review — ( ) Yes (●) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — (●) Yes ( ) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — (●) Yes ( ) No

If Yes, please identify the accreditation organization(s)

i) ☑ Commission on the Accreditation of Rehabilitation Facilities

ii) ☑ The Joint Commission

iii) ☑ Other (please specify)

Accreditation Association for Ambulatory Health Care
National Committee for Quality Assurance

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ◉ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ◉ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state ◉ Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ◉ Yes ○ No

c) Performance-based accountability: ○ Yes ◉ No

d) Data collection and reporting requirements ◉ Yes ○ No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs ◉ Yes ○ No

b) Addition of training sessions designed to increase employee understanding of recovery support services ◉ Yes ○ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ◉ Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ◉ Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ◉ Yes ○ No

b) Mental Health TTC? ○ Yes ◉ No

c) Addiction TTC? ○ Yes ◉ No

d) State Targeted Response TTC? ◉ Yes ○ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ○ Yes ◉ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

Disorder Programs. Substance Use Disorders: https://www.michigan.gov/lara/0,4601,7-154-89334_63294_30419-152686--,00.html
Mental Health: http://www.legislature.mi.gov/(S(iwzizl4qfjrhtyprvnckqnmf))/mileg.aspx?page=GetMCLDocument&objectname=mcl

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11. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2020-FFY 2021? ○ Yes ○ No

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

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12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

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

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? ○ Yes ○ No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? ○ Yes ○ No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? ○ Yes ○ No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ○ Yes ○ No

5. Does the state have any activities related to this section that you would like to highlight.

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

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13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**

[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1.	Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?	○ Yes ○ No
2.	Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?	○ Yes ○ No
3.	Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?	○ Yes ○ No
4.	Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?	○ Yes ○ No
5.	Does the state have any activities related to this section that you would like to highlight? Please indicate areas of technical assistance needed related to this section.	

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14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], 49 [4], and 63[5].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

TIP 40 - https://www.ncbi.nlm.nih.gov/books/NBK64245/ [ncbi.nlm.nih.gov]

TIP 43 - https://www.ncbi.nlm.nih.gov/books/NBK64164/ [ncbi.nlm.nih.gov]

TIP 45 - https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf [store.samhsa.gov]

TIP 49 - https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf [store.samhsa.gov]

TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? (●) Yes ( ) No

- **a)** ☑ Methadone
- **b)** ☑ Buprenophine, Buprenorphine/naloxone
- **c)** ☑ Disulfiram
- **d)** ☑ Acamprosate
- **e)** ☐ Naltrexone (oral, IM)
- **f)** ☑ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

Michigan has implemented a hub and spoke model for opioid treatment that is primarily supported with Medicaid, but expansion sites have been supported with discretionary grant funds and supplemental block grant funds. The goal of the model is to expand the availability of Medication Assisted Treatment and ensuring that co-occurring mental and physical health needs are also being met. This model has not been implemented statewide but has been targeted to regions with high populations of individuals using opioids and considered opioid dependent. One of the positive features of this model is the care coordination that is provided by the nurse care managers. This has ensured frequent contact with the individual in services and fostered the

ability to increase service intensity as needed.

Training for peer recovery coaches has been offered statewide in the Medication Assisted Recovery Services curriculum to provide a better match between the individual in OTP services and the peer recovery coaches available for support in the communities.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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15. Crisis Services - Required for MHBG

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☐ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☑ Psychiatric Advance Directives
- **c)** ☑ Family Engagement
- **d)** ☑ Safety Planning
- **e)** ☑ Peer-Operated Warm Lines
- **f)** ☐ Peer-Run Crisis Respite Programs
- **g)** ☑ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☐ Assessment/Triage (Living Room Model)
- **b)** ☐ Open Dialogue
- **c)** ☑ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☐ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☑ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Michigan is in the process of developing or strengthening the three primary components of a public crisis system for all Michiganders: crisis line, crisis receiving and stabilization units, and mobile crisis. All three of these services will coordinate with each other and the other components of publicly funded behavioral health care in Michigan. Michigan Crisis and Access Line, a statewide crisis and access line which is based on SAMHSA's air traffic control model, is being piloted in two regions of Michigan with statewide rollout to be completed by the end of 2022. This line will provide primary or secondary NSPL/988 coverage for the whole state and is legislatively required to coordinate care with CMHSPs and PIHPs in addition to other entities. Michigan recently passed legislation authorizing MDHHS to develop a certification process for crisis stabilization units. MDHHS has hired consultants who are partnering with a broad group of stakeholders to design a "Michigan model" and develop draft certification criteria. These same consultants will help make recommendations on a mobile crisis model which will work in all areas of Michigan. Rural areas are a special focus area of this crisis services work.

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

MDHHS would appreciate technical assistance in the following areas:
• how to successfully implement mobile crisis 24/7 in Michigan's culturally and geographically diverse landscape given the significant behavioral health workforce shortage, especially in rural and frontier areas
• implementing CSUs for children
• CSU models for rural and frontier areas
• crisis workforce development ideas
• bundled rate funding ideas for CSUs and mobile crisis

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16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a)	Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?	(•) Yes ( ) No
b)	Required peer accreditation or certification?	(•) Yes ( ) No
c)	Block grant funding of recovery support services.	(•) Yes ( ) No
d)	Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?	(•) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? ( ) Yes (•) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Recovery and recovery support services in Michigan include support for Peer Recovery Coaching, recovery and alumni groups, recovery community organization activities, recovery focused events such as health fairs, self-care focused events, and workshops focused on topics relevant to the recovery community.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Recovery and recovery support services in Michigan include support for Peer Recovery Coaching, recovery and alumni groups, recovery community organization activities, recovery focused events such as health fairs, self-care focused events, and workshops focused on topics relevant to the recovery community.

5. Does the state have any activities that it would like to highlight?

Michigan uses SAMHSA's working definition of recovery "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential". In addition to the working definition, the four dimensions and 10 guiding principles are built upon in all trainings and events related to recovery. The department is committed to building, developing and sustaining a Recovery Oriented System of Care (ROSC). As part of the strong commitment of ROSC a Transformation Steering Committee (TSC) consisting of a diverse group of stakeholders representing state agencies, treatment and prevention agencies, families, and individuals in recovery.
The TSC continues to inform the department and provide advocacy on policies, procedures, legislation and promote services that assist people in leading a meaningful life in their communities of choice. The Transformation Steering Committee's vision is: Michigan's recovery-oriented system of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The opportunities established through collaboration, partnership and a broad array of services promote life, enhancing recovery and wellness for individuals, families and communities.
In addition to the TSC several other efforts continue to increase knowledge and understanding of recovery principles and practices. Over 820 individuals employed have achieved state certification as peer recovery coaches. Peer recovery coaches work in a variety of practice areas including Recovery Community Organizations, hospital emergency rooms, drug courts, residential treatment programs, The curriculum used was provided by SAMHSA BRSS TACS funding and includes 10 state certified coaches as the trainers. A strong focus of the training is providing education on multiple pathways of recovery. Continuing education is areas of trauma informed care, harm reduction, SMART recovery, Intentional Peer Support, motivational interviewing, Wellness Recovery Action Planning (WRAP), supervisor training and Community Health Worker certification are some of the trainings provided throughout the year.
Drop-in centers, which exemplify recovery in action by providing opportunities for both peer life skill-building for peers running the centers and the sharing of recovery life lessons and examples for peers who attend activities to learn, grow in hope and heal and recover. Due to the COVID-19 pandemic drop-in centers were among organizations included in state-mandated closure during lockdown. Some drop-in centers utilized social media applications to stay in touch with participants and held outdoor activities, as the weather became warm enough to do so

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

No technical assistance is needed at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	○ Yes ○ No
Home and community based services.	○ Yes ○ No
Peer support services.	○ Yes ○ No
Employment services.	○ Yes ○ No

2. Does the state have a plan to transition individuals from hospital to community settings? ○ Yes ○ No

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

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Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? (●) Yes ( ) No

c) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

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

As indicated earlier in the application, legislation passed in Michigan required that each Coordinating Agency (CA) be incorporated into an existing PIHP to formally integrate mental health and substance use disorder services statewide by January 1, 2013. Some PIHPs had already placed a specific focus on training on COD for youth and these include Oakland and Central Michigan. Oakland County PIHP has held training in Motivational Interviewing in order to increase engagement of families in

treatment, as well as addressing the mental health and substance use issues of adolescents and family members. CMH for Central Michigan also includes a specific COD focus on children/adolescents to assist with meeting goals around their substance use.

Several other PIHPs use Multi-Systemic Therapy (MST) as a strategy for addressing CODs. Additionally, Michigan received a State Youth Treatment-Planning (SYT-P) grant in Fiscal Year 2015 to develop and expand the infrastructure for adolescent and transitional age youth treatment and recovery support services. Through the SYT-P grant, an Interagency Council was formed, consisting of state agencies invested in the successful treatment of adolescents and transitional age youth. With the help of the Interagency Council and subcommittees, a financial map and strategic plan were developed to help identify gaps in funding, and needed services and activities to support youth and their families. In Fiscal Year 2017, Michigan received a Youth Treatment-Intervention (YT-I) grant to continue the work identified in the SYT-P grant in Fiscal Years 2018-2021. As a result, providers who serve adolescents and transitional age youth have received training and coaching in identified evidence-based practices such as Motivational Interviewing, Seeking Safety, Adolescent Community Reinforcement Approach (A-ACRA), and Trauma Informed Cognitive Behavioral Therapy (TF-CBT). A youth peer recovery coach curriculum was developed, and training piloted in 2021. Training will be implemented statewide in 2022 to support adolescents entering treatment and to sustain in recovery. The grant has improved statewide knowledge of resources and available treatment for youth and families/caregivers impacted by SUD and co-occurring mental health issues.

There has been increased interagency collaboration in the state which has contributed to a more comprehensive SOC for children with SED that will continue into FY22-23. In responding to Request for Proposals (RFP) for the children's portion of the federal mental health block grant for the past five years, CMHSPs were asked to take the lead with their community stakeholders including the other agencies (child welfare, juvenile justice, education, etc.) and family members to plan the SOC for children with SED and propose projects in their RFP submissions that would fill identified gaps in the local SOC. The most recent RFP was for CMHSPs to proposed collaborative mental health screening projects to identify youth with mental health needs who have come in contact with the juvenile justice system, or are at risk for becoming involved in that system, and refer them to appropriate services. The original seven funded projects plus the additional three newly funded projects are joint mental health and court and/or school projects. Michigan also continues to apply for and receive local SOC grants from SAMHSA and most recently were awarded several SOC expansion grants. Michigan was also awarded a Healthy Transitions grant to fund two pilot sites to implement the Transition to Independence model for transition age youth with SED/SMI. This grant is in its first year and MDHHS is very excited to learn from the pilot sites in hopes of improving the public mental health system for all transition age youth. However, many barriers remain in the development of a statewide comprehensive SOC and access to mental health services for children who need them. Human service agencies recognize that they need to continue to explore ways to reduce the duplication of services, especially case management and the provision of services through the use of the wraparound process and family-driven and youth-guided practice, to maximize the use of funds.

Historically in Michigan and currently, efforts have been made to move children into communities from more restrictive out-of-home placement, while still providing beneficial and helpful treatment interventions. This movement has continued and will continue to be supported with mental health block grant funding. The development and implementation of intensive community-based services has been crucial to moving children into the least restrictive environment without compromising treatment effectiveness. Mental Health Block Grant dollars were offered to the CMHSPs in FY18-19 for start-up of Intensive Crisis Stabilization Services (Mobile Crisis) and Crisis Residential for children/youth. These services are essential pieces of the continuum of service for children with SED and providers continue to work on establishing and supporting these services in sufficient capacity. A major part of Michigan's transformation plan has been the incorporation of family-driven and youth-guided practice, which has led to increased consumer choice and treatment interventions that are designed as the child and family desires. The MDHHS child welfare residential transformation process that MDHHS has embarked upon with consultation from children's mental health staff continues. MDHHS continues to consult with the Building Bridges initiative to determine how this approach may enhance residential treatment for the youth to whom it may be beneficial. MDHHS is also beginning the process to pilot Treatment Foster Care – Oregon in four communities. The hope is that these types of approaches will provide additional options for children requiring out of home care to receive appropriate treatment and return to their communities as soon as possible.

MDHHS has been a leader in increasing collaboration with other state agencies, local communities, and families. MDHHS participates in many interagency groups and emphasizes collaboration for children's services. Through these groups, the SOC has improved through the elimination of duplicative efforts and new projects being planned with joint efforts in development, implementation, and evaluation of services. More work is being planned to further improve the SOC, increase parent leadership development, and increase and maintain youth involvement on interagency committees. FY20-21 continues to bring opportunities for collaborative efforts in the areas of juvenile justice, screening, identification and treatment of social/emotional/mental health issues in home and community-based environments, services to transition-aged youth and public/private collaboration to address the needs of children with SED (and often times SED along with a developmental disability and/or cognitive impairment) who repeatedly cycle through residential and psychiatric placements.
MDHHS also supports the Michigan Child Collaborative Care (MC3) Program in collaboration with the University of Michigan which provides behavioral health consultation, including direct doctor to doctor psychiatric consultation, to pediatric and family medical practices in several communities across the state. Additionally, Michigan has been awarded a HRSA grant, Pediatric Mental Health Care Access, to expand MC3 in the upper peninsula and the thumb region of the state.

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

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

Key components of SOC (family-driven and youth-guided, cross system funding for services for child welfare foster care children with SED, etc.) have been the focus of interagency planning at the state level for many years, and great strides have been made in the past two years. As a result of participation in the February 2009 National Federation of Families for Children's Mental Health's Policy Academy on Transforming Children's Mental Health through Family-Driven Strategies and continuing work by that team, an official MDHHS policy on Family-Driven and Youth–Guided Practice is utilized by PIHP/ CMHSP providers to operationalize the concepts of family-driven and youth-guided service provision. A statewide Parent Support Partner training curriculum was developed in a partnership between the family organization and MDHHS, and training began in 2010 and will continue in FY20-21. The youth peer curriculum trainings have been operational since FY16 and continue to add Youth Peer Support Specialists to the public mental health workforce. The mental health block grant supports both these statewide training initiatives.

With regard to MDHHS monitoring progress made in and the effectiveness of public mental health services to children and youth with SED and their families and carrying out one of the activities specified in the authorizing statute of the MHBG (evaluating programs and services carried out under the plan), MDHHS will continue to contract with Michigan State University to procure the services of Dr. John Carlson and student assistants required to evaluate particular approaches and services and the system as a whole, at amounts not to exceed those listed next to each project annually, to ensure that public mental health services funded by all sources are producing optimal results for the required population. The Level of Functioning (LOF) Project evaluates functional assessment data collected on every child with SED served by the public mental health system. MSU LOF Project staff will work collaboratively with Multi-Health Systems (MHS), the purveyor of the CAFAS and PECFAS tools, to obtain functional assessment information entered into the FAS Outcomes system by direct service providers who serve children with SED in the Michigan public mental health system. This information is analyzed and used to generate reports that demonstrate the amount of improvement in functioning of children with SED served that has occurred under several pre-determined conditions. Special attention is given in analysis to the variables associated with positive outcomes as measured by both initial (from previous fiscal years) and most recent/exit CAFAS and PECFAS ratings. For those receiving evidence-based practices (EBPs), scores prior to receiving those services will be used to reflect the potential improvements resulting from the EBP. Reports are shared with CMHSPs/PIHPs annually to utilize in children's mental health services quality improvement activities.

The following projects target specific EBPs and/or services for evaluation:
• Children's Trauma Initiative Evaluation): MSU and MDHHS Children's Trauma Initiative staff work collaboratively with CMHSP direct service providers involved in the Michigan public mental health system's Children's Trauma Initiative to determine the effectiveness of the services being provided to children who have experienced trauma. Outcome and fidelity information is collected via the Research Electronic Data Capture (REDCap) system and analyzed. Information is analyzed on a regular basis and consultation provided to allow project staff to generate/create brief reports to be shared with the field across the year. An end of the fiscal year report for each of the three subprojects (TF-CBT, Screening, Caregiver Education) is generated as well.

• Parent Support Partner Evaluation: MSU, MDHHS, ACMH and direct Parent Support Partner (PSP) service provider agencies work together to collect and analyze information being submitted via REDCap about the provision of the PSP service to parent participants who are receiving PSP services in the public mental health system. Providers can access the online system for real-time data review and additional analysis through the availability of report features to monitor service provision and outcomes. Through a peer-parent relationship, parents/caregivers feel increased hope and confidence and are empowered to find and use their voices so, in partnership with providers, they can inform services and supports for their child/youth-thus leading to better outcomes.

• Wraparound Evaluation): MSU, MDHHS and direct Wraparound service providers work together to determine and demonstrate the effectiveness of Wraparound services being provided to children with SED in the public mental health system across the state of Michigan.
The purpose of this analysis is to examine the effectiveness and fidelity/acceptability of services currently being delivered under the leadership of Wraparound facilitators. Information regarding outcomes gathered from Wraparound facilitator ratings on the Family Status Reports (FSR) is submitted via REDCap and analyzed regularly and full feedback reports are completed semi-annually. Analysis involves looking at outcome variables over time for improvement and the relationship between outcome data and fidelity data to determine if certain Wraparound practices and services are leading to improved outcomes.

• Children with Serious Emotional Disturbance (SED) and Neuro-developmental Disorders (NDD) Strategies Evaluation: MSU SED/NDD Strategies staff work collaboratively with MDHHS and CMHSP/PIHP participants that are serving children with SED/NDD in the public mental health system using specified techniques to determine if these techniques improve outcomes for this population and to inform treatment for children with SED/NDD in the entire system. Outcome and fidelity variables are

collected from CMHSP/PIHP direct service providers via REDCap. An annual report for each of the treatment initiatives (e.g., screening and assessment, Families Moving Forward, SED/NDD Strengths and Strategies) is provided annually to be shared with

MDHHS, the sites and the entire public mental health system.

• Infant and Early Childhood Mental Health Consultation (IECMHC) Evaluation: MSU IECMHC staff work collaboratively with MDHHS and CMHSP/PIHP IECMHC participants that are serving children with SED to determine the effectiveness of the intervention. Evaluation includes assessment of program impact on (1) child care provider caregiving practices, (2) the impact of these practice changes on young children's social and emotional development, (3) the impact of these practice changes on program/child expulsion rates, (4) caregiver reflective capacity; (5) carrying out the IECMHC model as intended (fidelity), and (6) perceptions of program acceptability. Reports of outcomes and trends are provided on an annual basis.

Infant Mental Health Home Visiting Evaluation: MSU IMH HV staff work collaboratively with MDHHS and CMHSP/PIHP IMH HV participants that are serving young children with SED to determine the effectiveness of the intervention. Outcome and fidelity variables are collected from each CMHSP/PIHP direct service providers via REDCap. An annual report for treatment initiative will be shared with MDHHS, the sites and the public mental health system. In addition to pre-post review of the measures, the study will also report on the use of tele-health approaches during the pandemic.

Dialectical Behavioral Therapy for Adolescents (DBT-A) Evaluation: MSU DBT-A staff work collaboratively with MDHHS and CMHSP/PIHP DBT-A participants (clinicians, supervisors) that are serving adolescents with SED to determine the effectiveness of the evidence based intervention in the public mental health system. Outcome and fidelity variables are collected from each CMHSP/PIHP direct service providers via REDCap. An annual report will be developed by the MSU DBT-A staff and shared with MDHHS, the project sites and the public mental health system. In addition to pre-post review of the adolescent/family and fidelity measures, the study will also report on the use of tele-health approaches during the pandemic.

Motivational Interviewing for Adolescents (MI-A) Evaluation: MSU MI-A staff work collaboratively with MDHHS and the CMHSP/PIHP MI-A participants (clinicians, supervisors) that are utilizing MI-A techniques when serving adolescents with SED. Since MI-A is not a "stand alone" intervention, evaluation activities have been focused on client surveys and model fidelity checklists as well as pre-post skill acquisition of clinical staff.

7. Does the state have any activities related to this section that you would like to highlight?

No

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

No technical assistance is needed at this time.

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19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? ○ Yes ◉ No

2. Describe activities intended to reduce incidents of suicide in your state.

The Michigan Association for Suicide Prevention has recently released a state suicide prevention plan. However, it has not been adopted by MDHHS as the official update to the 2005 state plan.

The Michigan Department of Health and Human Services has received a new five-year SAMHSA-funded state youth suicide prevention grant, which started on June 30, 2019. A number of activities will be taking place under that grant including:
o Expansion of the suicide risk screening program for youth entering foster care developed under our previous grant.
o Development of a statewide network of general medicine emergency departments implementing evidence-based assessment, intervention, continuity of care, and follow-up strategies for youth at risk of suicide and their families.
o Implementation of a new Postvention Work Group to improve care for suicide loss survivors.
o Supporting local communities to implement suicide best practices tailored to community needs via technical assistance, training, education, and funding opportunities.
o Continuation of support for ASIST (Applied Suicide Intervention Skills Training) and AMSR (Assessing and Managing Suicide Risk) workshops for communities statewide.
o Continuation of support for the annual Suicide Prevention Community Technical Assistance meeting that is open to anyone interested in suicide prevention at the local level.

MDHHS has also supported Zero Suicide implementation activities through our previous SAMHSA grant. These activities included initial work to establish the Zero Suicide model in one local health department and one community mental health agency. The grant also supported training and the development of a Zero Suicide Network for a large urban county in the state.

3. Have you incorporated any strategies supportive of Zero Suicide? ◉ Yes ○ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ◉ Yes ○ No

5. Have you begun any targeted or statewide initiatives since the FFY 2020-FFY 2021 plan was submitted? ○ Yes ◉ No

If so, please describe the population targeted.

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

No technical assistance is needed at this time.

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20. Support of State Partners - Required for MHBG

Narrative Question

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

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

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ○ Yes ◉ No

2. Has your state identified the need to develop new partnerships that you did not have in place? ○ Yes ◉ No

If yes, with whom?

We have not identified the need to develop any new partnerships

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

No technical assistance is required at this time

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Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC).SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

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

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

The state developed and published an Office of Recovery-Oriented Systems of Care (OROSC) Strategic Plan (FY21 - FY23), that includes priority focus areas including:

Children: Improve Outcomes for Children (youth and families) by:
• Reducing Childhood and Underage Drinking
• Reducing Youth Access to Tobacco and Illegal Sales to Minors
• Reducing Substance Exposed Births
• Increasing Youth Awareness of Gambling Disorder
• Reducing the effects of parental substance use on youth

Adult and Family Support: Promote and Protect Health, Wellness, and Safety (across the lifespan within communities) by:
• Building community assets to address behavioral health needs
• Reducing prescription and over-the-counter drug misuse and abuse
• Reducing misuse and abuse of alcohol, opioid medications, and illicit drugs
• Reducing barriers to accessing treatment for opioid use disorders
• Increasing longevity and quality of life, by reducing health disparities and improving self-management

Health Services: Align Behavioral and Physical Healthcare by:
• Continuing the implementation of a recovery-oriented system of care across the lifespan
• Expanding integrated behavioral health and primary care services for persons at risk for and with substance use and mental health disorders
• Promoting opportunities for individuals with mental health disorders to self-direct their services and supports
• Promoting and strengthen the role of consumer-run programs
• Treat addiction as a chronic disease
• Improving behavioral health outcomes while leveraging efficiencies in cost and societal consequence
• Implementing Trauma Informed Care throughout the Systems of Care for all populations in Michigan

Workforce: Strengthen Workforce and Economic Development by:
• Providing statewide training in best-practice behavioral health services including prevention, treatment, and recovery technology

• Increase the number of individuals certified as peer support specialist and recovery coaches
• Providing training and continuing education to strengthen skills of Certified Peer support Specialist and Certified Peer Recovery Coaches
• Expanding employment opportunities for Certified Peer Recovery Coaches and Certified Peer Support Specialists in primary and integrated care settings
• Increasing the capacity of prevention efforts to address Gambling Disorder

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

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

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

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

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

No technical assistance is needed at this time.

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

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

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Footnotes:

Behavioral **H**ealth **A**dvisory **C**ouncil
Bylaws

ARTICLE I

Name

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

ARTICLE II

Function

1. The purpose of the Behavioral Health Advisory Council shall be to only advise the Michigan Department of Community Health (MDCH) concerning proposed and adopted plans affecting both mental health and substance use disorder services provided or coordinated by the State of Michigan and the implementation thereof.

2. The Council's responsibilities as defined in the applicable federal law include, but are not limited to:
    a. Improve the behavioral health outcomes (addressing both mental health and substance use disorders) of the people of the State of Michigan receiving behavioral health services.
    b. Assist the Department of Community Health in planning for community-based programs targeted to persons with behavioral health issues.
    c. Advocate for improved services to persons with behavioral health problems.
    d. Monitor and evaluate the implementation of the applicable federal law.
    e. Advise the Director of the Department of Community Health as to service system needs for persons with behavioral health problems.

3. The Director of the Department of Community Health may assign additional areas of responsibilities to the Council.

ARTICLE III

Members

1. Members shall be appointed by the Director of the Michigan Department of Community Health in accordance with the requirements of the applicable federal law.

2. Council member composition shall follow the guidelines set forth in the applicable federal law and any subsequent regulations pertaining to council membership.

3. The Council shall have a maximum of 40 members.

a. More than 50% of the members shall be consumers/clients/advocates.
b. Every effort shall be made to assure the composition of the Council reflects the social and demographic characteristics of Michigan's population.

4. Members shall be appointed for 2 year terms and may be re-appointed.

5. Each member may designate to the Department an alternate to represent the member at Council meetings. The officially designated alternates attending as representatives of members shall be given voting privileges at the Council meeting.

6. Attendance:
   a. Members shall be excused by notifying Council staff when unable to attend a scheduled meeting.
   b. Absent members who do not notify staff to be excused from a meeting and do not send an alternate shall be noted as un-excused.
   c. Two un-excused absences during a members term shall trigger an interview of the member by the executive committee to determine the member's continued status on the Council
   d. Three absences (excused or un-excused) during one year shall trigger an interview of the member by the Executive Committee to determine the member's continued the member's status on the Council.

7. Vacancies: Vacancies on the Council shall be filled by appointment by the Director of the Department of Community Health in accordance with the applicable federal law.

8. The department director may remove any member from the Council if the department director determines the member has not fulfilled his or her council responsibilities in a manner consistent with the Council's or departments best interests. If exercising this authority, the department director shall inform the removed member and the Council Chairperson of the reason(s) supporting such action.

ARTICLE IV

Officers

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

2. The Chairperson shall be responsible for conducting the meetings. The Chairperson shall be an ex-officio member of all committees formed by the Council. As the ex-officio member the Chairperson shall have no voting rights in said committees. The Chairperson shall serve for a 1 year term with a maximum of 2 consecutive terms.

3. The Vice-Chairperson shall act in the absence of the chair. The Vice-Chairperson shall serve for a 1 year term with a maximum of 2 consecutive terms.

4. The Recording Secretary shall be responsible for assuring that minutes are recorded, recording attendance, and working with the other officers. The recording secretary shall serve for a 1 year term with the maximum of 2 consecutive terms.

5. Vacancies among officers: A vacancy shall exist when an officer resigns from the office held or ceases to be a member of the Council. In the event the position of the Chairperson becomes vacant, the Vice-Chairperson shall perform the duties and exercise the powers of the Chairperson for the remainder of the term. The Council shall fill vacancies in the offices of Vice-Chairperson and Recording Secretary for the remainder of the term.

6. Nominations shall be submitted to Council staff for specific officer positions. Individuals can nominate themselves as well as any other member of the Council. Those who are nominated have the opportunity to decline to take part in the election process.

ARTICLE V

Meetings

1. The regular meetings of the Council will occur no less than 4 times per calendar year.

2. Notice of the dates, time, location, and agenda of regular meetings of the Council shall be distributed in accordance with the Open Meetings ACT (P.A. 267 of 1976). In addition, notice of dates, time, location, and agenda of regular meetings shall be posted publicly at least 3 days prior to any meeting of the Council.

3. The Director of the Department of Community Health, Council Chairperson or a minimum of 6 members may call a special meeting of the Council as necessary.

4. A quorum shall be more than ½ of the number of members serving on the Council at the time of the vote.

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

6. The current edition of Robert's Rules of Order shall govern the conduct of all meetings.

7. Electronic meetings, using telephone conference calls, or video conferencing are allowed when circumstances require Council action or to establish a quorum.

ARTICLE VI

Executive Committee

1. The Council's Executive Committee shall consist of the Chairperson, Vice-Chairperson, Recording Secretary, and immediate past Chairperson, if still a Council member. If none of the described positions includes a consumer/client/advocate, then a consumer/client/advocate member will be added to the Executive Committee as a Member at Large through the same nomination and election process used for Council Officers

2. The Executive Committee may draft and finalize letters and communications on behalf of the Council as directed by the Council.

3. The Executive Committee members may represent the Council in meetings with state and federal government officials within the scope of the Council's business. The Executive Committee may act on behalf of the Council when it is in the Council's best interests to do so. Any action by the Executive Committee shall be subject to subsequent ratification by the Council.

4. Any other duties, tasks, or responsibilities assigned to the Executive Committee shall be delegated by official Council action at a Council meeting.

ARTICLE VII

Committees/Workgroups

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

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

2. The scope and tenure of special committees shall terminate when the designated period of time has lapsed or the task is completed.

3. Special committees shall report on the committee's work to the Council. The establishment and dissolution of special committees shall be noted in the Council minutes.

4. A special committee may request the invitation of technical resource persons to provide information and answer questions, or the Council Chairperson may appoint persons outside the Council to serve on a committee.

ARTICLE VIII
Amendments

1. These bylaws shall be amended by a two-thirds vote of the Council at a regularly scheduled meeting following a 30-day review period of the proposed amendments and enacted with the concurrence of the Director of the Department of Community Health.

2. A committee of the Council shall review these bylaws not less than every four years.

3. These bylaws were last amended by the Behavioral Health Advisory Council at its regular meeting held on June 28, 2013.

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Julie Barron	Family Members of Individuals in Recovery (to include family members of adults with SMI)		3333 Moores River Drive Lansing MI, 48911 PH: 517-346-9600	barron@ceiemh.org
Karen Cashen	State Employees	Michigan Department of Health and Human Services	Behavioral Health and Developmental Disabilities Administration Lansing MI, 48913 PH: 517-335-5934	cashenk@michigan.gov
Elmer Cerano	Family Members of Individuals in Recovery (to include family members of adults with SMI)		6737 Landsdown Dimondale MI, 48821 PH: 586-940-0368	ecerano@aol.com
Mary Chaliman	State Employees	Michigan Department of Health and Human Services	Child Welfare Medical Unit Lansing MI, 48933 PH: 517-898-0707	Chalimanm2@michigan.gov
ShaRon Crandell	State Employees	MDHHS - Children's Mental Health Agency	Children's Mental Health Agency Lansing MI, 48909 PH: 517-335-6258	scrandell@michigan.gov
Lindsey DeCamp	State Employees	Michigan Department of Health and Human Services	State Public Health Agency Lansing MI, 48913 PH: 517-304-8001	decampl@michigan.gov
Norm DeLisle	Others (Advocates who are not State employees or providers)	Michigan Disability Rights Coalitition	635 Ewers Rd. Leslie MI, 49251 PH: 517-614-1886	ndelisle@mymdrc.org
Kevin Fischer	Others (Advocates who are not State employees or providers)	National Association on Mental Illness	401 S. Washington Ave Ste 104 Lansing MI, 48933 PH: 517-853-0951	kfischer@namimi.org
Marianne Huff	Others (Advocates who are not State employees or providers)		Mental Health Association of Michigan Lansing MI, 48901 PH: 517-898-1109	mhuffmham@gmail.com

Bianca Jacob	Providers		52377 Creek Lane Chesterfield MI, 48197 PH: 810-650-7619	briana.jacob@harboroaks.com
Greg Johnson	State Employees	Michigan Department of Corrections	Huron Valley Correctional Facility Ypsilanti MI, 48197	johnsong16@michigan.gov
Benjamin Jones	Providers	National Council on Alcoholism and Drug Dependence	2400 E. McNichols Detroit MI, 48212 PH: 313-868-1340	president@ncadd-detroit.org
Arlene Kashata	Representatives from Federally Recognized Tribes	Tribal Behavioral Health Communication Network	2815 Hilltop Court Traverse City MI, 49686 PH: 231-735-0491	akashata@hotmail.com
Michael Leathead	State Employees	Department of Education	608 W Allegan St Lansing MI, 48933 PH: 517-241-1500	williamsS8@michigan.gov
Mark Maggio	Persons in recovery from or providing treatment for or advocating for SUD services		1106 Ethel Ave Hancock MI, 49930 PH: 906-281-1909	markmaggio88@yahoo.com
Kevin McLaughlin	Persons in recovery from or providing treatment for or advocating for SUD services		2673 Oakleigh Rd Middleville MI, 49333 PH: 616-262-8531	kevin@recoveryallies.us
Janelle Murray	Providers		7215 Westshire Drive Lansing MI, 48917 PH: 517-827-0875	jmurray@mpca.net
Paula Nelson	Providers	Saced Heart Rehabiltation Center	400 Stoddard Rd Richmond MI, 48062 PH: 810-392-2167	pnelson@sacredheartcenter.com
Malkia Newman	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		279 Summit Drive Waterford MI, 48328 PH: 248-871-1482	mnewman@cnshealthcare.org
Stephanie Oles	State Employees	Michigan State Housing Development Authority	735 E. Michigan Ave Lansing MI, 48912 PH: 517-241-8591	OlesS@michigan.gov
Jamie Pennell	Parents of children with SED/SUD		211 Butler Street Leslie MI, 49251 PH: 517-589-9074	jpennell00@yahoo.com
Eva Petoskey	Representatives from Federally Recognized Tribes	Inter-Tribal Council of Michigan	2848 N. Setterbo Road Peshawbestown MI, 49682 PH: 231-357-4886	epetoskey@centurytel.net
Melissa Potter	State Employees	MI Dept of LEO- Michigan Rehabilitation Services	320 N. Walnut St. Lansing MI, 48933 PH: 517-272-4471	potterm7@michigan.gov
Michelle Roberts	Others (Advocates who are not State employees or providers)	Michigan Protection and Advocacy Services	4095 Legacy Parkway Lansing MI, 48911 PH: 517-487-1755	mroberts@mpas.org
Kristie Schmiege	Family Members of Individuals in Recovery (to include family members of adults with SMI)		37450 Schoolcraft Road Livonia MI, 48150 PH: 810-965-2675 ext	kschmiege@hegira.net

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Larry Scott	State Employees	MDHHS - State Mental Health Agency	Office of Recovery-Oriented Systems of Care Lansing MI, 48913 PH: 517-335-0174	scottl11@michigan.gov
Jane Shank	Others (Advocates who are not State employees or providers)	Association for Children's Mental Health	6017 W St Joe Hwy Lansing MI, 48917 PH: 231-383-1595	acmhjane@sbcglobal.net
Lois Shulman	Others (Advocates who are not State employees or providers)		5532 Abington Rd West Bloomfield MI, 48322 PH: 248-361-0219	loisshulman@comcast.net
Sally Steiner	State Employees	Michigan Department of Health and Human Services	Aging and Adult Services Agency Lansing MI, 48909 PH: 517-284-0164	steiners@michigan.gov
Maxine Thome	Others (Advocates who are not State employees or providers)	NASW (MI)	741 N Cedar St Lansing MI, 48906 PH: 517-487-1548 ext 14	mthome.naswmi@socialworkers.org
Lyndsay Tyler	State Employees	MDHHS - State Medicaid/Social Services Agency	State Medicaid Agency Lansing MI, 48933 PH: 517-575-8128	tylerl4@michigan.gov
Jeff VanTreese	Persons in recovery from or providing treatment for or advocating for SUD services		665 136th Avenue Holland MI, 49424 PH: 616-795-9969	JVTLAW@gmail.com
Brian Wellwood	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		520 Cherry St Lansing MI, 48933 PH: 517-371-2221 ext 313	brwellwood@yahoo.com
Algeria Wilson	Others (Advocates who are not State employees or providers)		1732 Cambria Drive, Unit 1 East Lansing MI, 48823 PH: 517-897-00150	awilson.naswmi@socialworkers.org

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	**34**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	2	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED/SUD*	1	
Vacancies (Individuals and Family Members)		
Others (Advocates who are not State employees or providers)	8	
Persons in recovery from or providing treatment for or advocating for SUD services	3	
Representatives from Federally Recognized Tribes	2	
Total Individuals in Recovery, Family Members & Others	**19**	**55.88%**
State Employees	11	
Providers	4	
Vacancies		
Total State Employees & Providers	**15**	**44.12%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations		
Providers from Diverse Racial, Ethnic, and LGBTQ Populations		
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	0	

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

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

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Footnotes:

There are several diverse racial, ethnic, or LGBTQ members of the BHAC. They were included in other categories rather than separated out. In addition, there is one member of the BHAC who is a provider that fits this criteria. This provider was not separated out from the other providers.

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

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

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (●) Yes ( ) No

b) Posting of the plan on the web for public comment? (●) Yes ( ) No

If yes, provide URL:

https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4902-359929--,00.html

c) Other (e.g. public service announcements, print media) ( ) Yes (●) No

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Footnotes:

Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

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