Michigan

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

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

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 06/22/2018 11.04.08 AM)

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	2018
End Year	2019

State SAPT DUNS Number

Number	113704139
Expiration Date	9/30/2018

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

Agency Name	Michigan Department of Health and Human Services
Organizational Unit	Behavioral Health and Developmental Disabilities Administration
Mailing Address	320 South Walnut, 5th Floor
City	Lansing
Zip Code	48913

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

First Name	Thomas
Last Name	Renwick
Agency Name	Michigan Department of Health and Human Services
Mailing Address	Behavioral Health & Developmental Disabilities Administration, Bureau of Community Based Services 320 S. Walnut, 5th Floor
City	Lansing
Zip Code	48913
Telephone	517-373-2568
Fax	517-335-5376
Email Address	renwickt@michigan.gov

State CMHS DUNS Number

Number	113704139
Expiration Date	9/30/2018

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

Agency Name	Michigan Department of Health and Human Services
Organizational Unit	Behavioral Health and Developmental Disabilities Administration
Mailing Address	320 S. Walnut, 5th Floor
City	Lansing
Zip Code	48913

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

First Name	Thomas
Last Name	Renwick
Agency Name	Michigan Department of Health and Human Services

Mailing Address	320 South Walnut, 5th Floor
City	Lansing
Zip Code	48913
Telephone	(517) 373-2568
Fax	(517) 335-5376
Email Address	renwickt@michigan.gov

III. Third Party Administrator of Mental Health Services

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	8/30/2017 3:34:50 PM
Revision Date	6/22/2018 11:01:50 AM

VI. Contact Person Responsible for Application Submission

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

Footnotes:

STATE OF MICHIGAN
EXECUTIVE OFFICE
LANSING

RICK SNYDER
GOVERNOR

BRIAN CALLEY
LT. GOVERNOR

August 10, 2017

The Honorable Thomas E. Price, M.D.
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Price:

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

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

Sincerely,

Rick Snyder
Governor

cc: Odessa F. Crocker, Supervisory Grants Management Specialist
Nick Lyon, Director
Lynda Zeller, Deputy Director

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

NICK LYON
DIRECTOR

August 15, 2017

Ms. Odessa F. Cocker
Supervisory Grants Management Specialist
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fisher Lane, Rm. 17E201
Rockville, MD 20857

Dear Ms. Crocker:

As the federal and state governments are working together to implement federal mental health and substance abuse block grants, this letter documents my designation of Thomas Renwick, Director of the Bureau of Community Based Services, as administrator of the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant, respectively, on behalf of the state of Michigan.

Additionally, Mr. Renwick is designated the authority to present the combined mental health and substance abuse application to the Substance Abuse and Mental Health Services Administration and to modify the plan if necessary.

Sincerely,

Nick Lyon

NL:lf

c: Lynda Zeller
Thomas Renwick
Larry Scott
Karen Cashen

333 SOUTH GRAND AVENUE • PO BOX 30195 • LANSING, MICHIGAN 48909
www.michigan.gov/mdhhs • 517-373-3740

State Information

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

Fiscal Year 2018

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

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

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

Signature of CEO or Designee[1]: _____

Title: Governor - State of Michigan

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

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

Fiscal Year 2018

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

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

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

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

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

Signature of CEO or Designee[1]: Rick Snyder

Title: Governor - State of Michigan

Date Signed: 08/10/2017

mm/dd/yyyy

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

Footnotes:

State Information

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

Fiscal Year 2018

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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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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).
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10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

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

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

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

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

Signature of CEO or Designee[1]: _____

Title: Governor - State of Michigan

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

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

Fiscal Year 2018

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
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Signature of CEO or Designee[1]: Rick Snyder

Title: Governor - State of Michigan

Date Signed: 08/10/2017

mm/dd/yyyy

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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

Nick Lyon

Title

Director

Organization

Department of Health and Human Services

Signature:

Date:

Footnotes:

State Information

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Organization

Department of Health and Human Services

Signature: Date: 8/3/17

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Organization

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Footnotes:

Planning Steps

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

Narrative Question:

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

Footnotes:

OVERVIEW

In Michigan, behavioral health prevention, early identification, treatment, and recovery support systems are the primary responsibility of the State's mental health and substance use disorder services authorities, collectively known as the Behavioral Health and Developmental Disabilities Administration (BHDDA), located within the Michigan Department of Health and Human Services (MDHHS). MDHHS, one of the largest of the 17 departments in Michigan's State government, is responsible for health policy and management of the State's publicly-funded health and human service systems. The 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.

Michigan PIHP Map

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.

In FY17, the Michigan Legislature charged MDHHS with conducting a stakeholder process to explore ways to better integrate behavioral health and primary care services, including streamlining and optimizing the provision of specialty behavioral health services. The result culminated in a final "Section 298" report that contained several financing model ideas and over 70 policy recommendations. After receiving the report, the Legislature and Governor Snyder enacted PA 107 of 2017, which instructs MDHHS to pursue up to three full financial integration pilots in FY18 whereby Medicaid Health Plans would receive first-dollar Medicaid monies and be expected to coordinate all physical and behavioral health care for their beneficiaries. In addition, the law also instructs MDHHS to pursue a provider level integration pilot in Kent County. All models must include willing providers and are subject to evaluation by a research university and are expected to incorporate metrics spanning health outcomes and quality of life measures. Any cost savings resulting from pilots must be re-invested in behavioral health services. MDHHS is in the process of developing and implementing the aforementioned pilots.

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 May 30, 2017, more than 679,892 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 1915b/c capitated managed care waiver includes: Applied Behavioral Analysis, Assertive Community Treatment, Assessments, Child Therapy, Clubhouse Psychosocial Rehabilitation Programs, Crisis Interventions, Crisis Residential Services, Family Therapy, Health Services, Home-Based Services, Individual/Group Therapy, Intensive Crisis

Stabilization Services, Medication Administration, Medication Review, Nursing Facility Mental Health Monitoring, Occupational Therapy, Personal Care in Specialized Settings, Physical Therapy, Speech, Hearing and Language, Substance Abuse (including outpatient, approved pharmacological supports, residential and sub-acute detoxification services), Targeted Case Management, Telemedicine, Transportation, Treatment Planning, Partial Hospitalization, and Inpatient Psychiatric Hospitalization. The specialty services and supports known as (b)(3) services which are included in the MDHHS contract include: Assistive Technology, Community Living Supports, Enhanced Pharmacy, Environmental Modifications, Family Support and Training, Housing Assistance, Peer-Delivered or Operated Support Services, Prevention-Direct Service Models, Respite Care Services, Skill-Building Assistance, Support and Service Coordination, Supported/Integrated Employment Services, Children's Serious Emotional Disturbance Home and Community-Based Services and Fiscal Intermediary Services.

The BHDDA requires that PIHPs have recovery-oriented services available for substance use disorder support and services. These consist of outpatient services (including intensive outpatient), residential services, sub-acute detoxification, medication-assisted treatment, case management, early intervention, peer recovery and recovery support, prevention, and integrated treatment for co-occurring mental health and substance use disorders. BHDDA has been expanding and improving integrated treatment for persons with co-occurring mental health and substance use disorders. This has been a focus of improvement over the last several years, occurring in partnership with the public mental health system. This process has been impacted at the state level through the statewide Practice Improvement Steering Committee (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 a number of mechanisms in place to provide leadership in the coordination of mental health services within the broader system. The PIHP contracts currently describe the PIHPs' responsibilities and deliverables. These contracts place a heavy emphasis on customer service, uniform data collection and encounter data reporting, fiscal management, quality assessment, and utilization.

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.

Also 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 withhold 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 July 1, 2016 United State Census Bureau information, Michigan's population is 9,928,300, a 0.4% increase from the April 2010 estimates. Race/ethnic origins are White- 79.6%; Black of African American- 14.2%; American Indian and Alaska Native-0.7%; Asian- 3.1%; two or more races (unspecified) - 2.4%; Hispanic or Latino- 5.9%. Population characteristics from 2011-2015 include 626,722 Veterans and 6.3% 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 been implemented 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, the most recent year a published report is available, population health, health equity, and social determinants of health requirements were 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.

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 issued a Request for Applications to the twelve federally recognized Tribes in Michigan. The Inter-Tribal Council (umbrella organization) plus eight Tribes submitted proposals and were awarded Mental Health Block Grant funding. Future Requests for Applications (RFAs) to the PIHP and CMHSPs for block grant funded projects will include information on CLAS standards. Potential applicants will be directed to review 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]

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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.*

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

Assisted by available block grant resources, Michigan has continued to make strides in improving our system of care to include the availability and delivery of many of these recommended practices. Among the strengths demonstrated across our State, efforts have continued to progress in the development and implementation of a range of SAMHSA-endorsed evidence-based practices (EBPs) and cross-cutting initiatives across our CMHSP provider system, including block grant-supported projects targeting the following adult service practice areas. As many of these practices are only partially implemented and/or are encountering sustainability challenges, they also continue to represent ongoing needs for the coming Fiscal Year 2018-19 grant cycle:

Assertive Community Treatment

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

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

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

Fully integrated into the public mental health system, ACT interfaces with many of Michigan's other supported evidence-based practices such as Integrated Dual Disorder Treatment (IDDT) and Family Psychoeducation. In FY17, an ACT MIFAST began to be developed. When

appropriate, these team members will join IDDT MIFAST members for a technical assistance visit; otherwise, they will function as their own MIFAST. ACT is also represented on the PISC; however, the ACT subcommittee has been disbanded and is poised to reconvene when policy and practice issues arise. ACT is one of the evidence-based practices on the www.improvingmipractices.org website and, as such, has a variety of resources and information available to ACT team members, the public, consumers, administrators, and families.

Family Psychoeducation

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

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

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

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

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.
  Dual Disorder Capability in Mental Health Treatment (DDCMHT) onsite reviews and follow-up technical assistance.

- PISC:
  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 at the Assertive Community Treatment (ACT) level.

The MIFAST group reviews programs for the purpose of assisting them in developing and sustaining IDDT teams that practice with a high level of fidelity. MIFAST does this by conducting a technical assistance conference to help agencies develop an implementation plan for IDDT, followed by an onsite visit to determine the degree to which the agency has achieved implementation by fidelity scoring of the 26 scorecard elements, and subsequent provision of technical assistance to aid in the improvement of areas that are shown to need further development. The MIFAST team has added the DDCMHT site review process to its menu of assistive activities. The MIFAST team underwent formal training through 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 2018-19 plan for MIFAST ITCOD (formerly IDDT) is to ascertain the number of teams practicing across the State of Michigan; determine the number of teams who have had four or more site reviews since 2006; determine the number of protocols that consistently score above a 4 and organize site reviews to target areas that score below 3.1; provide both review and technical assistance for areas below 3.1 in site reviews and follow-up; initiate site reviews for IDDT teams who have not yet participated or have had <3 reviews; conduct DDCMHT site reviews for all outpatient level of care programs; conduct MIFAST inter-rater reliability enhancement training for veteran and new reviewer team members; and 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 review process.

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

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

Motivational Interviewing

Motivational Interviewing (MI) is a goal-directed, client-centered counseling style for eliciting

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

Goals for 2018-2019 and beyond with regard to MI include:

- Expanding the MI internal trainer project by using trainers developed through a state-funded initiative to strengthen supervisor skills for observing, coaching and enhancing MI skills with the people they supervise.
- Continue to add modules for the MI training on the www.improvingMIpractices.org website. These modules will be specific to supervisors of contact level staff and intended to teach them how to provide MI skill enhancement supervision, coaching and feedback.
- Begin to recruit and include individuals from provider agencies across the state that wish to become local trainers through the regularly scheduled learn-and-share for trainers.
- Develop a pilot project for implementing MI in Opioid Treatment Programs across the state.
- Provide regional and on-site MI training and consultation.
- On-site activity is predicated on the outcome of an ascertainment visit through the MIFAST for motivational interviewing.

Dialectical Behavior Therapy (DBT)

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

- With approximately 50 DBT teams delivering services across Michigan's public behavioral health system, each existing PIHP regions feature one or more available DBT team providing this evidence-based treatment to service recipients with Borderline Personality Disorder.
- Ongoing core and refresher training continues to be provided annually to Michigan's public behavioral health workforce, along with evaluation of the effectiveness of the current training approach, using outcomes from training surveys as well as information on the continuing development of the model to make improvements that are cost- effective and help strengthen and sustain program and practitioner skills.
- Increase use of the practice knowledge exam that has been developed to better gauge the level of core knowledge and skills, as well as to inform future training and support for performance quality. The DBT practice knowledge exam is available via the www.improvingmipractices.org website. Test results are immediately available to MDHHS for aggregation and analysis for the purposes of supporting high-quality service delivery, and to help inform needed training moving forward.
- Statewide efforts to improve and expand the quality and availability of DBT services is being guided by a DBT Subcommittee, led by experienced practitioners from within

Michigan's behavioral health service network, which advances the products of its work to the 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 20 reviews and follow-up consultation and training for areas identified by the site visit activity as requiring further development. In 2018 the goal will be to conduct a minimum of five additional reviews and provide follow-up consulting and training.

Supported Employment / Individual Placement and Support

Michigan presently has 21 Individual Placement and Support (IPS) sites actively providing services and striving to achieve or maintain at least fair fidelity. A conscious decision was made to adopt the IPS title as opposed to "supported employment" in recognition of IPS as an evidence-based practice, with higher expectations and standards. These IPS sites represent 12 of the 46 CMHSPs in Michigan and provide these services in 21 of the 83 counties in Michigan. The Upper Peninsula as well as other rural areas struggle with efforts to build and/or follow the IPS model, and are challenged to determine enough potential candidates to merit a full-time staff. Funding and budgeting for this distinct position is also challenging. Outreach has continued through technical assistance for counties considering the IPS model.

The State lead continues to meet with the Michigan core review team on a quarterly basis. Training events are intentionally by invitation to supervisors, sites and organizations sincerely trying to follow the IPS model.

In Fiscal Year 2016, approximately 1,319 individuals with serious mental illness were supported through the Michigan IPS initiative. The cumulative average wage per hour was $9.98 and cumulative average hours worked per week was 24.63. The cumulative average wage of $9.98 per hour is $1.08 per hour above current minimum wage for Michigan. All of these jobs were reported as competitive, integrated employment. Although significant progress has been made in recent years, efforts continue to increase reporting to better track data, set goals, and promote stronger partnering with vocational rehab for shared successes. Key focus areas to increase quality employment outcomes for FY 2018 and beyond include:

<u>Core Review Team</u>:
The core review team has consistently maintained eight active members, which will meet the review needs for the immediate future.

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

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.

Staff Development/Training Events clearly needed include:

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

In 2017, much of the training transitioned to Michigan DB101 - Disability Benefits 101 at http://www.mi.db101.org. By focusing on webinar trainings on the use of this site, it saved IPS professionals working with an individual time spent in training, 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. This website was established several years ago for other evidence-based practices and now has a section dedicated to IPS with Michigan specific resources available. It 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 is considering implementing a requirement that each CMHSP will report quarterly the number of individuals employed (focus on individual, competitive, integrated employment), average hours and average wage. Establishing these quarterly data is expected to then allow the State to more effectively create policy, procedures and contracts to emphasize IPS. Some updates have been able to be made to the Medicaid Provider Manual to more clearly identify IPS as the preferred employment outcome for persons with serious mental illness. Additional efforts to require CMHSPs or providers to attain State approval to present themselves as an IPS site are continuing.

Partnerships with Michigan Rehabilitation Services (MRS), the vocational rehabilitation provider in this state, continue to be challenging given limited funding and differing philosophies. The recent Work Innovation and Opportunity Act (WIOA) has been used to guide the development of an updated Memorandum of Understanding (MOU) at the state level, which will then be used as a roadmap for local CMHSPs and their MRS partners to establish inter-agency joint agreements describing shared roles of each agency. It is anticipated this MOU will greatly polish Michigan's IPS initiative and provide growing opportunities to increase high quality fidelity and employment outcomes for Michigan citizens.

Older Adults

Older adults are eligible for the same service array as younger adults within the public behavioral health system. In FY 2016 over 7,734 older adults (65 and over) received public

behavioral health services, which is approximately 3% of the total number of adults served. Approximately 2,527 of these individuals had an Intellectual/Developmental Disability, 2,527 had a mental illness, and 1,083 had both.

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

MDHHS continues to work with the Geriatric Education Center of Michigan (GECM) and the Center for Rural Health. Collaboration with GECM has extended to their "Alzheimer's Disease and Related Disorders Supplemental Training Grant," with enhancements to curriculum and relevant case studies (e.g., cases of persons with physical and mental health issues and accompanying dementia), and expansion of training participation to mental health professionals, which builds on the department's focus on Integrated Health. Involvement in the Michigan Dementia Coalition, a grassroots collaboration of representatives of universities, community agencies, and state government units continues. As adjunct members of NASMHPD Older Persons Division, Department staff share state programming information and participate in regular calls regarding services and needs.

Clubhouse

Currently there are 40 Clubhouses that serve over 4,500 consumers in the state. Sixteen of these Clubhouses are fully accredited with Clubhouse International, with an additional two being fully accredited by the end of FY17. An additional nine Clubhouses are actively engaged in the accreditation application process.

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 2014 Michigan Clubhouse Survey (the last available as of this application), 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 emersion training: In FY16 MDHHS sponsored 20 different Michigan Clubhouses to participate in 2-3 emersion training though-out the United States. The initiative provided funding for Clubhouse colleagues (members & staff) to attend comprehensive trainings at any of the 6 accredited training bases in North America. Comprehensive trainings come in the form of 3-week or 2-week courses. All trainings are for 1 staff and 1 member for the full duration, and one administrator for the final week. The trainings follow a uniquely experiential program where colleagues are immersed in the practices of some of the strongest Clubhouses in the world. Training content includes Employment Development, Education Support, Meaningful Work-Ordered Day & Relationships Opportunities, Physical Wellness and more. 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.

Benefits training: Many people with serious mental illness (SMI) do not consider working for fear that they will lose their government benefits (especially Medicaid). The goal of benefits training is to provide high-quality training to behavioral health staff so that they can help people who use CMHSP services and navigate through the complex maze of work incentives available. The main target population was: Certified Peer Supports Specialists, other people with SMI receiving services from PIHPs/CMHPs, as well as other administrators, benefits coordinators, training coordinators and supports coordinators/case managers from the PIHP/CMHSPs. In FY16, four-two-day trainings with (25-30 participants) were offered thought-out Michigan. In addition, four one- day training events were also provided serving 25-30 individuals as well. Also ongoing Technical assistance was provided to all training participants as needed. Approximately 160 contacts per year are typical in any given year.

Clubhouse Mentoring: FY16 also saw the establishment of a 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 three-to-six Clubhouses across the state, based on proximity. A total of 32 Clubhouses are currently being mentored. This new program will result in an additional six (6) Clubhouses being involved with a Clubhouse Mentor in FY18.

Jail Diversion

Through Executive Order 2013-7, Governor Snyder mandated the establishment of the Mental Health Diversion Council within the (then) Michigan Department of Community Health to advise and assist in the implementation of a diversion action plan and to provide recommendations for statutory, contractual or procedural changes to improve diversion efforts statewide. This Council consists of 18 members who have been vetted by the Lt. Governor as agents of their respective fields and include representation from: Michigan Department of Health and Human Services; Michigan Department of Corrections; State Court Administration

Office; Medicaid pre-paid inpatient health plan; adult service agencies/providers (CMHSM); Judiciary; prosecutors; community prisoner re-entry; court administrators; county sheriffs; local law enforcement; attorneys representing MI, DD interests; mental health, DD advocate; school administration; juvenile courts; and children's medical psychiatric.

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

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

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

Priority Considerations for Pilots:

1. Those agencies seeking to initiate expanded services with law enforcement to include in their communities Crisis Intervention Teams (CIT) that would train local police, first responders and dispatch personnel in the 40 hour CIT training model to help better deal with the mentally ill and developmentally disabled in the field prior to potential incarceration. Further, that police departments would be backfilled while their officers are trained.
2. Those agencies that are exploring the need for a centralized crisis assessment/diversion facility for law enforcement to utilize in lieu of jails.
3. Those agencies that desire to focus on more comprehensive and enhanced mental health treatment for those in jail and transitioning out of jail. Efforts may include access to psychotropic medications in the jail setting as well as easy access to meds upon release, bolstered housing efforts prior to and after release; minimal wait times to see doctors/psychiatrists in and out of jail, increased support systems in place prior to and after release, utilization of educational and vocational opportunities pre and post release.

4. Those agencies looking to initiate or bolster efforts to expand the use of Alternative Outpatient Treatment by way of "Kevin's Law." Recent legislation has made the existing law more streamlined, easier to understand and implement as well as more "user friendly" for courts, CMH's and family members. This will go a long way in obtaining help for the mentally ill before they become an immediate threat to themselves or others and subsequently have interaction with law enforcement.

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

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

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

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. Currently, four jail diversion projects are funded covering ten counties. Two of these projects are mental health court expansion efforts 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 have had a long standing partnership in funding, expanding drug treatment courts and mental health courts since 2000. The remaining two projects are post- booking efforts where individuals are identified at the local county jail booking as potentially needing behavioral health services rather than jail. Individuals are then assessed immediately by the local CMHSP to determine appropriateness and service need upon release.

Veteran and Military Family Members

Based on national data that demonstrated the need for a more direct approach to Veteran and Military family behavioral health intervention, in May 2016 MDHHS/BHDDA created a Veteran Liaison position. This Veteran Liaison 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, a decision was made for BHDDA to lead the effort with creative, innovative, collaborative and intentional approaches regarding Veterans, members of the military, and their families.

The overarching goal of the BHDDA Strategic Plan 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 will lead toward achieving this goal:
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 is 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.

This plan will be phased in over the course of three years utilizing three cohorts identified by PIHP Regions. Cohort 1 (C1), prioritized for Year 1 includes the counties in PIHP Regions 2, 3, 9 and 10. Cohort 2 (C2) includes the counties in PIHP Regions 1, 4, 5 and 6. Cohort 3 (C3) will be implemented in the final year of the plan, and includes PIHP Region 7 and 8. Regions were determined based on identified need, capacity, and readiness. Outcomes will be monitored beginning in Year 1, and any adjustments needed will be made prior to the next cohort initiating activity. In part due to these roll-out efforts and assessing at each stage, in FY17 a decision was made to utilize combined MHBG and SABG to fund a PIHP Regional Veteran Navigator in all ten PIHP regions. This effort was initiated in the later part of FY17, and it is anticipated will be fully operational in all ten regions by the beginning of FY18.

BHDDA believes that with this all-encompassing approach of collaboration and coordination, an effective environment can be created to greatly increase capacity to provide adequate services to Veteran and Military families accessing the publicly funded behavioral health care system in Michigan.

Recovery-Oriented Care / Recovery Support Services

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

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

This fiscal year a health coach certification is being developed for both CPSS and Certified Peer Recovery Coaches (CPRC). Approximately 30 individuals will be part of the initial pilot. Ongoing continuing education trainings for peer specialists are provided including Wellness Recovery Action Planning (WRAP), emotional CPR, art and skill of facilitating effective

groups, smoking cessation, motivational interviewing, Whole Health Action Management (WHAM), trauma informed care, housing outreach, and development and forensic peer support. Training is focused on developing recovery cultures and practices statewide.

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

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 approximately fifty 501(c)3 consumer run drop-in agencies 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.

MDHHS also provides funding to the National Alliance for Mental Illness (NAMI) in Michigan. NAMI provides Family and Consumer Peer Education and Support, including referrals, education, and public awareness. NAMI advocates on the federal, state, and local levels for nondiscriminatory and equitable public and private-sector policies, as well as for federally- funded research for treatment and cures for mental illness.

Integrated Physical & Behavioral Health

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

In prior years, a statewide Integrated Health Learning Community was implemented in partnership with the Michigan Association of Community Mental Health Boards (MACMHB). Assistance and coaching calls in conjunction with the National Council for Behavioral Health were made available following the learning communities. Topics of discussion for the Learning Communities included: how agencies fund integrated health activities, developing and enhancing clinical services in an integrated health setting, national trends in integrated

care, case rate tool kit for health homes, what works when working with health plans, hospital and community behavioral health partnerships, federally qualified health care and community health center providers. After a few years of these broad learning communities, the focus shifted to more individualized projects applicable to individual community needs through MHBG funding.

In FY17, BHDDA made MHBG funds available to PIHPs and CMHSPs through a competitive application process for six prioritized efforts, one being the development and use of peers as Health Coaches to support integrated behavioral and physical health care and another to develop the establishment of new MHBG integrated healthcare projects that includes participation in a learning community process and continued development of current goals and objectives related to integrated physical and behavioral health. Thirteen projects spanning thirty-three counties were approved for two-year funding, ranging from electronic health record and data analytics enhancement, nurse practitioners and peer support specialists as care coordinators, health navigators performing outreach within the community, an embedded health clinic within a CMHSP, and a "Food as Medicine" nutrition care coordination model. Two MHBG funded Integrated Care programs have been featured in the www.improvingmipractices.org quarterly newsletter and website.

Trauma-specific and Trauma-informed Services

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

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.

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

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 the Michigan's system of care (SOC) for children with SED includes many state and local agencies, advocacy groups, family members, and local providers of services.

Within MDHHS, a new Children's Services Agency (CSA) has been established. The CSA is responsible for foster care and adoption, child protective services, juvenile justice services and includes the Mental Health Services to Children and Families Division, which was moved out of the Behavioral Health and Developmental Disabilities Administration into the CSA. The Family Division of County Circuit Courts is responsible for juvenile court services. The Michigan Department of Education (MDE) is responsible for educational services and the implementation of Parts B and C of the Individuals with Disabilities Education Act. The Michigan State Housing Development Authority, a division of the Department of Licensing and Regulatory Affairs, is responsible for housing services.

The array of Medicaid mental health specialty services and supports provided through PIHPs under a 1915b/c capitated managed care waiver includes: Applied Behavioral Services, Assertive Community Treatment, Assessments, Case Management, Child Therapy, Clubhouse Rehabilitation Programs, Crisis Interventions, Crisis Residential Services, Family Therapy, Health Services, Home-Based Services, Individual/Group Therapy, Intensive Crisis Stabilization Services, Medication Administration, Medication Review, Nursing Facility Mental Health Monitoring, Occupational Therapy, Personal Care in Specialized Settings, Physical Therapy, Speech, Hearing, and Language, Substance Abuse, Treatment Planning, Transportation, Partial Hospitalization, and Inpatient Psychiatric Hospitalization.

Additional state plan services were added though the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for those 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.

Some PIHP/CMHSPs have focused on training in treatment of co-occurring disorders (COD) in youth and these include Oakland and Central Michigan. Oakland County PIHP has held training in Motivational Interviewing in order to increase engagement of families in treatment, as well as addressing the mental health and substance use issues of adolescents and family members. CMH for Central Michigan also includes a specific COD focus on children/adolescents to assist with meeting goals around reducing their substance use. Several other PIHP/CMHSPs use Multi- Systemic Therapy (MST) as a strategy for addressing co-occurring disorders. In FY15, a new multi-year MST project was established across three CMHSPs and funded with Mental Health Block Grant to obtain training in MST in a regional area and maximize training dollars. Another CMHSP also expanded their MST services using Mental Health Block Grant dollars. Finally in FY18, MDHHS will be sponsoring a Motivational Interviewing training for CMHSP staff using MHBG funding. There continues to be a need for additional cross-agency cooperation between mental health and substance use disorder service providers with regard to serving youth with co- occurring disorders.

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 FY18-19. In responding to Request for Proposals (RFP) for the children's portion of the federal mental health block grant for FY16, CMHSPs 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. 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, efforts have been made to move children into communities from more restrictive out-of-home placement, while still providing beneficial and helpful treatment interventions. This movement has continued and will continue to be supported with mental health block grant funding. The development and implementation of intensive community-based services has been crucial to moving children into the least restrictive environment without compromising treatment effectiveness. A major part of Michigan's transformation plan has been the incorporation of family-driven and youth-guided practice, which has led to increased consumer choice and treatment interventions that are designed as the child and family desires.

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

Another very successful initiative that kicked off March 1, 2015 is the Children's Transition Support Team (CTST) (formerly the Children's Behavioral Action Team (CBAT) pilot. The CTST is responsible for developing successful community-based services which has allowed over 50 extremely complex children/youth to return home to their families or to the most family-like setting possible. The target population of the CTST includes children/youth ages 5 to 18 currently residing in Hawthorn Center, who present with any and/or all of the following challenges: multiple hospitalizations and failed community placements; extensive trauma

histories; Fetal Alcohol Spectrum Disorder; Serious Emotional Disturbance (SED); Primary SED with Secondary Intellectual/Developmental Disabilities; as well as other behavioral and physical health needs. The CTST works in conjunction with a state-level CTST Leadership Team, Hawthorn Center administration and staff, multiple community providers (PIHPs/ CMHSPs, local MDHHS, schools, courts, primary care and other physical health providers, etc.) as well as families/ guardians and the children/youth themselves to create unique, individualized community living arrangements and plans for treatment, supports and services to successfully maintain these youth in the community. The team has offices on the Hawthorn Center campus but travel around the state to provide hands-on training and support to the community service providers who will be serving these children/youth long-term. The Guidance Center in Detroit was awarded the contract to provide CTST services. This initiative was funded by state general fund dollars specifically earmarked for this purpose. The CTST is overseen by an inter-departmental state leadership team which monitors implementation and assists in barrier busting at the systems level.

Michigan has also successfully utilized the 10% set-aside for First Episode Psychosis services for young adults. There are four pilot sites in Michigan funded utilizing the 10% set-aside currently implementing the NAVIGATE approach from the RAISE model. These sites began serving people in FY15 and will continue into FY18-19 if funding continues from SAMHSA for this purpose, as proposed. This is another way Michigan is attempting to utilize community-based services and supports to maintain youth with SED and young adults with SMI in their homes and communities.

MDHHS has been a leader in increasing collaboration with other state agencies, local communities, and families. MDHHS participates in many interagency groups and emphasizes collaboration for children's services. Through these groups, the SOC has improved through the elimination of duplicative efforts and new projects being planned with joint efforts in development, implementation, and evaluation of services. Michigan has been awarded several collaborative federal grants, including Safe Schools Healthy Students and Project AWARE, in which MDHHS is a partner. Michigan has achieved some success in creating the foundation for a statewide SOC for children with SED. All public mental health providers in Michigan utilize a standard definition of SED and uniform access standards, as outlined in an attachment to the MDHHS contract with the PIHPs and with the CMHSPs. Standardized, validated and reliable outcome measures, the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 1989)[3] for youth ages 7-17 and its counterpart for children ages 3 to7 the Preschool Early Childhood Functional Assessment (PECFAS) (Hodges, 1994a)[4] are used to assess treatment effectiveness for all children served in the public mental health system. MDHHS is supporting with block grant funds the statewide implementation of two evidence-based practices Parent Management Training-Oregon Model (PMTO) (Bank, Rains, & Forgatch, 2004; Forgatch, 1994)[5] and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (Cohen, Mannarino, Deblinger, 2006)[6].

In fiscal year 2009, the SOC planning process was formally incorporated into the public mental health system through the Program Policy Guidelines (PPGs) through which MDHHS requires CMHSPs to provide an assessment of their local SOC and how they plan to move forward to improve outcomes for children with SED and their families and children with developmental disabilities and their families. MDHHS continues to work individually with PIHPs to provide technical assistance regarding progressing to more comprehensive SOCs. CMHSPs were also required to utilize a SOC planning process to prepare their applications for funding through the children's portion of the mental health block grant and/or in implementing the 1915(c) Waiver

for children with SED (SEDW). MDHHS has been particularly interested in increasing access to specialty mental health services and supports for Medicaid eligible children/youth with SED in child welfare (i.e., abuse/neglect, foster care and/or adopted children/youth) and juvenile justice. As an example of this, MDHHS provides an incentive payment to PIHPs/CMHSPs who serve children involved in various levels of child welfare services to encourage access to the public mental health system for those children.

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 recent 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.

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

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

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

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

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 FY18-19. MDHHS has also worked with youth and other stakeholders to develop a youth peer curriculum and training protocol for statewide implementation of youth peer support. This has also been added as a Medicaid covered service in Michigan. These trainings began in FY16 in partnership with the statewide family organization and will continue in FY18-19.

Another key component of SOC that 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 proposal to expand the SED Waiver (SEDW) to all counties in Michigan. Currently 36 counties in Michigan participate in the SEDW. The proposed expansion is part of the 1115 Waiver application that MDHHS currently has pending with the Centers for Medicaid and Medicare. The SEDW provides access to the comprehensive mental health services array available through the public mental health system by waiving the income requirement for Medicaid eligibility for children that meet psychiatric hospital level of care but can be safely served in the community with intensive community-based services.

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

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 addiction. OROSC allocates Substance Abuse Prevention and Treatment (SAPT) Block Grant (BG) funding through 10 regional Prepaid Inpatient Health Plans (PIHPs), whose responsibilities include planning, administering, funding, and maintaining the provision of substance abuse treatment and prevention services for 83 counties in Michigan. All PIHPs have Substance Use Directors and Prevention Coordinators (PCs), who receive input from and empower local communities in their response to substance abuse prevention needs. PIHPs contract with local prevention coalitions as providers to implement the specific prevention activities in the target communities in their respective regions.

Overall, a sound-functioning and well-organized community prevention infrastructure exists in Michigan. PIHPs are contractually required to submit multiple year Action Plans (APs) to OROSC, which address identified priority problems, and target specific interventions related to the appropriate intervening variables. These prevention strategies illustrate evidence of the five step Strategic Prevention Framework planning process by utilizing local community coalitions, parents, and youth as part of this ongoing planning process. The PIHPs must complete a comprehensive strategic plan, based on this data-driven planning model process, and complete a planning chart using a logic model approach with their submission. 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 Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018, Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness, OROSCs approach to prevention aligns with the following goals: 1.1: Promote emotional health and wellness, prevent or delay the onset of and complications from substance abuse and mental illness, and identify and respond to emerging behavioral health issues; 1.2: Prevent and reduce underage drinking and young adult problem drinking; and 1.4: Prevent and reduce prescription drug and illicit opioid misuse and abuse. 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 among persons aged 12-20 and prescription drug misuse and abuse among persons aged 12-25 - by building upon and enhancing the current community substance abuse prevention infrastructure and capacity at the PIHP regional level by strengthening collaboration and partnerships specifically with primary care providers, local intermediate school districts and school health centers and the communities they serve.

Since 2002, OROSC has received seven major awards specific to substance abuse prevention: 1) State Incentive Grant (SIG); 2) Strategic Prevention Framework State Incentive Grant (SPF/SIG); 3) Center for Substance Abuse Prevention (CSAP) State Epidemiology Outcomes Workgroup (SEOW) award; 4) Strategic Prevention Enhancement (SPE); and 5) Strategic Prevention Framework Partnerships for Success II (PFS II), Partnership for Success 2015-2020 Grant and recently the State Targeted Response to the Opioid Crisis Grant. 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, expand the use of evidence-based programs (EBPs), develop epidemiological profiles and logic models, and increase the capacity to address mental, emotional, and behavioral conditions to support and improve the quality of life for citizens of Michigan.

As a mechanism to collaborate with Native American Tribes and communities in Michigan, the Michigan Inter-Tribal Council (ITC) has been an integral partner for SPF/SIG, SEOW and PFS II, PFS 2015-2020 and STR Grant Projects; and OROSC has supported substance use disorder training and technical assistance to member tribes of the ITC. This relationship exemplifies an ongoing process and support system that addresses and responds to the substance abuse prevention related needs of tribes and tribal organizations in the state.

The required inclusion of government agencies and community stakeholders in the SIG, SPF/SIG, SEOW, SPE and PFS II and PFS 2015-2020 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 the OROSC, has established several workgroups, one of which is the Prevention Workgroup (TSC-PW). Membership of this group includes Prepaid Inpatient Health Plans (PIHPs), substance abuse coalitions, Department of Education (MDE), Children and Families Administration, Michigan Army National Guard, 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 formal partnerships and collaborative initiatives with:

- DHHS Pathways to Potential Program (PPP) – OROSC provided funding to PIHPs to establish prevention programs in school districts with PPPs. The programs provide Success Coaches to poor performing schools in an effort to improve social support and behavioral health service delivery.
- Michigan Department of Education's Safe Schools Healthy Students (SSHS) Project – OROSC staff serve on the SSHS State Core Team. OROSC provided funding to PIHPs to implement prevention programs in schools districts funded by the SSHS Grant Project.
- Michigan State Police, Office of Highway Safety Planning (OHSP) – OROSC staff serve on the OHSP Impaired Driving Action Team.
- The Michigan Office of the Attorney General, PIHPs, Community Coalitions, Michigan Petroleum 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.

Through intensive training, technical assistance provided by OROSC, the Central Center for the Application of Prevention Technologies, and a contract with the Michigan Association of Community Mental Health Boards, the state has been able to strengthen and expand our State Prevention Framework, thereby increasing capacity to support effective substance abuse and mental health prevention services across systems. The TSC-PW has provided oversight and coordination of environmental scans to assess capacity and gaps. These environmental scans have helped develop the Capacity Building/Infrastructure Enhancement Plan for prevention prepared communities, including the development of a comprehensive five-year strategic prevention plan as well as plans for enhancing workforce development and developing state policy to support needed service system improvements.

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. **Progress:** MiBRFS estimates are more representative by oversampling Hispanics, which also allows for precise estimates. Results from the 2012 Michigan Hispanic/Latino standalone and Asian/Pacific Islander survey, the 2013Michigan Arab/Chaldean standalone survey, and the 2013-2014 Black Non- Hispanic survey are available at www.michigan.gov/bfrs. In addition, ATOD rates for LGBT are being monitored using MiBRFS.

- 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.). **Progress:** MiYRBS is tracking lifetime prescription drug use without a prescription and past 30day 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.). **Progress:** Michigan Young Adult – targeting aged 18 to 25- survey has been implemented to examine substance use behaviors including some risk factors.
- Limited access to the Michigan Automated Prescription Monitoring Systems (MAPS) data for local coalitions, providers, and communities. Although somewhat limited by law, there are some statewide totals available to the general public. To access regional or county-level data requires a special request to the Michigan Licensing and Regulatory Affairs (LARA) department. Some community coalitions are not aware of this option, and the ability to fulfill special requests is determined by LARA staff member time. **Progress:** Opioid prescriptions rates by county have been estimated on a yearly basis based on MAPS public report.
- The need to strengthen partnerships (at both the local and state level) with specific primary care providers, dentists, and pharmacies. Although the medical disciplines are somewhat aware of issues related to prescription drug misuse and abuse, they have a limited understanding of their role in reducing access, as well as other community partners that are available to assist in their efforts. **Progress:** Current PFS 2015-2020 project allows building and enhancing community level collaboration with primacy care providers.
- 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 SAPT block grant funds are under no obligation to use this system; and most do not. **Progress:** As information sharing and dissemination, the annual summary of MPDS data will be shared with PIHPs.

INDIVUDALS WITH SUBSTANCE USE DISORDERS (SUD)

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

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

BHDDA subscribes to the belief that a Recovery Oriented System of Care 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 evidenced-based programs, develops epidemiological profiles and logic models, and increases the capacity to address mental, emotional, and behavioral conditions to support and improve the quality of life for citizens of Michigan.

Early Identification

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

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

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

Recovery Support Systems are a network of supports put into place to assist an individual in maintaining their recovery or sobriety. These supports can be in the form of, but not limited to, peer mentors, recovery coaches, aftercare programming, employment assistance, housing assistance, educational counseling, supportive housing and a commitment to supporting an individual throughout their recovery journey. Recovery supports are organized at the regional level, and vary by PIHP. Michigan has developed a Recovery Coach Technical Advisory for the SUD field and a Recovery Coach Curriculum has been developed for training and credentialing efforts statewide. We are receiving technical assistance from SAMHSA and about Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) with a national consultant from the Center for Social Innovation. Training opportunities for peer recovery support specialists and coaches will continue regionally in FY 2018 and 2019.

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

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

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

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

treatment coordinator for follow up.

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

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

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

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

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

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

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

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

- Individuals with mental and/or substance use disorders who are homeless or involved in the criminal or juvenile justice systems.
- Individuals with mental; and/or substance use disorders who live in rural areas.
- Underserved racial and ethnic minority and Lesbian, Gay, Bisexual, Transgendered, and questioning (LGBTQ) populations.
- Persons with disabilities.
- Community populations for environmental prevention activities, including policy changing activities, and behavior change activities to change community, school, family and business norms through laws, policy and guidelines and enforcement.
- Community settings for universal, selective and indicated prevention interventions, including hard-to-reach communities and “late” adopters of prevention strategies.

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system 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 behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

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

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

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

Through the **Healthy People Initiative**[1] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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

Footnotes:

ADULTS WITH SERIOUS MENTAL ILLNESS (SMI)

Michigan's estimated population was around 9,935,116 persons as reported by the 2016 United States Census Bureau. Of that number 74% were over the age of 18, constituting an estimate of 7,342,677 adults. Per the 2014-2015 data set provided by the National Survey on Drug Use and Health (NSDUH), 4.33% (317,937) of Michigan's adult population are estimated to have serious mental illness, and there were 236,291 adults served through the Michigan mental health services system in 2016. Penetration rate per 1000 was 23.81, slightly higher than national rate of 22.73. Nearly 70% of these adults served met the federal definition of having a serious mental illness, slightly below the US average of 70.6%. According to this same data set, 30% of adults served were individuals with a co-occurring MH/SA disorder, a slight increase above national rate of 27%.

These figures suggest a significant gap between the prevalence of serious mental illness estimated in Michigan's adult population and the penetration of public sector mental health services. It is unlikely this difference of 81,646 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. There are needs that block grant funding resources can assist in meeting.

Characteristics of adults served in Michigan based on the 2016 SAMHSA Uniform Reporting System show the largest age group is aged 25-44 (31.6%), with a 31.1 per 1000 population penetration rate. Across the nation, this is also the largest age group receiving services (30.9%), with a slightly lower penetration rate of 27.0 per 1000. The next largest age group receiving services in Michigan are aged 45-64 (29.1%) with a 24.9 penetration rate, compared to national data showing 26.5% served with a 23.3 per 1000 penetration rate.

Other age demographics and percentage of Michigan adults served were age 18-20 (4.8%) with a penetration rate of 28.0; 21-24 (6.6%) with a penetration rate of 26.9; 65-74 (3.5%) with a penetration rate of 9.0; and age 75 and over (1.2%) with a penetration rate of 4.4. Michigan demographic percentages of adults served are higher in each age group with the exception of age 75 and over (US 1.4%). Michigan penetration rates are also higher than both the Midwest and the US with the exception of this same 75 and over age group. Although Michigan's penetration rate of 4.4 for age 75 and over is higher than the Midwest rate of 4.0, it is lower than the US rate of 5.3.

Compared to the US, Michigan has a lower percentage of women receiving services than men at 47.7%; national percentage of 51.9%. Men receiving services in Michigan comprises 52.2%, compared to US at 47.9%. 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 22.3, compared to the Midwest at 24.2 and the US at 23.2. The penetration rate for men in Michigan is 25.3, compared to the Midwest at 22.7 and the US at 22.1.

In terms of race, individuals who are white comprise 54.8% of persons served in Michigan as compared to the US at 61.1%, with the corresponding penetration rates of 16.4 in Michigan compared to 18.4 in the US. The next largest race receiving services are Black/African American at 21.9% in Michigan compared to 18.9% in the US. Michigan has a higher penetration rate of 35.1 per 1000, compared to both the Midwest at 34.7 and the US at 32.8. A difference in Michigan is shown among Multi-Racial individuals at 8.8% of persons served, compared to the US (2.4%). Penetration rate is also significantly higher for Multi-Racial population: Michigan is at 90.8 per 1000, compared to 35.6 in the Midwest and 22.5 in the US, which may contribute to a higher percentage of Multi-Racial individuals receiving services. American Indian/Alaskan Native population accounted for 0.7% of individuals receiving services in Michigan, compared to 1.3% in the US. Penetration rate for this population in Michigan was the same as in the US (23.7 per 1000), however significantly lower than other states in the Midwest (41.8). In Michigan, 3.9% of individuals receiving services identified Hispanic/Latino ethnicity, compared to 14.5% in the US, with penetration rates being higher in Michigan (19.1) versus the Midwest (11.3) and the US (18.2). Ethnicity was not available for 19% of individuals receiving services in Michigan, compared to 10.7% in the US.

As previously noted, nearly 70% of adults served in Michigan met the federal definition of having a serious mental illness. In Michigan, more men (50.8%) than women (49.2%) met this definition, which is reverse national figures of 48.3% men and 51.6% women. Another variance in Michigan as compared to the US revealed a smaller proportion of young adults ages 18 to 20 in Michigan (2.4%) suffered serious mental illness than in the nation overall (4.1%), however penetration rate for this age group in Michigan was 8.7 per 1000 population, compared to 16.0 rate for the nation.

According to 2014-15 NSDUH findings regarding any mental illness experienced within the prior year, Michigan's young adults in the 18-25 age range were comparable, but slightly higher in proportion (22.10%) to the national average (21.7%). Findings of any mental illness for Michigan adults aged 26 and older were similar (17.38%) when compared to the national average (17.2%).

An additional indicator that demonstrates the need for public mental health services in Michigan is suicidality. According to data provided by the Michigan Division for Vital Records & Health Statistics, Michigan's 2015 age-adjusted suicide rate was 13.2 per 100,000 individuals, gradually trending upwards every two years by 0.4 per 100,000 individuals, and demonstrates an increase from the 2009 rate of 11.4 per 100,000. As is true with national tendencies, more Michigan deaths confirmed as suicide have been male. Of 1,390 suicides for all ages in 2015, 78% (1,089) of the decedents were male and 22% (301) were female. In 2015, intentional self-harm or suicide was the fourth leading cause of death in Michigan, compared to the tenth leading cause of death in the nation.

Data supplied by SAMHSA's Uniform Reporting System – 2016 State Mental Health Measures report indicates that Michigan continues to lag behind the reported national average in each of the following areas of adult evidence-based practice (EBP) delivery:

Evidence-Based Practice	Michigan Rate	US Rate
Family Psychoeducation	0.2%	1.9%
Integrated Dual Diagnosis Treatment	1.9%	10.5%

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 of the state. Budget constraints and staff turnover have made it difficult for providers to commit resources to the developing this program when other support services can be provided/offered to families. Michigan continues to support the development of this program by offering needed trainings and certification in this model of treatment.

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

According to the same SAMHSA data source, Michigan is above the national average in terms of the evidence-based practices of Assertive Community Treatment (Michigan rate: 4.3%; national rate: 2.1%) and Supported Employment (Michigan rate: 3.2%; national rate 2.1%).

CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

According to 2016 US Census figures, Michigan has approximately 2,194,154 child residents (ages 0-17.) Prevalence data supplied by SAMHSA's 2013 National Outcome Measures Prevalence Report suggests 6-12% of the 1,184,104 children from ages 9 to 17 in Michigan could be identified as having a serious emotional disturbance (SED). That means anywhere from 71,046 to 142,092 children ages 9 to17 may have been eligible for services in the public mental health system in 2013 alone. However, data compiled by MDHHS for FY15 indicates 44,514 children (ages 0 through 17) with SED were served in the public mental health system in Michigan. Using this data, Michigan can make a case for continued focus on identifying and engaging children who may be in need of mental health services from the public mental health system.

In June 2017, 13,042 were residing in out-of-home foster placements per MDHHS. According to the Michigan Department of Education (MDE) the statewide high school drop-out rate in 2017 was 8.91%, which has shown steady improvement over recent years but continues to be higher than desired. 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 4.7% in April 2017 which was much better than previous years but remained 0.3% above the national average of 4.4% for that same time. According to the Michigan League for Public Policy's 2017 Kids Count Data Book, (http://www.aecf.org/m/resourcedoc/aecf-2017kidscountdatabook.pdf), Michigan ranked 31st out of 50 states for economic well-being. In 2015, 22% of children in the state lived in a family with income below the poverty line. This is a full percentage point above the national average for this same time period. Data reported in the MDHHS' Green Book Report of Key Statistics, June 2016 edition, indicates that 1,788,831 Michigan residents were eligible for Medicaid in that month. Of those eligible residents, 777,776 were members of families, 65,450 were other children and 38,989 were recipients of MiChild. In addition, Medicaid births in Michigan are now approximately 44% 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 is rebounding, 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 still has not bounced back. This is unfortunate, but helped to create an environment where the former MDCH and MDHS (now MDHHS) were open to collaborating and matching funds which resulted in the SEDW pilot project. The project has helped the child welfare system to realize that the expertise of the mental health system may assist them in their vision of better outcomes for children. It also has helped the mental health system develop a sense of responsibility for children that are in the child welfare system. There are opportunities to improve fiscal efficiencies and to re-direct dollars from ineffective, costly out-of-home models into effective community-based models inherent in this partnership. The MDHHS SEDW Pilot continues to demonstrate fiscal saving and better outcomes for children and families which has

acted as a catalyst for other collaborative projects. Now that the two departments have merged, there is hope that administrative and fiscal barriers may be reduced.

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 Recovery Oriented System of Care (ROSC) Transformation Steering Committee (TSC). The chairperson of the SEOW (or his/her designee) attends TSC meetings to not only provide input into the overall ROSC efforts from a SEOW perspective, but also to be available as a resource to the TSC if data needs are identified. Recommendations from the SEOW will be made to the TSC, which in turn will make recommendations to OROSC for ultimate decisions. The project director for the SEOW is an OROSC staff member, as are the SEOW epidemiologist and the SEOW liaison.

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

The primary activities of the SEOW for FY 2017-2019 will be to: 1) expand the scope of the SEOW to include treatment and recovery (not just prevention) and to include mental health disorder prevention and treatment, as well as mental health promotion; 2) continue to gather new data as it becomes available, particularly around prescription and over-the-counter drug abuse; 3) analyze data being gathered, and serve as a resource for both the state and local Community Epidemiology Workgroups (CEWs); 4) continue work on establishing a web-based central data repository for Michigan that can be easily accessed and updated; and 5) evaluate and prioritize continued data gaps, and develop plans for filling these gaps.

The SEOW is chaired by the Provider Network Administrator of the Mid-State Health Network Regional Prepaid Inpatient Health Plan (PIHP), Community Mental Health Authority of Clinton, Eaton, and Ingham Sub Regional Entity (CMHA-CEI SRE). Membership on the SEOW includes representatives of various state-level departments including Michigan Department of Education, Michigan State Police, and various divisions and administrations within MDHHS including epidemiology, local health services, mental health, and SUD treatment. In addition, community coalitions, and the Michigan Primary Care Association are represented on the SEOW. As of January 31, 2017, the following are SEOW members:

Member Name	Organization	Workgroup Affiliation
Elizabeth Agius	Wayne State University	Member
Lisa Coleman	Region10 Prepaid Inpatient Health Plan	Member
Joseph Coyle	MDHHS/Division of Communicable Disease	Member
Jane Goerge	Community Mental Health Partnership of Southeast Michigan	Member
Brian Hartl	Kent County Health Department	Member
Denise Herbert	network180	Member
Patrick Hindman	MDHHS/ Lifecourse Epidemiology & Genomics Division	Member
Joel Hoepfner	Community Mental Health Authority of Clinton, Eaton, and Ingham Counties	Member/Chairperson
Jeanne Kapenga	Physician	Member
Kim Kovalchick	Michigan Department of Education	Member
Tom Largo	MDHHS/Injury Prevention	Member
Brittany Leek	MDHHS/OROSC (Prevention)	Member
Mary Ludtke	MDHHS, Mental Health	Member
Kelli Martin	MDHHS/OROSC (Prevention)	Member
Su Min Oh	MDHHS/OROSC (Prevention)	Member/SEOW Epidemiologist/Staff Liaison
Dianne Pérukel	MSP/Office of Highway Safety Planning	Member
Larry Scott	MDHHS/OROSC (Prevention)	Member/PFS 2015 SEOW Project Director
Angela Smith-Butterwick	MDHHS/OROSC (Treatment)	Member
Gery Shelafoe	NothCare Network	Member

Member Name	Organization	Workgroup Affiliation
Brenda Stoneburner	MDHHS, Mental Health	Member
Joe Tran	Michigan Primary Care Association	Member
Stephanie VanDerKooi	Lakeshore Regional Partners	Member
Adrian Zeh	MDHHS/Injury Prevention	Member
Richard Isaacson	Drug Enforcement Administration	Consultant
Jeff Wieferich	MDHHS/Quality Management and Planning	Consultant
Bret Bielawski	Internal Medicine	Consultant
Eva Petoskey	Anishnaabek Healing Circle Access to Recovery Inter-Tribal Council of Michigan	Consultant

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:

1. **Access to treatment for pregnant and parenting women, and pregnant women who inject drugs.**
   NSDUH data compiled from 2007 to 2012 indicate that on average, 21,000 pregnant women need treatment annually for opioid misuse in the past month. The same data indicate that past month opioid misuse was more prevalent for those 15 to 25 years, than those 26 to 34 years of age. In FY2015 there were 16,306 treatment admissions where the route of use was identified as injecting. This number includes primary, secondary and tertiary drugs of choice. Of that number, 7,183 were women, and 1,391 were identified as pregnant and parenting. Additionally, 331 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.

2. **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 133 TB cases reported in 2016, 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 2010 through 2016. MDHHS estimates that there were 2,250 HIV cases attributed to individuals who inject drugs in 2015. Individuals who inject drugs comprised 12% 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 providers 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.

3. **Identify current and improve data collection among LGBT populations and evaluation of programs and practices targeted toward LGBT populations, as well as mainstream programs that serve LGBT clients.**
According to the Institute of Medicine (IOM) (2011), LGBT populations are at substantially greater risk for substance abuse and mental health problems. LGBT 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 substance use disorders. Gay men, lesbians and male-to-female transgender persons, as a population, have a significant problem with methamphetamine use. 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 LGBT students. Current known data sources are limited in Michigan. There is a need and desire to improve data collection, as well as identify and implement evidence based programs and practices to address this target population.

4. **Adolescent Treatment**
The current system of care reflects poor penetration rates for the treatment of adolescents with less than 10% of those with an identified need receiving substance use disorder (SUD) treatment services. In addition, there is no identified mechanism for conducting effective outreach to this population, direction for collaboration with referral sources, or linking to resources. 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, and supporting the development of a family/caregiver and youth network for those who enter treatment and their families.

There is low use of integrated treatment and recovery support services for this population. Approximately 40% indicate a co-occurring substance use and mental health disorder. In order to be effective, more providers will be utilizing co-occurring treatment services to treat the population. In addition, building a system of support and recovery services for youth and their families will increase their successful recovery potential. Due to only a small number of providers utilizing recovery supports, approximately 4%, the majority of families do not have access to services after formal treatment ends.

5. **Recreational Marijuana**
There is no state legalization bill currently in play, but 15 *Michigan* cities, including Detroit and Lansing (the state capital) have already legalized the possession of small quantities of pot for private use. Nationally, perceived risk of marijuana use among students in 8th, 10th, and 12th grades decreased since the mid-2000s. Fewer teens now believe using marijuana is harmful, but 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 18.8% in 2005 to 19.3% in 2015 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.

6. **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 is ongoing. Data from the death certificates file indicate that, from 2005 to 2015, deaths due to heroin and prescription opiate overdose rose from 447 to 1275 (rates of 4.5 to 13.2 per 100,000 population). Recent NSDUH surveys (2014-2015) reported that 0.37% (n=31,000) of Michigan residents, 12 or older, reported heroin use in the past year. Drawing upon the 2013-2014 NSDUH surveys, the estimated prevalence of illicit drug dependence or abuse in the past year for Michigan was 2.5% among persons aged 12 or older. The Medication Assisted Treatment (MAT) workgroup continues to address issues related to opiate use, abuse, and addiction within OROSC and the state. Michigan's providers continue to work to implement the MAT Guidelines fully.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

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

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

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

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

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

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

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

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

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

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).
3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-

identifying information)?

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

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

Footnotes:

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

   Michigan's community behavioral health system has been collecting HIPAA compliant 837 encounter data as well as demographic data statewide since 2003. This behavioral health information is reported for the individual client, the providers as well as the program. Since 1992, Michigan's publicly-funded substance use disorder service delivery system has been collecting and reporting Treatment Episode Data SETS (TEDS) at the client and provider level. In 2010, a web-based data collection system for TEDS was developed to allow submitters to track submissions, fix errors, and monitor reported admissions and discharges. In December 2016, Michigan expanded the TEDS web-based platform to implement SAMHSA's new Behavioral Health (BH) TEDS. Michigan took this step in order to follow SAMHSA's transition to a common substance abuse and mental health client-level data (CLD) system. Michigan has been successful in implementing SAMHSA's BH-TEDS to collect demographic data on all persons receiving behavioral health services (MH and SUD).

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

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

   The BH-TEDS system mentioned in #1 is a stand-alone system dedicated to the collection of substance use disorder and mental health data. The Behavioral Health and Developmental Disabilities Administration (BHDDA) has sole responsibility for the design and maintenance of this system.

   The information in BH-TEDS has also been made available within the state's Medicaid encounter system. This structure allows data linkages between a consumer's behavioral health encounter and demographic information, and information on their physical health and pharmaceutical services. For example, through this system Michigan can determine which Medicaid-enrolled behavioral health consumers receive tobacco-use cessation counseling. As another example, Michigan's system links the Michigan Automated Prescription System

(MAPS) and encounters to follow up with the public behavioral health agencies on prescribers who have been sanctioned as well as consumers who are at risk of drug abuse.

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

   Yes, Michigan's collection of encounter and demographic data is at the individual level. The use of unique ID assigned by the Prepaid Inpatient Health Plan (PIHP) allows reporting of client-level data without client-identifying information. Michigan's behavioral health information is currently reported to SAMHSA via the BH-TEDS data collection system at the client level.

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

   Michigan is currently collecting and reporting BH-TEDS files to SAMHSA. Specifications for Michigan's BH-TEDS can be found on the MDHHS Reporting Requirements web site:

   http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

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

No technical assistance is needed at this time.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Mental Health Services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

To improve health outcomes of consumers with chronic conditions

Objective:

To identify the number of consumers with chronic conditions involved in care coordination services

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of consumers involved in care coordination activities

Baseline Measurement: 520 involved in care coordination in FY17 to date

First-year target/outcome measurement: 575

Second-year target/outcome measurement: 600

Data Source:

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 2

Priority Area: Increased Employment Outcomes

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase IPS competitive employment outcomes

Objective:

Focus on improved, timely, and recurring fidelity reviews to achieve higher employment outcomes

Strategies to attain the objective:

1. Conduct timely and effective quality fidelity reviews. 2. Conduct Annual Data Snapshot Report of current sites to compare metrics for number of sites, average hours, average wages, and new job starts.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase average fidelity score

Baseline Measurement: 99.5 on the 125 scale

First-year target/outcome measurement: 101 on the 125 scale

Second-year target/outcome measurement: 102 on the 125 scale

Data Source:

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Increase number of IPS sites

Baseline Measurement: 21 active sites in FY with a baseline review

First-year target/outcome measurement: 22 active sites in FY with a baseline review

Second-year target/outcome measurement: 23 active sites in FY with a baseline review

Data Source:

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Average hours worked per week

Baseline Measurement: 24.63 hours a week from most recent report

First-year target/outcome measurement: 25 hours a week from most recent report

Second-year target/outcome measurement: 26 hours a week from most recent report

Data Source:

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 3

Priority Area: Peer Recovery Support Clubhouses

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

To increase model fidelity for Clubhouses throughout Michigan

Objective:

1) Seven clubhouses will successfully complete the accreditation process in FY18. 2) Twenty clubhouses will participate in comprehensive clubhouse

training at a Clubhouse International Training Base in FY18.

Strategies to attain the objective:

1) Clubhouse International and Clubhouse Michigan will continue to provide information, training, mentorship, and support for clubhouses seeking accreditation. 2) Clubhouse international will: a) Update Clubhouse MI of all accreditation visits. b) Provide a training calendar for all comprehensive trainings being offered. c) Include an action plan for improving model fidelity.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: To increase model fidelity for Clubhouses throughout Michigan

Baseline Measurement: Currently 16 Michigan clubhouses are accredited and 4 first successful time accreditations in FY17

First-year target/outcome measurement: Seven clubhouses will successfully complete accreditation by end of FY18

Second-year target/outcome measurement: Eight clubhouses will successfully complete accreditation by end of FY19

Data Source:

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Twenty additional Clubhouses will participate in comprehensive Clubhouse training at a Clubhouse International Training base

Baseline Measurement: Seven Michigan clubhouses participated in comprehensive training through May, 2017

First-year target/outcome measurement: Ten clubhouses will participated in comprehensive training during FY18

Second-year target/outcome measurement: Ten clubhouses will participated in comprehensive training during FY19

Data Source:

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 4

Priority Area: Veterans

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increased identification

Objective:

Identifying veterans who would not otherwise be identified for MH/BH/SUD challenges.

Strategies to attain the objective:

PIHP regional veteran navigators working with Buddy to Buddy to identify veteran and military families in the communities and regions who may have need of BH/MH/SUD treatment.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Data report showing number of veterans interacted with and referred for MH/SUD assessment

Baseline Measurement: No previous or clear data prior to FY18. There are 650,000 veterans in Michigan. Estimates indicate approximately 60,000 military families in Michigan have been unable to access adequate and effective MH/SUD treatment.

First-year target/outcome measurement: Identify 100 families across 10 regions that have not been previously identified for MH/SUD assessment and/or treatment.

Second-year target/outcome measurement: Identify an additional 200 families across 10 regions that have not been previously identified for MH/SUD assessment and/or treatment.

Data Source:

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 5

Priority Area: Improving access to supports & services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase the frequency of participation in supports and services by recipients who live in remote rural locations and do not have access to reliable transportation to treatment locations.

Objective:

Develop a transportation infrastructure that will enable persons who live in remote rural areas to access treatment more reliably.

Strategies to attain the objective:

1) Develop contracts with available transportation services in rural areas. 2) By the end of FY18, develop a method for payment to persons who provide transportation to recipients and are not contracted directly for this service. 3) Develop an orientation and training for anyone who wants to contract with or seek payment for providing transportation to recipients that ensure safety, confidentiality, and complies with recipient rights. 4) Increase use of natural supports by providing assistance to the expense of travel t o treatment locations.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase in frequency of consumers participating in grant transport services

Baseline Measurement: Projected baseline FY17 = 178 unduplicated consumers

First-year target/outcome measurement: Increase of 30 unduplicated consumers

Second-year target/outcome measurement: Increase of 30 unduplicated consumers

Data Source:

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Percent of consumers receiving routine transport services who also received at least one crisis service within the reporting period

Baseline Measurement: Consumers who received routine transport services & at least 1 crisis within the FY divided by the unduplicated # of individuals who received routine transport services in that same = 10%

First-year target/outcome measurement: Percent of individuals receiving routine transport service and crisis services within the FY will decrease to 7%

Second-year target/outcome measurement: Percent of individuals receiving routine transport service and crisis services within the FY will decrease to 5%

Data Source:

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 6

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

Priority Type: MHS

Population(s): SED

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

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

2. 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 support activities.

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percent of children assessed with the CAFAS statewide who demonstrate at least a 20 point (statistically significant) reduction in their overall CAFAS score from intake to discharge will maintain or increase in FY18 and in FY19 from a baseline average obtained in FY16.

Baseline Measurement: 56%

First-year target/outcome measurement: 56% or more

Second-year target/outcome measurement: 56% or more

Data Source:

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

Description of Data:

Statewide aggregate CAFAS data

Data issues/caveats that affect outcome measures::

We hope that we have resolved statewide aggregate CAFAS data issues at this time.

Indicator #: 2

Indicator: The number of children/youth with SED served in the public mental health system that receive wraparound services will surpass 2,000 in FY18 and again in FY19.

Baseline Measurement: 2,000

First-year target/outcome measurement: 2,100

Second-year target/outcome measurement: 2,150

Data Source:

MDHHS Division of Quality Management and Planning State encounter data.

Description of Data:

Numbers served in wraparound.

Data issues/caveats that affect outcome measures::

None.

Indicator #: 3

Indicator: The number of children/youth with SED served in the public mental health system that receive PMTO will increase in FY18 and again in FY19 from a baseline of number served in FY16.

Baseline Measurement: 1,042

First-year target/outcome measurement: 1,050

Second-year target/outcome measurement: 1,060

Data Source:

MDHHS Division of Quality Management and Planning state Fingertip Report.

Description of Data:

Numbers served in PMTO

Data issues/caveats that affect outcome measures::

None.

Indicator #: 4

Indicator: The number of children/youth with SED served in the public mental health system that receive TFCBT will increase in FY18 and again in FY19 from a baseline of number served in FY16.

Baseline Measurement: 790

First-year target/outcome measurement: 800

Second-year target/outcome measurement: 825

Data Source:

MDHHS Division of Quality Management and Planning state encounter data.

Description of Data:

Number served in TFCBT

Data issues/caveats that affect outcome measures::

None.

Indicator #: 5

Indicator: The number of Parent Support Partners trained to work in the public mental health system will increase in FY18 and again in FY19 from a baseline of number trained in FY16.

Baseline Measurement: 171

First-year target/outcome measurement: 180

Second-year target/outcome measurement: 190

Data Source:

Michigan Parent Support Partner Training Project.

Description of Data:

Number of Parent Support Partners trained

Data issues/caveats that affect outcome measures::

None.

Indicator #: 6

Indicator: The number of Youth Peer Support Specialists trained to work in the public mental health system will increase in FY18 and again in FY19 from a baseline of number trained in FY16.

Baseline Measurement: 14

First-year target/outcome measurement: 20

Second-year target/outcome measurement: 25

Data Source:

Michigan Youth Peer Support Training Project.

Description of Data:

Number of Youth Peer Support Specialists trained

Data issues/caveats that affect outcome measures::

None.

Priority #: 7

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

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Enhanced partnerships exist to serve children/youth with SED and their families, including traditionally underserved populations, using block grant

funds and other resources; that reduce duplication of efforts.

Objective:

Continue to support joint projects and foster the relationship between MDHHS divisions and other child serving systems to encourage more collaborative work.

Strategies to attain the objective:

1. Continue to pursue and support collaborative projects like integrated physical health and behavioral health initiatives, mental health screening projects and co-occurring services for children and youth with SED (and co-occurring SUD) and their families.

2. Continue to utilize the 10% set-aside for integrated first episode psychosis services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Youth who are involved in or at-risk for involvement in the juvenile justice system and need mental health services will be identified via a screen and referred to appropriate mental health services.

Baseline Measurement: 225

First-year target/outcome measurement: 225

Second-year target/outcome measurement: 275

Data Source:

Michigan Mental Health Juvenile Justice Screening Projects.

Description of Data:

Number of youth screened.

Data issues/caveats that affect outcome measures::

None.

Indicator #: 2

Indicator: The number of children served in integrated physical and mental health projects will increase in FY18 and again in FY19 from FY16 baseline.

Baseline Measurement: 1,615

First-year target/outcome measurement: 1,700

Second-year target/outcome measurement: 1,750

Data Source:

Michigan Child Collaborative Care (MC3) Project data.

Description of Data:

Number of children served by MC3 projects.

Data issues/caveats that affect outcome measures::

None.

Indicator #: 3

Indicator: The number of youth receiving co-occurring services will increase in FY18 and again in FY19 from FY15 baseline.

Baseline Measurement: 1,345

First-year target/outcome measurement: 1,350

Second-year target/outcome measurement: 1,355

Data Source:

MDHHS Division of Quality Management and Planning Encounter data.

Description of Data:

Number of youth receiving co-occurring services.

Data issues/caveats that affect outcome measures::

None.

Indicator #: 4

Indicator: The number of young adults receiving NAVIGATE first episode psychosis services through the 10% set-aside pilots will increase in FY18 and again in FY19 from the baseline obtained in FY16

Baseline Measurement: 75

First-year target/outcome measurement: 130

Second-year target/outcome measurement: 140

Data Source:

10% Set-aside Project Coordinator.

Description of Data:

Number of young adults receiving NAVIGATE first episode psychosis services through the 10% set-aside pilots.

Data issues/caveats that affect outcome measures::

None.

Priority #: 8

Priority Area: Promote Healthy Births

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Healthy births will be promoted.

Objective:

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

Strategies to attain the objective:

1. Increase outreach to pregnant women to increase the population's access to treatment.
2. Provide extended case management to pregnant women to provide support after the treatment episode in order to promote a healthy birth.
3. Promote recovery support services to extend engagement and support retention.
4. Build capacity to provide trauma-informed care.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of reported drug free births

Baseline Measurement: FY16 Baseline = 209 drug free births reported by programs serving PWWDC

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

Second-year target/outcome measurement: FY18 Target = 220 drug free births

Data Source:

Women's Specialty Services Report

Description of Data:

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

Data issues/caveats that affect outcome measures::

This measure must be tracked by hand and, if a woman leaves treatment unexpectedly, a program may never know if she has a healthy birth. MDHHS has worked diligently to ensure numbers are reported accurately and continue to encourage case management and recovery supports for pregnant women as they exit formal treatment. MDHHS is piloting NAS projects in each PIHP region to help connect women with an opioid use disorder with all the services she and baby need for a successful delivery and postpartum period, and this allows for better tracking of healthy pregnancies as well.

Priority #: 9

Priority Area: Reduce IVDU wait times

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

IVDU wait times will be reduced.

Objective:

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

Strategies to attain the objective:

1. Encourage case management services for IVDUs entering services to promote sustained recovery and manage the multiple issues that this population experiences when they participate in treatment services.
2. Work with regional Prepaid Inpatient Health Plans to manage wait lists and expand services as needed to limit wait times for methadone treatment.
3. Encourage the use of recovery support services to extend engagement and support retention.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Time to Treatment

Baseline Measurement: FY16 Baseline = 15.3% of individuals waiting over 10 days to enter treatment

First-year target/outcome measurement: FY17 Target = 14.5% of individuals

Second-year target/outcome measurement: FY18 Target = 13.75% of individuals

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures::

Priority #: 10

Priority Area: Increased Access to Treatment

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Access to treatment will be increased.
FY17 Target = 8.7% of individuals

Objective:

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

Strategies to attain the objective:

1. Outreach to collaborative partners to ensure that parents are identified as priority populations.
2. Ensure that programs identified as serving pregnant and parenting women are able to serve the entire family or have agreements for referral to other agencies.
3. Encourage the use of recovery support services to extend engagement and support retention.
4. Encourage case management services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Parents with Dependent Children Access/Retention in Residential Care

Baseline Measurement: FY16 Baseline = 42.3% of parents with dependent children who continue 14 days in residential treatment

First-year target/outcome measurement: FY17 Target = 43.2% of parents with dependent children

Second-year target/outcome measurement: FY18 Target = 44.5% of parents with dependent children

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures::

None

Priority #: 11

Priority Area: Increase the use of integrated services

Priority Type: SAT

Population(s): Other ()

Goal of the priority area:

The use of integrated services will be increased.

Objective:

Increase the percentage of integrated treatment expenditures by 10%.

Strategies to attain the objective:

1. Encourage case management when an individual entering treatment is identified as having a co-occurring disorder (COD) to help manage the many issues resulting from their disorder.
2. Encourage regions to provide technical assistance to those agencies working to become co-occurring capable and enhanced.
3. Encourage the use of recovery support services to extend engagement and support retention.

4. Build capacity to provide trauma-informed care.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of Prepaid Inpatient Health Plan expenditures on integrated services for individuals with co-occurring disorders.

Baseline Measurement: FY16 Baseline = 12.1% of expenditures

First-year target/outcome measurement: FY17 Target = 12.8%

Second-year target/outcome measurement: FY18 Target = 13.3%

Data Source:

Section 908 of the Legislative Report provides information on expenditures for integrated services for individuals with co-occurring disorders. TEDS admission and discharge data indicates those individuals who had HH modified encounters reported.

Description of Data:

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

Data issues/caveats that affect outcome measures::

None

Priority #: 12

Priority Area: Underage Drinking

Priority Type: SAP

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

Goal of the priority area:

Childhood and underage drinking is reduced.

Objective:

Reduce childhood and underage drinking.

Strategies to attain the objective:

1. Increase multi-system collaboration to implement strategies identified in the Underage Drinking Strategic Plan.
2. Reduce adult abuse by engaging all segments of the community in establishing a recovery-oriented system of care and increase the use of brief intervention.
3. Engage parents and other adults in helping reduce underage drinking.
4. Community coalitions will implement at least one environmental or community based process strategy each year.
5. Continue to build and enhance community substance abuse prevention infrastructure and capacity by strengthening collaboration with primary care providers to implement screening, brief intervention and referral (SBIR)
6. Encourage the use of Communities that Care, Community Trials, Strengthening Families and Prime for Life.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Past 30 days use of alcohol among youth 9th- 12th grade will be reduced

Baseline Measurement: FY15 Baseline = 25.9% of youth

First-year target/outcome measurement: 24.0% of youth

Second-year target/outcome measurement: 23.0% of youth

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures::

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

Priority #: 13

Priority Area: Priority Area: Youth Access to Tobacco

Priority Type: SAP

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

Goal of the priority area:

Youth access to tobacco will be reduced.

Objective:

Reduce youth access to tobacco

Strategies to attain the objective:

1. Synar and Non Synar compliance checks to discourage sells to minors - During annual Synar required inspection periods and Non Synar regionally scheduled phases throughout the year.
2. Reduction in the initiation of tobacco use among children, adolescents and young adults – Use of research-based practices and classroom curriculum / Ongoing.
3. Increased vertical driver's license education – Promote "Read the Red" and, Secretary of State awareness website / Ongoing.
4. Encouragement through positive community recognition – Mass media, Associated Food & Petroleum Dealers (AFPD) magazine feature and E-blast acknowledgment / Quarterly.
5. Increased merchant retailer education – OROSC ImprovingMIPractices.org free online certificated training / Ongoing; AFPD tobacco awareness article series / Quarterly; and One hundred percent birthdate and legal awareness signage mailing to all merchants on the state's tobacco Master Retail List /Annually.
6. Increased environmental efforts – "Kick Butts" annual smoking cessation day. Alliance with existing "Do Your Part" campaign using fact sheets, PowerPoint and video resources by developing an attention getting website for educators, merchants, parents and research resources for youth.
7. Increased collaborative enforcement efforts – Violation reports to Michigan Liquor Control Commission to increase licensing consequences and Michigan State Police for follow-up action by Tobacco Tax Enforcement Teams.
8. Sensitivity to cultural diversity - Aggregate information regarding targeted HR, minority and underserved populations from annual plans; Review best practice evidence-based interventions for specific populations; Set minimum state goal that 20% of populations identified by Census data must include HR populations.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Effect a 10% retail merchant sells rate to minors

Baseline Measurement: FY17 Baseline = 13.7%

First-year target/outcome measurement: FY18 Target = 11%

Second-year target/outcome measurement: FY19 Target = 10%

Data Source:

Annual Synar Survey

Description of Data:

The state must conduct a formal Synar survey annually to determine retailer compliance with the tobacco youth access law and to

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

Data issues/caveats that affect outcome measures::

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

Priority #: 14

Priority Area: Health Disparities

Priority Type: SAP

Population(s): Other (LGBTQ)

Goal of the priority area:

Health disparities among LGBTQ youth and adults will be decreased.
Objective: Decrease health disparities among LGBTQ youth and adults in relation to behavioral health issues.

Objective:

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

Strategies to attain the objective:

1. Gather and review data from existing sources to establish baseline indicators on substance abuse and mental health issues among target population.
2. Provide funding to include question on sexual orientation on the BRFSS; identify other mechanisms to increase sources for data.
3. Once data is identified, prioritize indicators to monitor.
4. Evaluate effective evidence based prevention programs and practices for this target population in anticipation of future pilot projects once data is gathered.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase LGBTQ data sources

Baseline Measurement: FY16 = Sexual orientation added on the 2015 BRFSS

First-year target/outcome measurement: FY18= Continue to provide funding for BRFSS

Second-year target/outcome measurement: FY19 = Continue to provide funding for BRFSS

Data Source:

Youth Risk Behavior Survey (YRBS); Behavioral Risk Factor Surveillance Survey (BRFSS); others to be determined.

Description of Data:

A question on sexual orientation in the BRFSS

Data issues/caveats that affect outcome measures::

A limited number of data sources for this target population has been identified by the SEOW as a gap for a number of years. Providing fund for a sexual orientation in the BRFSS is a progress.

Indicator #: 2

Indicator: Past 30 days smoking among LGBT persons aged 18 and older

Baseline Measurement: FY15 = 35.9% of LGBT adults are current smokers

First-year target/outcome measurement: FY18 = 34.9%

Second-year target/outcome measurement: FY19 = 33.9%

Data Source:

BRFSS

Description of Data:

The percentage of current smoker among LGBT persons aged 18 and older

Data issues/caveats that affect outcome measures::

None

Indicator #: 3

Indicator: Past 30 days binge drinking among LGBT persons aged 18 and older

Baseline Measurement: FY15 = 30.9% of LGBT adults are binge drinkers

First-year target/outcome measurement: FY18 = 29.0%

Second-year target/outcome measurement: FY19 = 27.5%

Data Source:

BRFSS

Description of Data:

The percentage of current binge drinkers among LGBT persons aged 18 and older

Data issues/caveats that affect outcome measures::

None

Priority #: 15

Priority Area: Marijuana Use

Priority Type: SAP

Population(s): Other (Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Decrease marijuana use and increase awareness

Objective:

Increase perceived risk of marijuana use and decrease marijuana use.

Strategies to attain the objective:

1. Develop a comprehensive strategic plan to prevent youth marijuana use.
2. Use fact sheets and infographics as a prevention tool to increase awareness of impact of marijuana use.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: FY14 = 21.4% of youth among 12 to 17 years old

First-year target/outcome measurement: FY18 =22.5%

Second-year target/outcome measurement: FY19 =23.5%

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

The percentage of youth (12-17 years old) expressed great risk of smoking marijuana once a month.

Data issues/caveats that affect outcome measures::

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

Indicator #: 2

Indicator: Past 30 day use of marijuana use among youth

Baseline Measurement: FY14 = 8.1% of youth among 12 to 17 years old

First-year target/outcome measurement: FY18 = 7.1%

Second-year target/outcome measurement: FY19 = 6.1%

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

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

Data issues/caveats that affect outcome measures::

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

Priority #: 16

Priority Area: Opiate Use

Priority Type: SAT

Population(s): Other ()

Goal of the priority area:

Treatment outcomes will be improved.

Objective:

Improve treatment outcomes for individual with opioid use disorders.

Strategies to attain the objective:

1. Initiate implementation of new Medication Assisted Treatment (MAT) Guidelines for Opioid Use Disorders.
2. Improve fidelity in the use of behavioral health therapies utilized in the treatment of opioid use disorders.
3. Require the availability of all three FDA approved medications for the treatment of opioid dependency in all publicly-funded opioid treatment programs.
4. Increase the use of peer recovery coaches within treatment settings.
5. Promote the utilization of recovery oriented services and systems to effectively treat the disease of addiction.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: FY16 Baseline = 17,607 admissions initiated into MAT services

First-year target/outcome measurement: FY18 = 18,107

Second-year target/outcome measurement: FY19 = 18,507

Data Source:

BH-TEDS admissions.

Description of Data:

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

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: Retention in MAT treatment

Baseline Measurement: FY16 Baseline = 8.7% of individuals who continue 180 days in MAT

First-year target/outcome measurement: FY18 = 10.0%

Second-year target/outcome measurement: FY19 = 11.0%

Data Source:

BH-TEDS treatment and discharge data. Service category of Detox would be excluded.

Description of Data:

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

Data issues/caveats that affect outcome measures::

None

Priority #: 17

Priority Area: Opiate Use

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Non-medical use of prescription drugs and heroin use will be reduced.

Objective:

Reduce non-medical use of prescription drugs and heroin use.

Strategies to attain the objective:

1. Increase multi-system collaboration at state and community levels.
2. Promote to develop leadership structure combining relevant agencies and organizations to oversee surveillance, intervention, education, and enforcement.
3. Promote the use of statewide media campaign entitled: Do your Part: Be the Solution to Prevent Prescription Drug Abuse.
4. Broaden the use of brief screenings in behavioral and primary health care settings.
5. Promote increased access to and use of prescription drug monitoring program.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

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

First-year target/outcome measurement: FY18 = 1.9%

Second-year target/outcome measurement: FY19 = 1.8%

Data Source:

NSDUH

Description of Data:

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

Data issues/caveats that affect outcome measures::

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

Indicator #: 2

Indicator: Past year use of heroin

Baseline Measurement: FY15 = 0.37% of individuals aged 12 years and older

First-year target/outcome measurement: FY18 = 0.35%

Second-year target/outcome measurement: FY19 = 0.33%

Data Source:

NSDUH

Description of Data:

The NSDUH data will be used to track the past year heroin use.

Data issues/caveats that affect outcome measures::

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

Priority #: 18

Priority Area: Persons with or at risk for contracting TB and other communicable diseases.

Priority Type: SAT

Population(s): TB

Goal of the priority area:

100% of individuals in treatment are screened for risk of TB and referred for services as needed.

Objective:

Increase the number of providers with a policy regarding the screening and referral of individuals in treatment.

Strategies to attain the objective:

1. Review Prepaid Inpatient Health Plan policies regarding TB and other communicable diseases to ensure that the message to provider agencies is appropriate.
2. Revise contracts as needed to include screening for TB and other communicable diseases.
3. Promote the use of screening tools as part of assessment process in SUD treatment.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Each PIHP has a current policy addressing appropriate services for SUD clients with or at risk of contracting communicable diseases.

Baseline Measurement: FY13 = 100%

First-year target/outcome measurement: FY18 = 100%

Second-year target/outcome measurement: FY19 = 100%

Data Source:

Policy review during site reviews

Description of Data:

MDHHS staff to record compliance of PIHPs with a Communicable Disease policy to include requirements related to appropriate services for persons with or at risk of contracting communicable diseases in accordance with OROSC.

Data issues/caveats that affect outcome measures::

Frequency of PIHP site visits may affect collection of outcome measures.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SMHA and/or the SSA will use available funds to provide authorized services for the planning period for state fiscal years 2018/2019.

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$84,088,135		$101,866,060	$6,400,000	$40,586,554	$0	$0
a. Pregnant Women and Women with Dependent Children**	$11,244,880		$0	$0	$2,807,396	$0	$0
b. Syringe Services Program	$0		$0	$0	$0	$0	$0
c. All Other	$72,843,255		$101,866,060	$6,400,000	$37,779,158	$0	$0
2. Primary Prevention	$22,423,503		$0	$0	$225,662	$0	$0
3. Tuberculosis Services	$0		$0	$0	$208,572	$0	$0
4. Early Intervention Services for HIV	$0		$0	$0	$0	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary							
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)							
10. Administration (Excluding Program and Provider Level)	$5,605,876		$0	$0	$1,264,978	$0	$0
11. SABG Total (Row 1, 2, 3, 4 and 10)	**$112,117,514**	**$0**	**$101,866,060**	**$6,400,000**	**$42,285,766**	**$0**	**$0**

* Prevention other than primary prevention

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

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA and/or the SSA will use available funds to provide authorized services for the planning period for state fiscal years 2018/2019.

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. Syringe Services Program		$0	$0	$0	$0	$0	$0
c. All Other							
2. Primary Prevention							
3. Tuberculosis Services							
4. Early Intervention Services for HIV							
5. State Hospital			$59,199,300	$0	$395,976,400	$35,328,000	$0
6. Other 24 Hour Care		$0	$0	$0	$0	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$0	$0	$0	$336,900	$0	$0
8. Mental Health Primary*		$0	$0	$0	$0	$0	$0
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		$4,197,042	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$2,098,521	$0	$0	$0	$0	$0
11. MHBG Total (Row 5, 6, 7, 8, 9 and 10)	**$0**	**$6,295,563**	**$59,199,300**	**$0**	**$396,313,300**	**$35,328,000**	**$0**

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
Pregnant Women	10115	1234
Women with Dependent Children	86356	11399
Individuals with a co-occurring M/SUD	166489	29968
Persons who inject drugs	107344	19644
Persons experiencing homelessness	69912	12724

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

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Expenditure Category	FY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	$42,044,068
2 . Primary Substance Abuse Prevention	$11,211,751
3 . Tuberculosis Services	$0
4 . Early Intervention Services for HIV*	$0
5 . Administration (SSA Level Only)	$2,802,938
6. Total	**$56,058,757**

* For the purpose of determining the states and jurisdictions that 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; 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 will be 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 are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for 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 a 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.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Strategy	IOM Target	FY 2018
		SA Block Grant Award
Information Dissemination	Universal	$878,352
	Selective	$16,151
	Indicated	$28,567
	Unspecified	$0
	Total	**$923,070**
Education	Universal	$1,842,057
	Selective	$1,757,560
	Indicated	$310,863
	Unspecified	$0
	Total	**$3,910,480**
Alternatives	Universal	$609,220
	Selective	$32,304
	Indicated	$58,452
	Unspecified	$0
	Total	**$699,976**
Problem Identification and Referral	Universal	$164,554
	Selective	$694,472
	Indicated	$154,519
	Unspecified	$0
	Total	**$1,013,545**

Community-Based Process	Universal	$2,627,198
	Selective	$94,922
	Indicated	$178,495
	Unspecified	$0
	Total	**$2,900,615**
Environmental	Universal	$421,730
	Selective	$0
	Indicated	$22,354
	Unspecified	$0
	Total	**$444,084**
Section 1926 Tobacco	Universal	$1,010,861
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$1,010,861**
Other	Universal	$309,120
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$309,120**
Total Prevention Expenditures		**$11,211,751**
Total SABG Award*		**$56,058,757**
Planned Primary Prevention Percentage		**20.00 %**

*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: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	FY 2018 SA Block Grant Award
Universal Direct	$3,302,498
Universal Indirect	$4,560,594
Selective	$2,595,409
Indicated	$753,250
Column Total	**$11,211,751**
Total SABG Award*	**$56,058,757**
Planned Primary Prevention Percentage	**20.00 %**

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

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

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

Footnotes:

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

FY 2018				
Activity	**A. MHBG**	**B. SABG Treatment**	**C. SABG Prevention**	**D. SABG Combined***
1. Information Systems	$1,029,520	$0	$0	$0
2. Infrastructure Support	$21,312,306	$0	$0	$0
3. Partnerships, community outreach, and needs assessment	$357,338	$250,000	$100,000	$0
4. Planning Council Activities (MHBG required, SABG optional)	$18,000	$0	$0	$0
5. Quality Assurance and Improvement	$3,107,554	$300,000	$100,000	$0
6. Research and Evaluation	$2,250,186	$100,000	$0	$0
7. Training and Education	$7,462,960	$744,000	$202,000	$400,000
8. Total	**$35,537,864**	**$1,394,000**	**$402,000**	**$400,000**

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

No ($0) planned primary prevention Block Grant expenditures are included in any Table 6 column.

Environmental Factors and Plan

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

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[25] 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.[26] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[27]

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.[28] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[29] 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.[30]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[31] SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[32] 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 behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between 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.[33] Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, 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[34] and ACOs[35] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. 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.[36] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[37]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[38] 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.[39] 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.[40] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[41] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[42] 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 behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. 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.[43] 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.[44] 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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[27] Comorbidity: Addiction and other mental illnesses, http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, JAMA Psychiatry. 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; http://www.samhsa.gov/co-occurring/

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[29] http://www.samhsa.gov/health-disparities/strategic-initiatives

[30] http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/

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[36] Waivers, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf

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

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

Please 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), the MI Care Team (Michigan's primary care health home via Section 2703 of the ACA), and Michigan's State Innovation Model.

The MI Health Link allows dually enrolled Medicare/Medicaid beneficiaries to utilize a single Integrated Care Organization for all of 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.

The MI Care Team is provider level integration at the primary care level, specifically within select Michigan Federally Qualified Health Centers (FQHCs). Eligibility requirements for beneficiaries include a diagnosis of depression and/or anxiety in addition to a chronic physical health condition such as asthma, COPD, diabetes, heart disease, and hypertension. The MI Care Team provider structure is comprised of a primary care provider, nurse care manager, community health worker, behavioral health consultant, and a consulting doctorate-level psychologist/psychiatrist. The intent of the program is to provide intense care management and care coordination to MI Care Team beneficiaries in addition to providing a single point of care for all health care services (including primary care, behavioral health care, and dental care) in one location to maximize treatment adherence and reduce barriers to access. MI Care Team providers are required to liaise to CMHSPs when appropriate. Finally, the MI Care Team utilizes Care Connect 360, which allows providers to be cognizant of a beneficiary's past medical history and future medical encounters outside of their four walls, including receiving ADT messaging from hospitals.

The State Innovation Model has two major components – the patient centered medical home payment piece for providers providing care management activities and the community health innovation region demonstrations. Eligible providers for the latter include primary care practices and CMHSPs. Moreover, there is a specific focus on beneficiaries with chronic health conditions, including SUD, with the goal of reducing preventable emergency department visits.

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

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ○ Yes ○ No

and Medicaid? ○ Yes ○ No

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

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

6. Do the behavioral health providers screen and refer for:

a) Prevention and wellness education ○ Yes ○ No

b) Health risks such as

i) heart disease ○ Yes ○ No

ii) hypertension ○ Yes ○ No

viii) high cholesterol ○ Yes ○ No

ix) 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 substance use disorder services? ○ Yes ○ No

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

10. 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

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**[45], **Healthy People, 2020**[46], **National Stakeholder Strategy for Achieving Health Equity**[47], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, 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)[48].

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."[49]

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[50]. 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[51]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the 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.

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

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

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

[48] **http://www.thinkculturalhealth.hhs.gov**

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

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

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

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, LGBT, 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 behavioral health 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) standard? ○ Yes ○ No

6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health 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

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the 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 behavioral health 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 behavioral health 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. NREPP 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. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[52], The New Freedom Commission on Mental Health[53], the IOM[54], and the NQF[55]. 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."[56] 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 behavioral health 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)**[57] are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private 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)**[58] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

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[53] 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.

[54] 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.

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

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

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

[58] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.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 focus on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

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.

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 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 outcome 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.

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). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). 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 CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the 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. Although the focus and requirements for this funding have changed over the years, Michigan felt it was ineffective to continually switch gears. We have maintained our commitment to implementing this First Episode Psychosis (FEP) model utilizing the 10% set-aside. All information contained in this section refers to our FEP project.

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

The Navigate model is still a very new approach for the public mental health system in Michigan. We do have one public mental health community-based provider who has received the Navigate training, outside the block grant supported project, in order to apply the approach in conjunction with the Assertive Community Treatment team. This is a different twist on the model and it is brand new so we are waiting see if the outcomes are comparable to the stand alone, traditional teams. We were planning to do a team recruitment push for FY18 but, since funds are being cut, it is not feasible to expand at this point. Consistent funding for this project is essential to growth and sustainability.

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 project are also MHBG funded.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a 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 2018 and FFY 2019 for your state's ESMI programs including psychosis?

The following activities will occur in FY18 and sustaining the activities will occur in FY19. All of these activities are dependent upon the availability of funds.

Objective: New implementation team will reach capacity (30 individuals)

Activity: Implementation team will continue development of referral sources, particularly within the local universities and colleges.
Expected outcome: Implementation team will receive referrals
Measurement: Implementation team will receive referrals

Activity: Implementation team will screen and enroll individuals
Expected outcome: Implementation team will reach capacity
Measurement: Implementation team will reach capacity of 30 individuals

Objective: Enrollment in each implementation team will be maintained at no more than 3 participants below capacity at any given time, once capacity is initially achieved.

Activity: Each contracted provider agency will ensure guidelines and processes are established and followed to enroll new program participants as existing program participants dis-enroll or "graduate."
Expected Outcome: Enrollment will be maintained at no more than 3 participants below capacity at any given time: InterAct Grand Rapids & ETCH capacity = 45; Easter Seals and InterAct- Kalamazoo capacity = 30
Measurement: Enrollment will be maintained at no more than 3 participants below capacity at any given time: InterAct Grand Rapids & ETCH capacity = 45; Easter Seals and InterAct- Kalamazoo capacity = 30

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

Activity: Implementation agencies will complete tasks necessary within 90 days for all staff eligible to be paneled with third party payers when: new staff is/are hired; a previously ineligible staff is identified as potentially being eligible, or; a program participant is enrolled whose insurance benefit is new to the implementation agency.
Expected Outcome: Eligible individual providers (therapists, prescribers) will be paneled by all payers accepting paneled providers
Measurement: Providers will submit applications within 90 days of new employee hire, identification of a staff being potentially eligible for paneling, or enrollment of the program participant, for 100% of payers accepting new paneled providers

Activity: Implementation agencies will ensure each program participant's assigned staff has licensing and credentials required in order to submit for reimbursement under the participant's insurance benefit.
Expected Outcome: 100% of claims for services for program participants having a benefit for therapy and/or psychiatric medication review will be submitted for reimbursement to the third party payer
Measurement: 100% of claims for services for program participants having a benefit for therapy and/or psychiatric medication review will be submitted for reimbursement to the third party payer

Objective: To promote the sustainability of FEP treatment programs

Activity: Attend trainings, webinars, and access other resources focused on fiscal sustainability of FEP- Coordinated Specialty Care treatment, to be able to advocate as needed in the interest of Michigan's efforts.
Expected outcome: Project Coordinator will have an understanding of the current environment, be able to share the information with sites and MDHHS, as well as advocate as needed
Measurement: Project Coordinator will access resources and report on the information at lease quarterly in reporting to MDHHS

Activity: As opportunity arises, agencies/providers will pursue conversation with primary payers of insurance benefits regarding development of a bundled or non-traditional payment structure for FEP services. Collaborative efforts between providers should be leveraged in this pursuit.
Expected outcome: Documented efforts to develop funding for FEP programs
Measurement: Documentation will support continued efforts to reach out to insurances within regions

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

Activity: ETCH, LLC will provide oversite for activities to monitor all implementation teams' staff fidelity to the NAVIGATE model of care as outlined by the National NAVIGATE Team, receiving consultation from the National NAVIGATE team as needed.
Expected outcome: All staff will maintain fidelity to the model of care
Measurement: ETCH, LLC will report each staff maintains fidelity to the NAVIGATE model of care

Objective: 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.

Activity: All uncertified implementation team Project Directors, FE, IRT, SEE and prescribers will participate in the required activities set forth by the National Navigate team to be certified.
Expected outcome: Implementation teams' individual staff will achieve certification
Measurement: Certification of individual team members

Objective: Outcomes on treatment for first episode psychosis will be available.

Activity: Implementation teams will collect and report outcomes data per the established evaluation process
Expected outcome: Raw data will be available for analysis
Measurement: All sites will submit complete data to support outcomes per the evaluation process

Activity: Outcomes data will be analyzed and reported to MDHHS
Expected outcome: Data analysis and presentation will be reported to MDHHS at least annually.
Measurement: Data analysis and presentation will be available at least annually

Activity: A final web application for collecting data and construction of a data warehouse will be completed
Expected outcome: An effective web application and data warehouse will be functional
Measurement: Implementation teams, and the contracted provider for data analysis and presentation will effectively utilize the finalized web application and data warehouse

Objective: To expand knowledge and education of FEP, treatment and resources.

Activity: The web page, Michigan Minds Empowered, will be maintained with relevant information
Expected outcome: The web page will contain relevant, up-to-date information and resources
Measurement: The information will be up-to-date and relevant

Activity: Video vignettes for the Michigan Minds Empowered web page focused will be created
Expected outcome: Video vignettes to feature on the Michigan Minds Empowered web page
Measurement: Video vignettes will be available

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 project coordinator. Quarterly and annual reports are provided to MDHHS by Project Coordinator. Data collected thus far includes demographic data, Clinical Global Impression (CGI) and the Service Utilization Review Form (SURF) data and COMPASS data. The first full-year outcome report for FY17 will be available in March 2018. One of the goals for FY18 and FY19 is to work with a university researcher to analyze data and get a web-based data collection portal up and running for the 4 teams to enter outcome data and generate reports.

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

Psychosis - first episode

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

Please see information provided above.

Also, the "Michigan Minds Empowered" website link is: https://michiganminds.org/home-2/

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

Sustainability and planning when funding is variable.

Footnotes:

Regarding Question #6 - MDHHS previously used the 10% set-aside to train 4 Navigate teams. If and when expansion is possible, the 10% set-aside will be used to train additional teams. No additional training is anticipated in FY18 or FY19 as of this writing.

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 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, 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.

MDHHS does not currently have any planned action steps.

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

Person Centered Planning 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 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 (the Michigan Mental Health Code (the Code) and federal law (the Home and Community Based Services (HCBS) 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 I/DD 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 or she has selected to support him or 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 (IPOS) that directs the provision of supports and services to be provided through the community mental health services program (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.

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

None at this time.

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

No technical assistance is needed at this time.

Footnotes:

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds,the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? (●) Yes ( ) No

2. Are there any concretely planned initiatives in our state specific to self-direction? (●) Yes ( ) No

If yes, describe the currently planned initiatives. In particular, please answer the following questions:

a) How is this initiative financed:

Eight trainings a year on self-direction are offered through the Michigan Association of Community Mental Health Boards and the trainings are funded through that association. BHDDA utilizes MHBG funds to support specific technical assistance and training for the use of self-direction within the SMI population. BHDDA also has a 0.5 FTE under contract to provide Self-Direction support and technical assistance to the field. Starting in FY 18, this position is being moved from contract status to the department and will be full-time.

b) What are the eligibility criteria?

Any client receiving services and supports within our behavioral health system is eligible for self-directed care.

c) How are budgets set, and what is the scope of the budget?

The Michigan Department of Community Health's (MDCH) Self-Determination Policy and Practice Guideline (SD Guideline) is attached to its contracts with Community Mental Health Services Programs (CMHSPs) and Prepaid Inpatient Health Plans (PIHPs). The guideline identifies control over an individual budget as an important way that individuals using arrangements that support self-determination exercise meaningful control over their mental health specialty services and supports. This Technical Advisory provides further guidance on the development, use, and monitoring of individual budgets.

An individual budget, for the purpose of this document, is the expected or estimated costs of a concrete approach to obtaining the mental health specialty services and supports in the IPOS for which an individual is choosing to use arrangements that support self-determination. An individual budget does not include mental health services and supports not obtained through arrangements that support self-determination or other funding sources. An individual budget also must be differentiated from the estimated costs of providing mental health specialty services and supports that must be provided to all individuals who receive services and supports in the public mental health system.

The person-centered planning process is used to develop the IPOS that the individual needs and the individual budget

necessary to implement that IPOS. The IPOS includes the amount, scope and duration for each medically necessary service and support. The individual and the PIHP/CMHSP agree to both the IPOS and the individual budget. If the individual's needs change, the person-centered planning process is used to revisit the IPOS and individual budget. The individual uses the funding in the individual budget to acquire and pay for the services and supports in his or her IPOS that he or she is obtaining through arrangements that support self-determination. The individual budget cannot be used to obtain mental health specialty services and supports not authorized for the individual or other services and supports not available through the public mental health system.

PIHP/CMHSPs (including their sub-contracted entities) are responsible for offering arrangements that support self-determination and working with each individual to develop those arrangements including an individual budget. These arrangements are partnerships between the PIHP/CMHSP and the individual in which PIHP/CMHSP delegates authority for the funding in the individual budget to the individual. That means that the individual is responsible for using the funding solely for the services and supports in the IPOS consistent with Medicaid and other requirements. The scope of authority and limitations on it are set forth in a Self-Determination Agreement that is signed by both the PIHP/CMHSP and the individual. The PIHP/CMHSP retains responsibility for monitoring and ensuring that the individual obtains the services and supports in his or her IPOS.

All individuals using arrangements that support self-determination have been determined to be eligible to receive medically necessary mental health services and supports. Their right to services and supports does not translate into either a right, or a requirement, that they obtain those services and supports at a certain cost. Each PIHP/CMHSP must have a uniform, transparent process for costing out services and supports that comports with the prudent purchasing framework and best value orientation and yet provides sufficient resources to enable the individuals to find qualified and capable providers.

Developing the Individual Budget:
Michigan uses a retrospective zero-based method for developing an individual budget. That means that the individual budget is based solely on the services and supports determined to be necessary. The budget is based on the IPOS rather than the IPOS being based on a targeted budget amount. After an IPOS that meets the individual's needs and goals has been developed, the amount of the individual budget is determined collectively by the individual, the PIHP/CMHSP, and others involved through the person-centered planning process. The individual budget is determined by costing out the services and supports in the IPOS (for example, a reasonable number of hours at a reasonable rate). The rate for directly-employed workers must include Medicare and Social Security Taxes (FICA), Unemployment Insurance, and Worker's Compensation Insurance. The individual budget must include the fiscal intermediary fee if the individual is directly employing workers and/or using the fiscal intermediary to process payments to other providers.

The individual budget should be developed for a period of time that allows the individual to exercise flexibility (usually one year). Therefore, if an individual uses more hours one week or month and less the next, it averages out. The individual is responsible to ensuring the use of service and supports does not exceed the individual budget authorization for the budget period. As set forth in the SD Guideline and the Fiscal Intermediary Technical Requirement, the fiscal intermediary is a fiscal agent for the PIHP/CMHSP that provides monitoring and safeguards to ensure that the individual budget is not overspent. Both documents also address the methods for addressing situations where an individual is not obtaining services and supports consistent with the IPOS and individual budget.

Elements of the Individual Budget:
An individual budget must meet three criteria to support each individual in implementing the arrangements that support self-determination. The budget must be accessible, flexible and portable. As described below, information on the amount of the individual budget and monthly reports on the use of the individual budget are critical for an individual to be able to direct and control the arrangements. When this information is provided in both a clear format and timely manner, the potential for budget overutilization is greatly reduced.

Accessible means that the individual is provided with amount and purpose of the budget in an easy-to-understand format. To the greatest extent possible, the individual and his or her allies are involved in the budget development process. Options and limitations for using the funds in the individual budget to obtain the services and supports in the IPOS are set forth in the Self-Determination Agreement.

Portable means that the individual is able to transfer budget resources from one provider arrangement to another without prior approval from the PIHP/CMHSP. However, the individual most still follow the process set by the PIHP/CMHSP for assuring the provider meets provider qualifications and the credentialing process for applicable providers.

Flexible means that the PIHP/CMHSP describes in writing the options for modifying the budget components within the overall individual budget in accordance with the IPOS to the individual.

The PIHP/CMHSP must inform individuals in writing of the options for, and limitations on, flexibility and portability, for example, how, when and what kind of changes they can make in the use of the individual budget, and when such changes need to be communicated and/or to the PIHP/CMHSP.

Documenting the Individual Budget (Accessibility):
As described above, the PIHP/CMHSP is responsible for ensuring that an individual budget is accessible to the individual using it. Components of accessibility include providing easy-to-understand information on:
• the amount, scope and duration for each service and support
• the dollar amount tied to each service and support (and how that might break down in terms of average monthly or weekly usage).
• the dollar amount for the entire individual budget.

Authority over an individual budget is a big responsibility. The PIHP/CMHSP must discuss the nature and scope of this responsibility with the individual during the person-centered planning process and describe it in writing in the Self-Determination Agreement including any limitations on the use of the individual budget. A copy of the individual's IPOS and individual budget must be provided to the individual with the Self-Determination Agreement (SD Guideline II.E.) and provided to the individual. The PIHP/CMHSP must include the framework for making an adjustment in the use of funds in the individual budget in the Self-Determination Agreement or in a separate writing attached to that agreement.

Changing Providers and Monitoring the Individual Budget (Portability):
Portability means that an individual budget is portable—in other words, an individual can easily switch to a different provider without the approval of the PIHP/CMHSP as long as the provider meets provider qualifications for the service or support (the individual must follow the procedures for establishing that the provider meets provider qualifications including the credential process for applicable providers). The PIHP/CHMSP should clearly set forth the procedure for assuring that potential providers meet provider requirements. Sometimes, this checking is done by the PIHP/CMHSP; other agencies contract with the fiscal intermediary to do this work. The ability to change providers is one of the hallmarks of meaningful control of the individual budget.

Another key to portability is having information about budget utilization. The fiscal intermediary must provide both the individual and the PIHP/CMHSP a monthly report of expenditures within 15 days after the end of the month. The monthly budget report is the central mechanism for monitoring implementation of the budget. Over- or under- utilization identified in the monthly report can be addressed by the PIHP/CMHSP and individual informally or through the person-centered planning process. In addition, the PIHP/CMHSP contract with the Fiscal Intermediary should require the FI to contact an individual's supports coordinator or case manager if there is an over- or underutilization of a specified amount or percentage (for example, ten percent). If a FI is not used, then the PIHP/CMHSP must provide the monthly budget report to the individual and his or her supports coordinator or case manager.

Modifying the Individual Budget (Flexibility):
The individual budget must be written to allow the individual flexibility in its use: an individual can decide when services and supports are used and make some adjustments between budget line items. The SD Guideline describes types of flexibility (SD Guideline II.E.4) considered.

Adjustments That Do Not Require a Modification to the Individual Budget:
The IPOS and individual budget can set forth adjustments that do not deviate from the goals and objectives in the IPOS, and that do not require additional authorization from the PIHP/CMHSP or advance notification of an intended adjustment:
"When a person makes adjustments in the application of funds in an individual budget, these shall occur within a framework that has been agreed to by the person and the PIHP/CMHSP, and described as an attachment to the person-self-determination agreement.

The IPOS must be written in a way that contemplates and plans for the manner in which the individual may use the services and supports:
• Specific goals in the IPOS are tied to flexible objectives that can be expanded or contracted, as the services are used day-to-day.
• Amounts, scopes, and durations should be written in a length of time that makes flexibility across the budget period (quarterly or annually) possible.
• Services and supports that are similar and may be substituted for one another should be identified in the IPOS and individual budget (for example, services and supports with the same provider qualifications).
• Services and supports for which there is no substitution should be identified.

When adjustments are made that are consistent with the framework set forth in the IPOS, the PIHP/CMHSP should develop a mechanism for individuals to use to communicate these adjustments back to the PIHP/CMHSP.

Adjustments that Require a Modification to the Individual Budget:
Sometimes, an individual wants to make an adjustment that fundamentally alters the IPOS (for example, substituting one service for another service that is not similar, forgoing services and supports, or using services and supports not authorized):

"If a person desires to exercise flexibility in a manner that is not identified in the IPOS, then the IPOS must be modified before the adjustment may be made. The PIHP/CMHSP shall attempt to address each situation in an expedient manner appropriate for the complexity and the scope of the change."

In this situation, a modification can often be made over the phone between the individual and his or her supports coordinator or case manager. The change should be accomplished as expeditiously as possible. More substantial changes may need to be made through the person-centered planning process. The PIHP/CMHSP must provide the individual with information on grievance procedures when the individual's request for a budget adjustment is denied or the amount of the budget is reduced.

Ultimately, the amount of an individual budget is the sum of the costs of those support and supports that are medically-necessary and agreed upon as desirable, achievable and prudent. Self-determination entails the principle of responsibility, involving, among other things, the expectation that the individual will use the public dollars in his or her individual budget wisely. The experience in Michigan to date has demonstrated very successful shared responsibility.

d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

Peers can be involved in any level of the process based on the request of the individual receiving services.

e) What, if any, research and evaluation activities are connected to the initiative?

No research and evaluation is connected at this time.

f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

There are no action steps for the state at this time.

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

Not at this time.

Please indicate areas of technical assistance needed to this section.

No technical assistance is needed at this time.

Footnotes:

Environmental Factors and Plan

7. 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 behavioral health 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 behavioral health 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 behavioral health 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 programs requirements, including quality and safety standard? (●) Yes ( ) No

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

No

Please indicate areas of technical assistance needed to this section

No technical assistance is needed at this time.

Footnotes:

Environmental Factors and Plan

8. 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**[59] 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.

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

Please respond to the following items:

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

The State of Michigan has conducted eight consultation sessions with federally recognized Tribes during 2017.

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

Specific concerns raised included: MISACWIS access, assorted funding concerns (including Medicaid Administration, grant funding, and behavioral health funding), coverage for traditional medicine, state and county border policies, federal and state language conflicts, transportation, and Indian Outreach Workers.

Does the state have any activites related to this section that you would like to highlight?

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

In addition to the formal consultation noted in response #1 above, the Michigan Department of Health and Human Service's Behavioral Health and Developmental Disabilities Administration 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 to this section

No technical assistance is needed at this time.

Footnotes:

Environmental Factors and Plan

9. 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:

- ***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;
- ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- ***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;
- ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- ***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

- [x] Data on consequences of substance using behaviors
- [x] Substance-using behaviors
- [x] Intervening variables (including risk and protective factors)
- [ ] Others (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)
- [ ] Adults (ages 27-54)
- [ ] 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)

- [x] Archival indicators (Please list)

Consumption data
Outcome data
Consequence data

- [x] National survey on Drug Use and Health (NSDUH)
- [x] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [x] Monitoring the Future
- [x] Communities that Care
- [x] State - developed survey instrument
- [ ] Others (please list)

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

If yes, (please explain)

We encourage regional entities (PIHPs) to readjust spending of primary prevention funding by prevention strategy, based on needs assessment.

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

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

None at this time.

Please indicate areas of technical assistance needed related to this section

No technical assistance is needed at this time.

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:

- ***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 Manager.

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. Training needs and technical assistance is determined by an advisory committee of the training contractor 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

We have used the Community Readiness Survey Model (Tri-Ethnic) to assess community readiness.

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

None at this time.

Please indicate areas of technical assistance needed related to this section

No technical assistance is needed at this time.

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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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)** [x] Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [x] Cultural competence component
- **g)** [x] 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. We have attached the link to the guidelines for selecting evidence-based practices.

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

None at this time.

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

No technical assistance is needed at this time.

Narratve Question

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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 fair, community round table
Speaking engagement (direct)–Presentation about SUD
Speaking engagement (indirect)– Radio or TV interview, print media

b) Education:

Classroom curriculum such as Botvin Life Skills, Project Alert
Teaching Anger Management to students at an alternative high school
Teaching Strengthening Families Program to parents

c) Alternatives:

Supervision and guiding ATOD free recreational event
Supervision and guiding Community events
Supervision and guiding Youth/Adult Leadership events

d) Problem Identification and Referral:

Student assistance program, 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 sales tobacco – Synar
Prevention of underage sales alcohol

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

We monitor SABG spending for primary prevention services via contract and consultation staff. Financial reports are submitted on a monthly basis to contract and consultation staff.

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

None at this time.

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

No technical assistance is needed at this time.

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.

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

The evaluation plan is attached.

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

- **a)** [x] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** [x] Includes evaluation information from sub-recipients
- **c)** [x] Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** [x] Establishes a process for providing timely evaluation information to stakeholders
- **e)** [x] 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)** [x] Numbers served
- **b)** [x] Implementation fidelity
- **c)** [x] Participant satisfaction
- **d)** [x] Number of evidence based programs/practices/policies implemented
- **e)** [x] Attendance
- **f)** [x] 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)** [x] 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** [x] Heavy use

- [x] Binge use
- [x] Perception of harm

c) [x] Disapproval of use

d) [x] Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) [ ] Other (please describe):

Footnotes:

Evaluation Plan for SABG Prevention Activity

The Office of Recovery Oriented Systems of care is currently working on a formal evaluation plan for substance use disorder prevention activity, per prevention priority and related activity, funded via the Substance Abuse Block Grant. The evaluation plan will include the following components:

- Establishment of prevention priorities based on needs assessment
- Establishment of population to be served
- Development and selection of measurable goals, related objectives and evidence-based strategies to address the prevention priorities
- Measure Fidelity of strategies employed
- Development of timeline to achieve goals, objectives and strategies
- Selection of indicators for tracking/monitoring progress toward meeting goals including baseline, benchmarks and proposed level of goal achievement given the duration of the funding
- Identification and selection of relevant data sources that would provide key indicators to track progress
- Identifying data issues and caveats to the data sources and indicators selected.
- Establishment of methodology for monitoring progress toward outcomes including benchmarks

Please note the following example for an evaluation plan for the prevention for a priority area:

I. Priority area based on needs assessment: Underage drinking
II. Population to be served: Adolescents w/SA and or /MH, Children/Youth at Risk for BH Disorder)
III. Goal: Childhood and underage drinking is reduced.
IV. Objective: Reduce childhood and underage drinking.
V. Strategies:
   A. Increase multi-system collaboration to implement strategies identified in the Underage Drinking Strategic Plan.
   B. Reduce adult abuse by engaging all segments of the community in establishing a recovery-oriented system of care and increase the use of brief intervention
   C. Engage parents and other adults in helping reduce underage drinking.
   D. Community coalitions will implement at least one environmental or community based process strategy each year.

E. Continue to build and enhance community substance abuse prevention infrastructure and capacity by strengthening collaboration with primary care providers to implement screening, brief intervention and referral (SBIR)
F. Recommend the use of Communities that Care, Community Trials, Strengthening Families and Prime for Life.

VI. Timeline: Two years – 2017 – 2019

VII. Selection of Indicators:
A. Past 30 day use of alcohol among youth 9th – 12 grade will be reduced
B. Baseline: FY 15 – 25.9 percent of youth
C. First Year: FY 18 Target – 24 percent of youth
D. Second Year: FY 19 Target – 23 percent of youth
E. Fidelity to Evidence-based strategies

VIII. Data Sources and methodology used to track progress
A. Michigan Profile for Healthy Youth (MiPHY) – Student survey administered every even year via computer state wide to middle and high schools in Michigan. Provides county level data
B. Michigan Youth Risk Behavior Survey (YRBS) – Student survey administered ever odd year via computer statewide to middle and high school students. Provides state level data only.
C. National Survey on Drug Use and Health (NSDUH) – Nationwide telephone survey provided to persons 12 and over every two years.

IX. Data Issues and Proposed Remedies
A. MiPHY – Without full participation of schools within school districts, county level data will be compromised. Remedy: Use coalitions to increase school participation in MiPHY.
B. YRBS – Provides state level data only. Remedy: None
C. NSDUH – While state level data reported every two years may be generalizable, data remains behind trends identified much sooner. Sub-state level data are reported a year or two after state level data reports are released. Remedy: None at this time.

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.

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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.

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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.

<u>What is a Peer Review Journal?</u>

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.

<u>When using peer review journals to determine whether an intervention has evidence of effectiveness:</u>

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. <u>Collaborative activities should be considered under the following criteria:</u>

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. <u>In addition to the above criteria, the following should be considered when conducting community-based processes:</u>

- 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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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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TELECONFERENCE

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Washington, D.C.

11/1/2004
Prevention Ethics Worksl
Las Cruces, New Mexico

11/3/2004
Take the Lead Preventioı 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.

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

Youth Conference
St. Paul MN

11/11/2004

CADCA Calendar

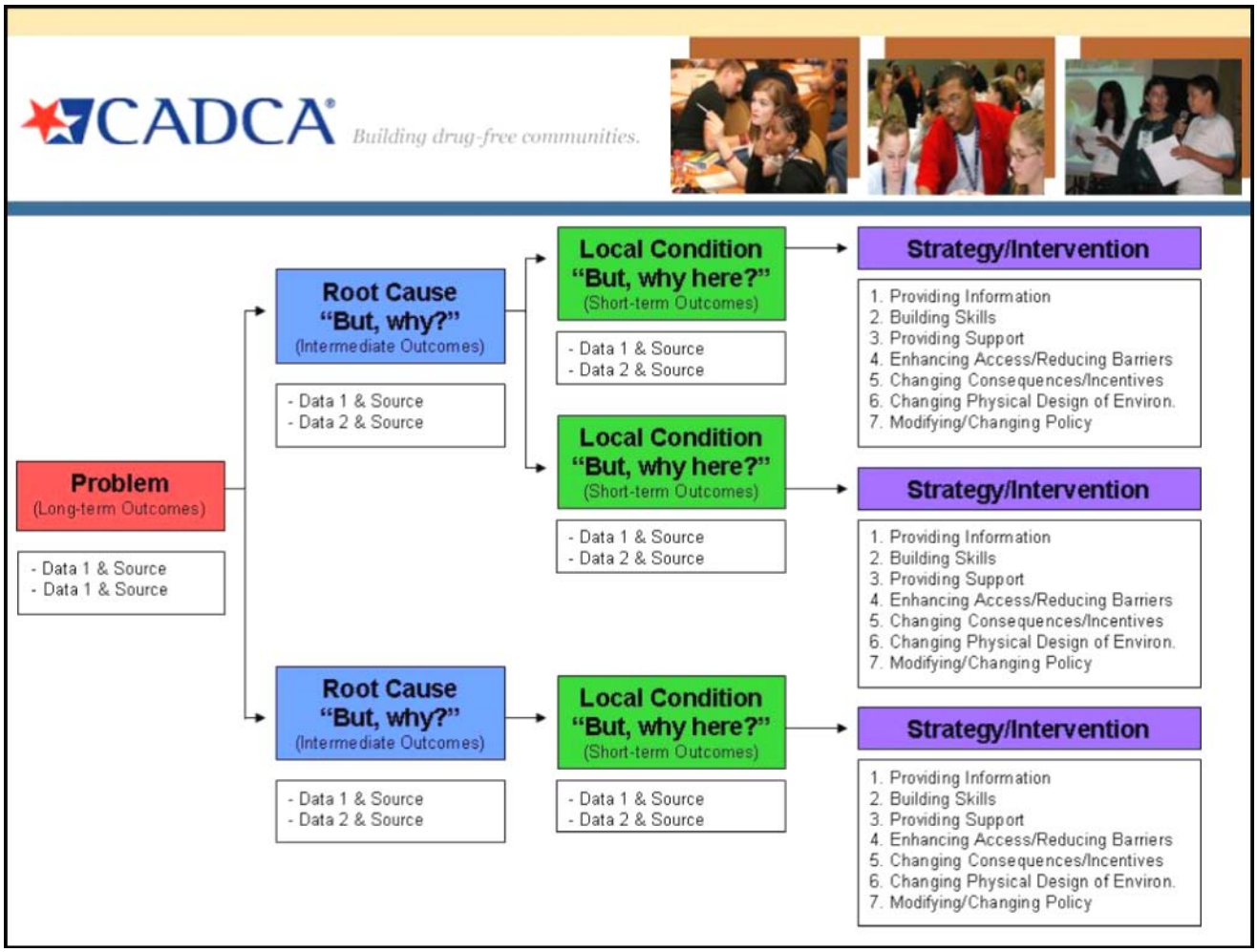
SAMPLE LOGIC MODEL

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 **Downstream Consequences (Health and Social Consequences)** % of young adults in treatment for meth addiction decreases % of meth arrests as a proportion of all drug-related arrests decreases % of meth related ER/Hospital visits 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 intend 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	
	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	

[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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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
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
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.
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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
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?			

NREPP 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:

MICHIGAN'S STATE PREVENTION ENHANCEMENT PROJECT AND FIVE-YEAR STRATEGIC PLAN

Michigan Department of Community Health
Bureau of Substance Abuse and Addiction Services

July 2012

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MICHIGAN'S STATE PREVENTION ENHANCEMENT PROJECT AND FIVE-YEAR STRATEGIC PLAN

INTRODUCTION

Michigan is a coastal state with picturesque lakes, a large, culturally diverse population, and a diversified economy. In 2010, it ranked as the nation's eighth largest state with an estimated 9,883,640 people.[1] Its diversity is manifested by a patchwork of racial, linguistic, geographic, gender, age, and socio-economic characteristics. Approximately, 79% of the state's population is White, 14% African American, 4.4% Hispanic, 2.5% Asian/Pacific Islander, and 0.6% Native American. English is the primary language spoken at home by 91% of the residents of Michigan, followed by languages other than English 9%, and Spanish 2.9%.[2]

An estimated 47% of Michigan's population resides in Southeast Michigan (Lapeer, Livingston, Macomb, Oakland, St. Clair, Washtenaw and Wayne Counties), according to the 2010 Census. Although minority populations reside throughout the state, there are concentrated sectors as follows: About 70% of all African Americans in Michigan reside in Southeastern Michigan, primarily in Wayne and Oakland counties; 43% of Michigan's total Hispanic population resides in Southeast Michigan; and higher densities of Asian-Americans tend to be in Western and Southeast Michigan. The largest Arab American and Chaldean population in the United States primarily resides in Wayne, Oakland and Macomb Counties, and combined, estimated population whose ancestry is Arab American and Chaldean totals 490,000.[3] In addition, many of the 12 federally acknowledged Native American tribes live in the northern part of Michigan.[4] Almost 14% of the state's population is over 65 years-of-age, with 24% under 18 years-of-age. An estimated 51% of the state's population is female; 49% is male.[5]

Michigan's population whose education level is completion of high school or higher remains above U.S. estimates. Eighty-eight percent of Michigan's residents, 25 years-of-age and older, possess a high school diploma or equivalent, and 33% have attained an Associate's Degree or higher. While Michigan tends to have a higher percentage of high school graduates than the U.S., the state trends for attainment of a Bachelor's degree remain lower than the national average.[6]

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1 U.S. Bureau of the Census. (2010).Population of Michigan by single year of age, race, sex, and Hispanic origin. Retrieved from *http://www.michigan.gov/cgi/0,4548,7-158-54534_51713_51714-261003--,00.html*.

2 U.S. Bureau of the Census. (2008-2010). American community survey. Retrieved from *http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_3YR_DP02&prodType=table*

3 The Arab American Institute. (2011). Demographics. Retrieved from *http://www.aaiusa.org/pages/demographics/*.

4 State of Michigan. (2010). Michigan tribal governments. Retrieved from *http://www.michigan.gov/som/0,1607,7-192-29701_41909---,00.html*.

5 U.S. Bureau of the Census. (2008-2010). American community survey. Retrieved from *http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_3YR_DP05&prodType=table*.

6 U.S. Bureau of the Census. (2008-2010). Educational attainment. American community survey. Retrieved from *http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_3YR_DP02&prodType=table*.

Michigan's socio-economic profile reflects a diverse set of industries, including agricultural, construction, manufacturing, wholesale trade, retail, transportation, financial, professional, scientific, education, health service, arts, entertainment, food service and public administration. However, from 2000 to 2008, Michigan has lost over 500,000 jobs in the manufacturing sector, primarily due to the downturn in the auto industry.[7]

Michigan's preliminary annual average unemployment rate of 10.4% in 2011 dropped by over two full percentage points from the 2010 annual rate of 12.5%. The national annual average unemployment rate in 2011 was 8.9%, seven-tenths of a percentage point below the 2010 annual rate of 9.6%. The state's 2011 preliminary annual jobless rate was nearly three full percentage points below Michigan's recent high unemployment rate of 13.3% in 2009. However, Michigan's unemployment rate remains elevated relative to historical levels.[8]

From 2010 to 2011, the average annual number of unemployed declined in Michigan by 110,000 or 18%, while total employment moved upward by 23,000 or 0.5%. The state's labor force dropped by 87,000 or 1.8% during 2010. This reflects the long-term trend in Michigan, with the state's workforce decreasing consistently since 2006. Although unemployment declined in 2011, the average number of weeks that individuals remained unemployed in Michigan increased from 40 weeks in 2010 to 45 weeks in 2011.[9]

The percentage of individuals living below the poverty line in Michigan has changed significantly over the last nine years, individual poverty rates for Michigan changed from 10.1% in 2000 to 14.4% in 2008 to 16.8% in 2010, while the U.S. individual poverty rate was 12.2% in 2000, 13.2% and 14.3% respectively. The percentage of families living below the poverty line showed a similar trend, the family poverty rate for Michigan was 7.7%, while the U.S. family poverty rate was 9.3% in 2000. In 2010, Michigan's family poverty rate was estimated as 12.1% and that of the U.S. was 10.5%.[10]

As of February 2012, over 158,000 residents are eligible to receive Family Independence Payments; 1.84 million are eligible for the Food Assistance Program; 8,926 are eligible to receive State Disability Assistance; 66,447 are eligible to receive Child Care and Development services; and 1.92 million are eligible to receive Medicaid benefits.[11]

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7 American Manufacturing Trading Action Coalition. (2008). Quick fact sheet for Michigan's worsening eight-year depression: paying the price for $1 trillion in U.S. auto-trade losses. Retrieved from http://www.amtacdc.org/SiteCollectionDocuments/2008/09%2026%2008%20Michigan%20factsheet.pdf.

8 Michigan Department of Technology, Management, and Budget. (2012). Michigan's December unemployment rate declines: 2011 Annual rate drops. Retrieved from *http://www.michigan.gov/documents/dmb/LMI-JanuaryRelease_373934_7.pdf*.

9 Ibid.

10 U.S. Bureau of the Census. (2009). American community survey. Retrieved from http://factfinder.census.gov/servlet/

11 Michigan Department of Human Services. (2012). Green book report of key program statistics. Retrieved from *http://www.michigan.gov/documents/dhs/DHS-PUB-0064_271204_7.pdf*.

MICHIGAN'S STATE PREVENTION ENHANCEMENT PROJECT

The primary purpose of Michigan's State Prevention Enhancement (SPE) project was to strengthen and expand Michigan's prevention framework; thereby increasing state capacity to support effective substance abuse and mental health promotion services across systems.

Since 2009, Michigan has adopted the recovery oriented systems of care (ROSC) concept as the core philosophy for the design and delivery of SUD prevention, treatment, recovery and mental health promotion services. The ROSC will be used as a roadmap on how to align substance abuse prevention and fiscal infrastructure with other state and community-level partners. Prevention prepared communities (PPCs) are essential to the successful implementation of a ROSC.

The increased capacity developed through the SPE Project will allow Michigan to implement the Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Initiative number one: Prevention of Substance Abuse and Mental Illness. By implementing Strategic Initiative #1, Michigan is developing five PPCs effective in achieving the following goals:

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

Based on the various need indicators including: non-medical use of pain relievers; level of past 30-day use of alcohol and binge drinking among youth 12-20 years-of-age; alcohol involved deaths and serious injuries; past year psychological distress; past year major depressive episode; and age-adjusted suicide rates, the following five high need communities were selected as sites for the development of PPCs: Riverhaven Coordinating Agency; Kalamazoo Community Mental Health and Substance Abuse Services; Mid-South Substance Abuse Commission; Pathways to Healthy Living; and Western Upper Peninsula Substance Abuse Services (CA).

These communities encompass 36 of 83 counties in Michigan and will develop and build capacity for prevention that will be effective in serving multi-racial, urban, and rural populations including: Hispanics; Arab Americans; Native Americans; lesbian/gay/bisexual/transgender/questioning/intersex (LGBTQI) youth and their families; and military families.

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Based on the success of these five communities in achieving the goals outlined above, the Bureau of Substance Abuse and Addiction Services (BSAAS) will provide a template for statewide expansion of PPCs.

FOUR MINI-PLANS

Required for inclusion according to the "Directions for completing the 5-year Strategic Plan." This is a summary of the progress and accomplishments made to date in meeting the goals and objectives outlined in the four mini-plans that comprise Michigan's Capacity-Building/Infrastructure-Enhancement Plan submitted at the end of the 3rd month of the grant.

Mini-Plan for Data Collection, Analysis and Reporting

1. State Epidemiological Outcomes Workgroup

   Michigan has maintained a functioning State Epidemiological Outcomes Workgroup (SEOW) that was implemented as part of the Strategic Prevention Framework, State Incentive Grant (SPF/SIG). 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 by incorporating mental health data that will allow us to create state and community profiles that share common indicators, intervening variables and consequences related to mental emotional and behavioral (MEB) disorders.

   Membership on the SEOW includes representatives of various state-level departments, including the Department of Community Health (MDCH), Department of Education (DOE), and Michigan State Police (MSP), as well as regional substance abuse coordinating agencies (CAs), community coalitions, and the Michigan Primary Care Association. The SEOW also includes a Centers for Disease Control and Prevention (CDC) fellow assigned to the state to research epidemiological trends related to alcohol use. The chairperson on the SEOW is the lead epidemiologist for the Department of Community Health.

   Michigan will be completing the second year of the CSAP funded SEOW project. To date, deliverables submitted to CSAP include a state charter; state-level epidemiological profile; community-level epidemiological profile; and a dissemination plan for products submitted by the SEOW.

   Also, currently under development by the SEOW is a web-based central data repository linking all the federal and state data sources that can be easily accessed and updated.

   Through BSAAS collaboration with MDCH, Bureau of Disease Control, Prevention, and Epidemiology, Michigan DOE and the MSP, the SEOW has direct access to state-level surveillance systems, as well as relevant primary and secondary data, on an annual basis. The SEOW also obtains, on an annual

basis, data directly from federal data sources, including the National Survey on Drug Use and Health (NSDUH) and the Drug Abuse Warning Network (DAWN).

For its initial activities, including the review of data sources, assessment of data quality and data utility, followed by its recommendations for prioritization of problems, Michigan's SEOW reviewed and utilized the State Epidemiological Data System (SEDS) indicators developed by SAMHSA for the SPF/SIG process. A listing of some of the major surveillance systems and indicators used during that process are included below. With the expansion to a SEOW model, mental health and other new domains will be examined using some of the same methodologies that were established to support the SPF/SIG process. The latter are highlighted by an asterisk (*).

Nationally Recognized Data Sources Utilized:

- National Survey on Drug Use and Health (NSDUH)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Treatment Episode Data Set (TEDS) - Admissions & Discharges
- Drug Abuse Warning Network (DAWN)
- Fatality Analysis Reporting System (FARS)

State-specific data sources utilized:

- **Child Adolescent Functioning Assessment Scale (CAFAS)*:** [MDCH, Bureau of Community Mental Health Services, Division of Mental Health Services to Children and Families (MHSCF)] The public mental health system utilizes standardized CAFAS subscales to assess a youth's functioning in the following domains: school/work, home, community (reflects on delinquent behavior), behavior toward others, moods/emotions (reflects on depression and anxiety, primarily), self-harmful behavior, substance use, and thinking (reflects major thought problems or severe communication problems). There are also two parent/caregiver subscales that assess basic needs/material and parent support. These tools provide historical data to assist the workgroup in refining priorities and action strategies.

- **Michigan Death Certificates:** (Michigan Department of Community Health, Bureau of Epidemiology, Division for Vital Records and Health Statistics) The death certificate database is a computerized dataset containing demographic and cause of death information for all Michigan residents (out-of-state deaths included) and non-Michigan residents dying in Michigan. Death certificates are one of public health's vital records for monitoring the health of citizens. Death certificates are used to determine the prevalence of acute and chronic alcohol and drug related mortalities in the state of Michigan.

- **Michigan Behavioral Risk Factor Surveillance System (BRFSS):** (Michigan Department of Community Health, Bureau of Epidemiology) The Michigan

BRFSS is the only source of estimates in the prevalence of certain health behaviors, conditions, and practices associated with the leading causes of death among adults. The BRFSS is used to determine the prevalence of alcohol, tobacco and other drug (ATOD) consumption and risky behaviors associated with ATOD for Michigan residents. The survey also annually collects health-related quality of life measures, including the number of days in the past month where a respondent's poor mental health (stress, depression, problems with emotions) interfered with daily activities. Estimates are based on annually collected data from a random-digit dial telephone survey of Michigan households. The proposed sample size for 2011 was 9,000 participants, with 600 cell phone users contributing. Statewide estimates are produced annually, and multiple years of data can be grouped to provide regional and county estimates for those with larger populations.

- **Michigan Traffic Crash Facts (MTCF):** (The Michigan State Police, Criminal Justice Information Center) The basic purpose of the MTCF is to provide data users the ability to analyze data to make Michigan roads safer and to save lives. This includes, but is not limited to, vehicle engineering, roadway engineering, occupant protection, Department of Natural Resources regulations, education, emergency medical care, along with the ability to assess if new or improved laws need to be implemented. MTCF is used to estimate the prevalence of alcohol-related automobile accidents and incidents. Information can be obtained on traffic crash summaries, reported alcohol involvement and age of drivers, by county. The database retains information for the current year, plus 10 previous years. Michigan Traffic Crash Facts consist of archives to 1992 with online data to 2004.

- **Michigan Inpatient Database (MIDB)*:** (Michigan Health and Hospital Association) These data help support the state health planning activities, and are used by healthcare facilities for internal evaluation. At MDCH, the Vital Records and Health Data Services Section of the Division for Vital Records and Health Statistics develop annual library tables containing discharge rates and length-of-hospital stay for various ICD-9-CM groupings, by age, sex, and county. Reports cannot be published that identify individual hospitals. The MIDB data are routinely used for public health surveillance, including annual provision of estimates on preventable hospitalizations. The MIDB will be used to provide prevalence estimates of alcohol- and drug-related hospitalizations for Michigan residents at both state and local (at least regional) levels. These data can also be used to examine hospital discharges related to mental health issues, although the data quality may be compromised due to reporting constraints associated with privacy concerns.

- **Michigan Youth Risk Behavior Survey (YRBS):** (Michigan Department of Education oversees the implementation of the Michigan YRBS.) The YRBS is part of a nationwide surveying effort led by the CDC, to monitor students' health risks and behaviors identified as most likely to result in adverse outcomes. The

YRBS is administered statewide to students in grades 9-12, every other year. The YRBS includes indicators related to ATOD use, including the illegal use of prescription drugs, unintentional injury, school violence, dietary behaviors, physical activity, depression and suicide, and sexual behavior that contributes to unintended pregnancy or disease. The YRBS provides state but not local-level estimates.

- **Michigan Profile for Healthy Youth (MiPHY):** (Michigan Department of Education) The MiPHY survey is administered during the years that the YRBS is not conducted. The survey is intended to secure information from students in grades 7, 9 and 11, regarding health risk behaviors including substance abuse violence, physical activity, nutrition, sexual behavior and emotional health in individual, school, community and family domains. The MiPHY results are extrapolated at the county level, and are useful for data-driven decisions to improve prevention programming performed at schools within the county.

- **Uniform Crime Reports:** The Michigan State Police is responsible for collecting this data from all law enforcement agencies within the state of Michigan, per Public Act 319 of 1968, and submit the data to the Federal Bureau of Investigation (FBI) Uniform Crime Program. This data is used to create the annual "Crime in Michigan" report that is published on the web every year, which is then forwarded to the FBI Uniform Crime Reporting Program. This data is also used by the governor, legislature, police agencies, and the general public to determine crime trends. MSP Uniform Crime Reports are also used to determine the prevalence of alcohol and drug-related crimes occurring in Michigan.

- **Liquor Licenses:** (Michigan Liquor Control Commission) The Michigan Liquor Control Commission collects data to determine the quota of issued and existing licenses. Liquor licenses are used to determine the density of alcoholic beverage outlets in urban and rural parts of Michigan.

- **Michigan Prevention Data System:** (BSAAS) Michigan has established a web-based Prevention Data System (PDS) used by all prevention providers and CAs to collect and report process and capacity data, which has been effective for both state- and community-level data collection. In addition to basic information related to core strategies and demographic information of the recipient, the number of evidence-based programs are reported to and captured in the PDS. BSAAS submits aggregate reports on prevention service capacity to SAMHSA in accordance with Substance Abuse Prevention and Treatment Block Grant reporting guidelines.

2. Michigan has developed several epidemiological planning tools for state and local communities:

   A. Michigan has a 2012 state-level epidemiological profile which may be found at www.michigan.gov/documents/mdch/Final_MI_Epi_Profile__2012_382198

_7.pdf. Additionally, regional epidemiological profiles are available for each of the five SPE CA communities and, most recently, the eleven expansion CA communities.

B. Currently under development is a web-based central data repository linking all the federal and state data sources that can be easily accessed and updated. This will be key for use by state, regional, and local groups assessing prevention needs and measuring outcomes.

C. Remaining efforts to be accomplished in the Data Collection, Analysis and Reporting Mini-Plan by the end of the capacity development year of the SPE grant:

- Expand representation of key stakeholders on the SEOW, including members of the recovery, Native American, Hispanic, Arab American, lesbian/gay/bisexual/transgender, and military communities.

- Develop and administer environmental scans to physicians, pharmacists and dentists to determine knowledge level of prescription drug abuse and opportunities for education and awareness around the subject.

- Increase state and community level data sources available to assess mental health issues in communities, and the link to risk and protective factors, life stressors, and other potential indicators.

Mini-Plan for Coordination of Services

1. The Bureau of Substance Abuse and Addiction Services (BSAAS) functions as the Single State Authority within the Michigan Department of Community Health (MDCH). Responsibilities include the administration of federal and state funding for substance abuse prevention, treatment, recovery, and gambling addiction. BSAAS allocates the Substance Abuse Prevention and Treatment Block Grant (SAPT BG) funding through 16 regional coordinating agencies (CAs), whose responsibilities include planning, administering, funding, and maintaining the provision of substance abuse treatment and prevention services for 83 counties in Michigan. All CAs, including the five CAs participating in the SPE Grant Project, have prevention coordinators (PCs), who receive input from and empower local communities in their response to substance abuse prevention needs.

2. Mental health and developmental disability services in Michigan are delivered through county-based community mental health services programs (CMHSPs). MDCH, along with 46 regional CMHSPs, contracts public funds for mental health and developmental disability services. Medicaid funds, which are paid on a per Medicaid-eligible capitated basis, are contracted with CMHSPs, or affiliations of CMHSPs, as prepaid inpatient health plans (PIHPs). Each region is required to

have an extensive array of services that allows for maximizing choice and control on the part of individuals in need of service. Individual plans of service are developed using a person-centered planning process for adults, and a person-centered process and family-centered care for children. MDCH is actively promoting values of recovery and resiliency. MDCH contracts with 18 of its PIHPs to provide Medicaid specialty services. Limited outpatient mental health services are available through Medicaid health plans (MHPs).

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

4. Since 2002, BSAAS has parlayed and leveraged the strength and value of our state and community level prevention infrastructure by securing four major awards specific to substance abuse prevention: 1) State Incentive Grant (SIG); 2) SPF/SIG; and the 3) Center for Substance Abuse Prevention (CSAP) State Epidemiology Outcomes Workgroup (SEOW) award; and the State Prevention Enhancement Grant.

   A. Deliverables from these four awards have strengthened our infrastructure systemically to:

      - Foster the use of a data-driven planning process.
      - Expand the use of evidenced-based programs.
      - Develop epidemiological profiles and logic models.
      - Undertake collaborative efforts with prevention, treatment, mental health and primary care.

      This has increased state and local capacity to address mental, emotional and behavioral conditions that support and improve the quality of life for citizens of Michigan.

   B. Implemented as part of the SPF/SIG grant, BSAAS convened the Evidence-Based Practices Workgroup (EBPW) and the Childhood and Underage Drinking Workgroup (CUAD).

- The EBPW provided guidance on the implementation of effective, evidence-based policies, programs and practices. Members of the EBPW included representatives from coalitions, MDE, CAs, OHSP, school health coordinators, and prevention providers. The workgroup published a guide in January 2012 for selecting evidence-based practices that will strengthen the development of sound prevention systems and strategies, and increase the ability of the system to identify and select appropriate evidenced-based interventions. This document may be found at http://www.michigan.gov/documents/mdch/Mich_Guidance_Evidence-Based_Prvn_SUD_376550_7.pdf. For the past decade, BSAAS has also required CAs to assure that a minimum of 90 percent of services funded are evidenced-based.

- The CUAD provided and distributed a best practice blueprint for preventing underage drinking at the community level, employing evidence-based and environmental strategies in 2010. This document may be found at http://www.michigan.gov/documents/mdch/Blueprint_for_Michigan_336742_7.pdf. The CUAD recently participated in the planning of an underage drinking video funded by CSAP. Members of this workgroup include representation from Michigan Beverage Association, OHSP, coalitions, prevention coordinators, and prevention providers.

C. In response to the epidemic of prescription and over-the-counter drug abuse in Michigan, BSAAS has identified the reduction of prescription and over-the-counter drug abuse as a priority focus. An interdisciplinary workgroup was established, consisting of a physician, prevention coordinators, (including prevention coordinators from the communities selected for the SPE Project), MDE staff, OHSP staff, Department of Human Services (DHS) staff, a pharmacist, Prevention Network (PN) staff, and coalitions. This team developed the Prescription and Over-the-Counter Drug Abuse Strategic Plan, http://www.michigan.gov/documents/mdch/RxOTC_Drug_Abuse_Strategic_Plan_Final_389362_7.pdf.

D. Historically, the MDE and BSAAS have coordinated funding, planning and programming of prevention initiatives including administration of the Governor's Discretionary Grant, Safe and Drug Free Schools and Communities funding and development and marketing of the Michigan Profile for Healthy Youth. A representative from MDE serves on the ROSC Transformation Steering Committee, the SPE Policy Enhancement Consortium, the SEOW, and the Prescription and Over-the-Counter Drug Abuse Workgroup. In 2011, a representative from BSSAS served on MDE's Strategic Planning Team for Building State Capacity for Youth Substance Use and Violence Prevention.

5. The required inclusion of government agencies and community stakeholders in the grants referenced above has helped to facilitate the Recovery Oriented

System of Care (ROSC) in Michigan. The ROSC Transformation Steering Committee (TSC), an advisory group to the BSAAS, has established several workgroups, one of which is the Prevention Workgroup. This workgroup serves as the SPE Policy Consortium.

Membership of this group includes representatives from the Michigan Association of Substance Abuse Coordinating Agencies (MASACA), MDE, OHSP, the five CAs participating in the SPE Grant Project, substance abuse coalitions, faith-based agencies, prevention providers, and administrators.

The state SPE Policy Consortium provided invaluable input into capacity building and infrastructure enhancement in the five SPE CA communities by coordinating and providing feedback to the development, implementation, and evaluation of the four mini-plans in "The Capacity Building/Infrastructure Enhancement Plan." In addition, the state SPE Policy Consortium will develop, implement, and provide coordination and oversight responsibilities for this comprehensive, five-year State Strategic Prevention Plan.

6. Prevention Network (PN) is another partner involved in the established organizational structure that works together to coordinate and allocate funding to high-need communities. PN provides support, training, technical assistance and mini-grants to grassroots community groups to offer a full continuum of substance abuse prevention services. As part of PN, the Michigan Coalition to Reduce Underage Drinking (MCRUD) assists local communities across the state, including the five communities participating in the SPE Grant Project, specifically with underage drinking initiatives. From 2004 to 2010, BSAAS and OHSP braided federal and state funding to support underage drinking initiatives conducted by PN.

7. The Michigan Inter-Tribal Council (ITC) has been an integral partner for SPF/SIG, SEOW and the Training Cadre, and BSAAS has supported substance abuse training to member tribes of the ITC. Two of the tribal communities – Little Traverse Bay Band and Grand Traverse Bay Band – are SPG/SIG Grant recipients and have participated in learning communities and technical assistance sessions provided by BSAAS. This relationship exemplifies an ongoing process and support system that addresses and responds to the substance abuse prevention related needs of tribes and tribal organizations in the state.

8. BSAAS has recently developed partnerships with the Michigan National Guard and the Michigan Primary Care Association (MPCA). The Michigan National Guard is an active participant on the Prescription and Over-the-Counter Drug Abuse Task Force. MPCA has become an active participant in the SEOW. Although relatively new to collaborative efforts with BSAAS, the partnership with this these two organizations will continue to be strengthened through the implementation of this five-year plan.

9. Under the direction of the SPE Policy Consortium, the evaluator from Wayne State University completed a Work Force Development Scan and an Environmental Scan in the five SPE CA regional communities. These were web-based surveys distributed through the CAs to their substance abuse prevention and treatment providers and local coalitions.

   There were 63 respondents to the Work Force Development Scan focused on describing: prevention services and clientele served; career/workplace attributes; and training and technical assistance needs. The report of this scan is at http://www.michigan.gov/documents/mdch/Workforce_Development_Survey_Report_Final_4_27_12_389418_7.pdf.

   There were 67 respondents to the Environmental Scan focused on describing: organizational characteristics, readiness to become a PPC and support ROSC, barriers to integration, training needs, and data collection. This report is at http://www.michigan.gov/documents/mdch/Environmental_Scan_Survey_Report_FINAL_4_23_12_389417_7.pdf.

10. Wayne State University will complete two more environmental scans by the end of the grant year targeting mental health and primary care service providers in the five SPE CA regional communities. This will provide data identifying strengths and challenges that may exist in collaboration and integration of services.

11. In response to information gathered through the Work Force Development and Environmental Scans of prevention and treatment and under the direction of the SPE Policy Consortium, training was provided to the five SPE CA regional communities to help their local coalitions to:

    - Assess their progress in establishing a recovery oriented system of care and identify next steps appropriate for their coalition to take in order to strengthen ROSC at the local level.

    - Learn more about how to become a prevention prepared community.

    - Identify and work with new collaborative partners.

    One hundred thirty-four individuals attended the trainings: Western UP (14), Eastern UP (23), Kalamazoo (46), Bay Arenac/Riverhaven (21), and Mid-South (30).

    The two trainings in the Upper Peninsula were scheduled for four hours each and the three CA regions in the Lower Peninsula held three hours sessions. The agenda included a PowerPoint presentation developed by the SPE Policy Consortium, completion of an extensive Local Community Readiness

Assessment activity, a case study on ROSC, updates on training plans, and a brief discussion on forming relationships with other agencies, groups, and organizations.

Generally, the trainings were well received though reactions were different in each of the regions. Comments about what was most helpful about the training were mixed but people definitely liked and intended to use the Local Community Readiness Assessment tools. Many people found the PowerPoint presentation to be helpful.

Wayne State University provided a compilation of the evaluations of the trainings using a four-point scale, with 1 representing Strongly Disagree and 4 representing Strongly Agree. On all objectives the mean scores for all five trainings together were 3.1 or higher. Mean scores evaluating the objectives for the individual trainings were 3.0 or higher with the exception of participants reporting learning more about ROSC. On this particular item, participants in regions in the Lower Peninsula did not "Strongly Agree" that they learned more as frequently (two of the three regions averaged 2.9) as the two regions in the Upper Peninsula who averaged 3.4 and 3.5. An explanation for this is that participants in the Lower Peninsula may have previously had access to more training and discussions on developing Recovery Oriented Systems of Care than the Upper Peninsula regions. Members of the SPE Policy Consortium had suggested this might be the case, which is why the training in the Upper Peninsula was scheduled for four hours and the Lower Peninsula for three.

12. This training will become part of a Prevention Prepared Community Tool-Kit that will be developed before the end of the grant year and made available to communities across the state as part of the expansion of SPE over the next five years.

Mini-Plan for Technical Assistance and Training

BSAAS provides training and technical assistance to the prevention, treatment and recovery practitioners in the state, via a contract through the Michigan Prevention, Treatment, and Education (MI PTE) Project. Funding for the training and technical assistance is supported by the SAPT Block Grant and state general fund dollars. Historically, about one third of the training budget had been dedicated to prevention.

An assessment of training and technical assistance needs is conducted by BSAAS, based on the requests provided by CAs in their action plans for prevention, treatment and recovery. Another assessment of training is conducted by the advisory committee to the MI PTE Project. These assessments are reviewed and prioritized by BSAAS staff and are incorporated into a training plan. Content experts in the state are identified and secured for training and technical assistance sessions. For the dissemination of prevention technology statewide, BSAAS employs a training cadre consisting of state of Michigan and community professionals.

Training and technical assistance on the application of evidence-based practices, including the design and implementation of a ROSC, has also been provided by CSAP, Center for Applied Prevention Technology (CAPT), and the Center for Substance Abuse Treatment (CSAT) Great Lakes Addiction, Treatment and Recovery Center (GLATRC.)

In an effort to encourage workforce development, the cost to participants for training and technical assistance has been minimal and all workshops offer credit toward certification to encourage attendance by as many practitioners as possible. Training and technical assistance supported by CSAP and CSAT has greatly enhanced the expansion and diffusion of prevention, treatment and recovery technology in Michigan. The Central CAPT has provided financial support and experts for training and technical assistance related to the implementation of the SIG, SPF/SIG and the SEOW projects.

BSAAS also holds an annual substance abuse conference including workshops on evidence-based practices for prevention, treatment and recovery issues. The conference includes plenary sessions performed by national experts representing behavioral health administration and service delivery. In addition to the plenary session, workshops on specific topic areas are provided to conference participants. In each of the last three years, attendance at the conference averaged over 1,000 persons.

During this SPE grant year the following related trainings have been provided in the state of Michigan

- Michigan Behavioral Health & Prevention Webinar – offered twice and filled both times – for a total of over 50 participants.

- Prevention and the ROSC Framework Webinar – 25 participants.

- Suicide Prevention Prepared Communities training – 6 hour training provided by the Michigan Department of Community Health Violence Prevention Program Coordinator/Suicide Prevention Program Director. This training was offered in four of the five SPE CA regions reaching 116 participants.

SBIRT Training the Trainer Workshops are in process statewide to selected CA representatives, including the five SPE CA regions.

Mini-Plan for Performance Evaluation

The performance management and evaluation process and methodology are accomplished through various mechanisms. Michigan has established the Prevention Data System (PDS) to collect and process data, which has been effective for both state and community-level data collection. In addition to basic information

related to core strategies and demographic information of the recipient, evidence-based programs are reported to the PDS. This system is being expanded to allow pre- and post-assessment of program effectiveness and to track perception of harm, 30-day use, and behavior changes tied to national outcome measures (NOMs).

In addition, site visits are conducted by coordinating agencies (CAs) and the Bureau of Substance Abuse and Addiction Services (BSAAS.) The focus of these site visits is to assure contract compliance, as well as provide technical assistance and quality assurance monitoring consistent with the fifth step of the SPF/SIG planning framework.

BSAAS also has developed closer collaboration with Wayne State University (WSU) to strengthen our evaluation processes.

DATA DRIVEN PRIORITIES

Required for inclusion per numbers 1 and 2 in the "Directions for completing the 5-year Strategic Plan." Using the 2012 Epidemiology Report prepared under the direction of the SEOW, the three priority need areas of reducing underage and adult problem drinking, preventing prescription drug abuse, and preventing suicide were affirmed and long-term and short-term consequences at the state and community levels are identified. This section also identifies and explains data-driven goals related to these priority need areas that can be quantified, monitored, and evaluated for change over time.

The following table shows data measuring consequences, consumption patterns, and intervening variables that may be used at the state, regional and local level to establish baseline measures for planning and developing data-driven goals for monitoring and evaluation.

From the Michigan Epidemiological Profile			
Area	***Consequences***	***Consumption Patterns***	***Intervening Variables***
Alcohol Use	***Youth:*** • Alcohol-Related Traffic Crash Deaths and Serious Injury (ARTCD/SI) • Underage Drinking (UAD) and Driving/Riding with Drinking Driver • Use Linked to Other Risky Behaviors and Consequences • Costs • Abuse and Addiction • ARTCD with Drinking Drivers Ages 16 to 25 **General/Adult:** • ARTCD • ARTCD/SI • Abuse and Addiction • Drove Vehicle After Drinking	***Youth:*** • *Current Use (last 30 days)* • *Lifetime Use* • *Early Initial Use* • *Binge Drinking* ***General/Adult:*** • *Current Use (last 30 days)* • *Heavy Drinking* • *Binge Drinking*	***Youth:*** • *Laws & Policies* • *Law Enforcement* • *Social Norms* • *Age of Onset* ***General/Adult:*** • *Safety Belt Use* • *Focus on ARTCD and UAD on statewide level*
Prescription Drug Abuse	***Youth:*** • *Overdoses, Poisonings, etc.* • *Related Risky Behaviors and Consequences* • *Death and Serious Injury from Impaired Driving/Riding* • *Abuse and Addiction* • *Related Crime (gap in data)* ***General/Adult:*** • Abuse and Addiction • Traffic Deaths and Injuries • Overdoses and Related Mortality	***Youth:*** • *Compared to Other States* • *Various Consumption Patterns* • *Special Population Patterns* ***General/Adult:*** • *National Data* • *Ranking Compared to Other States*	***Youth/General/Adult:*** • *Access: Point of Access and Disposal* • *Military Considerations* • *Social Norms* • *Perception of Risk* ***General:*** • *Access: Prescriptions Written* • *Social Norms and Perception of Risk*

Area	***Suicide Prevalence and Prevention***	***Depression and Serious Mental Illness Prevalence and Prevention***
Mental Health Indicators	**Youth:** • *Attempted Suicide* **General/Adult:** • *Suicide*	**Youth:** • *Depressive Feelings* • *Co-Occurrence of Depressive Feelings and Alcohol Consumption/Illicit Drug Use* • *Functioning Outcomes* **General/Adult:** • *Depressive Episode and Serious Mental Illness*

Note Priorities are shown above in Italics.

Alcohol Data

Alcohol Use Consequences - Youth

ALCOHOL-RELATED TRAFFIC CRASH DEATHS AND SERIOUS INJURIES

Youth may be killed or seriously injured as an innocent victim or as an impaired driver, and they may kill or severely injure others. Alcohol-related traffic crashes involving at least one driver 16-20 years-of-age who had been drinking, caused an annual average of 173 deaths and serious injuries (KAs) in Michigan each year between 2004 and 2010. Between 2004 and 2010, Michigan averaged 29 fatalities annually in which at least one driver was 16-20 years-of-age and had been drinking, with a corresponding rate of 2.9 deaths per million residents. The annual average of incapacitating injuries was 144, with a corresponding rate of 14.4 serious injuries per million residents, as indicated in Table 1.

Table 1 – Fatal Traffic Crashes Attributable to Alcohol Impaired Underage Drivers 16 to 20 Years-of-Age, 2004-2010

Alcohol Impaired Average Fatalities per Year	*Alcohol Impaired Average Fatality Rate per 1,000,000 Population*	*Alcohol Impaired Average Incapacitating Injuries per Year*	*Alcohol Impaired Incapacitated Injury Average Rate per 1,000,000 Population*	*Alcohol Impaired Total Fatalities for 2004-2010*	*Alcohol Impaired Total Incapacitating Injuries for 2004-2010*
29.0	*2.9*	*144.0*	*14.4*	*204*	*1,013*

Source: Michigan Office of Highway Safety Planning, February 2012

UNDERAGE DRINKING AND DRIVING/RIDING WITH DRINKING DRIVER

Data from the 2009 MiYRBS indicated that 8.0% of 9th through 12th graders had driven while drinking, and 28.0% had ridden in a vehicle with someone who had been drinking, during the last 30 days.[12]

ALCOHOL USE LINKED TO OTHER RISKY BEHAVIORS AND CONSEQUENCES

According to the 2009 MiYRBS, 25.0% of 9th through 12th graders who had sex in the last three months reported doing so after using alcohol or drugs.[13] Binge drinking is most common in late teens and early twenties; however, it is reported as continuing well into the thirties and forties.[14] Binge drinking is defined as five

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12 Michigan Department of Education. (2009). Michigan youth risk behavior survey 2009. Contact Kim Kovalchick at kovalchickk@michigan.gov or (517) 241-4292. Retrieved from http://www.michigan.gov/documents/mde/09YRBSDetail_327165_7.pdf.

13 Ibid.

14 Michigan Department of Community Health. (2009). Binge drinking in Michigan youth and adults. Retrieved from http://www.michigan.gov/documents/mdch/Youth__Adult_Binge_Drinking_Fact_Sheet_342124_7.pdf.

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or more drinks of alcohol in one occasion for youth, four or more drinks in one occasion for women, and five or more drinks in one occasion for men.[15]

Binge drinking leads to several adverse outcomes for men, women, and children. These adverse outcomes include intentional and non-intentional injuries, unplanned sexual intercourse, unprotected sex, sexually transmitted diseases, and unintentional pregnancy.

Women with unintended pregnancies are more likely to start prenatal care later in their pregnancy and are less likely to engage in healthy behaviors such as quitting smoking during pregnancy or consuming adequate amounts of folic acid. Thus, unintended pregnancies can also have adverse impacts on infants and children. No amount of alcohol is safe for a fetus during pregnancy. Exposure to alcohol in early phases, often before a teen realizes she is pregnant, is linked to miscarriage, mental retardation, and other preventable birth defects, such as Fetal Alcohol Syndrome.[16]

California researchers who compared the brains of teen drinkers to non-drinkers found that young alcohol users suffered damage to nerve tissues that could cause attention deficits among boys and faulty visual information processing among girls.[17] A multitude of research has documented the effects of alcohol on the developing brain, noting that brain development is not complete until about 25 years-of-age.

COSTS

It is estimated that underage alcohol use costs Michigan taxpayers over $2 billion per year, including the cost of youth violence, treatment, traffic crashes, property crimes, and medical costs. Underage drinking (UAD) cost Michigan $2.1 billion in 2010, which translated to an annual cost of $2,084 for each youth in the state; and ranked Michigan as the 28th highest among the 50 states,[18] as indicated in Table 2. Excluding pain and suffering, the direct costs of UAD incurred through medical care and loss of work cost Michigan $820 million each year. Youth violence and traffic crashes by underage drinkers represent the largest UAD costs for the state. Among teen mothers, fetal alcohol syndrome (FAS) alone costs Michigan $34 million yearly.[19]

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15 Center for Disease Control. (2009). Behavioral Risk Factor Surveillance System (BRFSS).Retrieved from http://www.cdc.gov/brfss/index.htm .

16 Michigan Department of Community Health, Family and Community Health. (2005). Preconceptional binge drinking and unintentional pregnancy. Michigan PRAMS Delivery, Vol.2 (4). Retrieved from http://www.michigan.gov/documents/April_2005_MI_PRAMS_Delivery_124472_7.pdf.

17 Join Together. (2010). Teen drinkers suffer nerve damage in brain. Newsroom. Retrieved from http://www.jointogether.org/news/research/summaries/2010/teen-drinkers-suffer-nerve.html.

18 Pacific Institute for Research and Evaluation. (2011). Underage drinking in Michigan, the facts. Funding from the Office of Juvenile Justice and Delinquency Prevention (OJJDP). Chapel Hill, N.C.

19 Ibid.

Table 2 – Cost of Underage Drinking by Problem, Michigan 2010

Problem	Total Cost (In millions)
Youth Violence	*$1,405.0*
Youth Traffic Crashes	*$251.1*
High-Risk Sex, Ages 14-20	*$122.3*
Youth Property Crime	*$158.4*
Youth Injury	*$53.9*
Poisonings and Psychoses	*$19.5*
Fetal Alcohol Syndrome among Mothers, Ages 15-20	*$34.2*
Youth Alcohol Treatment	*$72.4*
Total	*$2,116.8*

Table 2 Source: 2010 Data from Underage Drinking in Michigan; The Facts, produced for the Underage Drinking Enforcement Training Center (UDETC) by the Pacific Institute for Research and Evaluation (PIRE) with funding from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), September 2011, available at http://www.udetc.org/factsheets/Michigan.pdf.

ALCOHOL ABUSE AND ADDICTION

Young people who begin drinking before the age of 15 are four times more likely to develop alcohol dependence and are two and a half times more likely to become abusers of alcohol, than those who begin drinking at 21 years-of-age.[20] In 2011, 3,993 youth, 12-20 years-of-age, were admitted for alcohol-involved treatment in Michigan, accounting for 10.8% of all alcohol involved treatment admissions in the state.[21]

Alcohol Consumption - Youth

The 2011 MiYRBS, for 9th through 12th graders in public schools, reported that 64% of these students had at least one alcoholic drink during their lifetime. Students initiating early alcohol use, before 13 years-of-age, trended significantly downward over the last decade, reported as 16% for all in 2011. Current use is defined as consuming one or more drinks on one or more occasion within the last 30 days. Thirty-one percent of the students reported currently drinking in 2011, which has decreased over the last ten years. Binge drinking trended downward from 1999 to 2011, 18 percent of youth reported binge drinking, which is five or more drinks in a row for youth, in the last 30 days in 2011.[22] Trend data shows general decreases in alcohol use from 1999 to 2011, as indicated in Table 7.

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20 Grant, B. & Dawson, D. (1997). Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence: results from the national longitudinal alcohol epidemiologic survey. Journal of Substance Abuse, 9(103-110).

21 Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services (n.d.). Treatment Episode Data Set (TEDS). Lansing, MI

22 Michigan Department of Education. (2012). Michigan youth risk behavior survey 2011. Contact Kim Kovalchick at kovalchickk@michigan.gov or (517) 241-4292.

Table 7 – Alcohol Trend Data from Michigan Youth Risk Behavior Survey

CB# Q #	Indicator Description	Behavior	MI 99	MI 01	MI 03	MI 05	MI 07	MI 09	MI 11
39 40	% of students who had at least one drink of alcohol on one or more days during their life	Alcohol Ever	81.7 79.4-84.1	77.4 74.2-80.6	75.9 74.0-77.7	72.6 68.9-76.4	72.2 69.0-75.1	68.8 65.8-71.7	63.8 60.8-66.8
40 41	% of students who had their first drink of alcohol, other than a few sips, before age 13	Alcohol before age 13	32.2 28.9-35.5	26.9 24.6-29.2	26.9 24.7-29.1	22.6 19.2-25.9	21.4 18.7-24.4	18.8 16.7-21.1	15.6 13.6-17.8
41 42	% of students who had at least one drink of alcohol on one or more of the past 30 days	Recent alcohol use (30 days)	48.5 45.4-51.7	46.2 42.6-49.8	44.0 41.2-46.7	38.1 34.7-41.5	42.8 39.4-46.2	37.0 34.4-39.7	30.5 27.3-34.0
42 43	% of students who had 5 or more drinks of alcohol in a row, that is, within a couple of hours, on one or more of the past 30 day.	Alcohol binge (30 days)	29.9 27.0-32.8	29.3 25.6-33.1	27.4 24.1-30.7	22.5 19.4-25.6	24.6 20.8-28.9	23.2 20.9-25.6	17.8 15.0-21.1

Source: Michigan Department of Education, MiYRBS, 1999-2011

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In September of 2011, the Pacific Institute for Research and Evaluation (PIRE) reported that in 2009 approximately 405,000 underage youth consumed 16.5% of all alcohol sold in Michigan, totaling $704 million, which provided profits of $345 million to the alcohol industry.[23]

The Michigan Liquor Control Commission, report of August 2011, noted 14% of 308 establishments were cited in their "controlled buy" activities for sales to minors, with 72% of sales occurring in spite of an ID check.[24]

Alcohol Intervening Variables - Youth

LAWS/POLICIES

Graduated licensing for first time drivers, zero tolerance, social host laws, and keg registration are in place in Michigan. In 2004, Michigan revised its underage drinking regulation to better track first time offenders who were being cited under local ordinances, provide an educational/treatment intervention for first time offenders, and use of jail time to enforce treatment requirement stipulated in probation for repeat violators. Since July 2009, Michigan drivers' licenses and identification cards issued by the Michigan Secretary of State to those under 18 years-of-age utilize vertical formatting with red highlights, contrasting the horizontal licenses for those 21 years-of-age and over, and making underage status much easier for clerks and servers to recognize.

Reductions in motor vehicle crashes are the result, in part, of many policy and program measures including: keeping the minimum legal drinking age to 21 years-of-age,[25] administrative revocation of licenses for drinking and driving,[26] lower legal blood alcohol limits for youth[27] and adults,[28] and higher prices through increased taxation of alcoholic beverages.[29, 30] Higher prices for alcoholic

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23 Pacific Institute for Research and Evaluation. (2011). Underage drinking in Michigan, the facts. Funding from the Office of Juvenile Justice and Delinquency Prevention (OJJDP). Chapel Hill, N.C.

24 Michigan Liquor Control Commission. (2011). August report. Retrieved from *http://michigan.gov/lara/0,4601,7-154-10570_15011-264672--,00.html*.

25 O'Malley, P. M., & Wagenaar, A. C. (1991). Effects of minimum drinking age laws on alcohol use, related behaviors and traffic crash involvement among American youth: 1976–1987. Journal of Studies on Alcohol, 52(5), 478-491. Retrieved from *http://www.ncbi.nlm.nih.gov/pubmed/1943105?dopt=Abstract*.

26 Zador, P. L., Lund, A.K., Fields, M., et al. (1989). Fatal crash involvement and laws against alcohol impaired driving. Institute for Highway Safety. Arlington, VA.

27 Hingson, R. Heeren, T., and Winter, M. (1994). Lower legal blood alcohol limits for young drivers. Public Health Reports 109(6) 738-744. Retrieved from *http://www.ncbi.nlm.nih.gov/pubmed/7800781?dopt=Abstract*.

28 Hingson, R.: Hereen, T.; and Winter, M. (1996). Lowering state legal blood alcohol limits to 0.08 percent: the effect on fatal motor vehicle crashes. American Journal of Public Health 86(9): 1297-1299.

29 Chalopuka, F. J.; Saffer, H.; and Grossman, M. (1993). Alcohol-control policies and motor-vehicle fatalities. Journal of Legal Studies 22:161-186.

30 Ruhm, C. J. (1996). Alcohol policies and highway vehicle fatalities. Journal of Health Economics 15:435-454. Retrieved from *http://www.ncbi.nlm.nih.gov/pubmed/10164038?dopt=Abstract*.

beverages also are associated with reduced frequency of drinking and driving.[31] In 2003, Michigan instituted a BAC limit of .08 (set to expire in 2013). Effective in November 2010, Michigan implemented mandatory use of ignition interlocks for first-time driving-under-the-influence offenders convicted with a BAC of .17 or higher. Training programs are in place for servers and clerks, and are often used as a consequence of sales to minors in regards to license protection or reinstatement by the Michigan Liquor Control Commission (LCC). In addition, community coalition/provider programs involving multiple city departments and private citizens have reduced both driving after drinking, and traffic deaths and injuries. Since 2005, the MDCH has focused on UAD and ARTCD with the SPF/SIG.[32]

LAW ENFORCEMENT

The OHSP funds Party Patrols, Public Service Announcements, and many other initiatives to the law enforcement community. Local law enforcement division partners with communities for compliance checks and other youth access prevention initiatives. However, the recent economic struggles have forced budget cuts in law enforcement. "Making It Click" is an initiative by the OHSP to encourage high school student seat belt use.[33]

ACCESS

Packaging for alcoholic energy drinks mimics that of the non-alcoholic energy drinks, confusing retail clerks, parents, and school staff, making it easier for minors to access and drink this form of alcohol. To address public health and safety risks associated with alcohol energy drinks, on November 4, 2010, the Michigan LCC issued an administrative order that banned the sale and distribution of alcohol energy drinks in Michigan.[34] According to the 2007 Youth Tobacco Survey, the most common source of alcohol for Michigan high school youth was 'giving money to someone to buy it for them' (29%). Almost as common, was 'someone giving it to them' (22%) which was equivalent to the percentage of those 'getting it some other way'. Eleven percent of students reported 'they took from a store or family member' and nine percent said, 'restaurant, bar or club'. Seven percent said 'convenience store' and 3% said 'concert or sporting event'.[35]

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31 Zador, P. L.; Lund, A. K.; Fields, M.; et al. (1989). Fatal crash involvement and laws against alcohol impaired driving. Institute for Highway Safety: Arlington, VA.

32 MDCH BSAAS. (2005). State prevention framework state incentive grant. Retrieved from http://www.michigan.gov/mdch/0,1607,7-132-2941_4871_29888-162850--,00.html.

33 Office of Highway Safety Planning. (2009). Making it click. Retrieved from http://www.michigan.gov/documents/msp/high_school_seatbelt_program_06_296925_7.pdf.

34 Michigan Department of Energy Labor and Economic Growth. (2010). Energy Drink Ban. Administrative Order. Retrieved from http://www.michigan.gov/documents/dleg/Alcohol_Energy_Drink_Order_11_4_2010_337775_7.pdf.

35 Usual Source of Alcohol Reported by Michigan Youth, (2011). MDCH, Bureau of Epidemiology, Alcohol Epidemiology Program, based on the 2007 Youth Tobacco Survey. Retrieved from. http://www.michigan.gov/documents/mdch/Usual_Source_of_Alcohol_Among_MI_Youth_Fact_Sheet_345057_7.pdf.

SOCIAL NORMING

Social norms are people's beliefs, attitudes, and expectations about the behaviors that are considered normal or acceptable in a certain social environment. Parental acceptance of underage drinking and the provision of alcohol to minors by family and friends remains a national issue. In Michigan, various media campaigns and evidence-based programming within communities address "It's Not a MINOR issue."[36] Popular drinking games and portrayal in media have increased. Many communities and college campuses are using social norms marketing campaigns to reduce underage and high-risk drinking. High school and college students often have inflated views of how much their peers use alcohol and other drugs. These exaggerated views may influence students to increase their own alcohol use to fit in with what they perceive is "normal." Social norms marketing campaigns use advertising techniques to correct these misperceptions, which have been associated with decreases in the perceived pressure to use alcohol. Social norms marketing messages are different from traditional prevention messages in their use of statistics and non-judgmental messages about behaviors the majority of students are engaging in, such as not using alcohol, in order to encourage that behavior in others. Social norms marketing campaigns have also been used to target parents who believe it is acceptable to host parties and provide alcohol to minors.

AGE OF ONSET

Efforts to delay age of onset are considered critical in research, noting that a need to screen and counsel adolescents about alcohol use should be coupled with policies and programs that delay alcohol consumption.[37]

Alcohol Consequences – General/Adult

ALCOHOL-RELATED TRAFFIC CRASH DEATHS AND SERIOUS INJURIES

Of the 9,876,187 persons living in Michigan in 2010, one out of every 10,548 was killed in a traffic crash and one out of every 140 persons was injured. The Michigan State Police (MSP) Criminal Justice Information Center (CJIC) and the Office of Highway Safety Planning (OHSP), in conjunction with the University of Michigan Transportation Research Institute (UMTRI), compiles and publishes an annual report. Overall 2001 to 2010 trend data are shown in Table 4. While alcohol and/or drug related traffic crash fatalities declined from 504 in 2001 to 357 in 2010, the relative percentage of overall traffic fatalities remained constant. In addition, the MSP also works with the Secretary of State (SOS) to produce a

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[36] New York State Office of Alcoholism and Substance Abuse Services. (n.d.). Underage drinking: not a minor problem. Retrieved from *http://www.oasas.state.ny.us/ud/OASAS_TOOLKIT/instructions.htm.*

[37] Hingson, R. W., Heeren, T., and Winter, M. (2006). Age at drinking onset and alcohol dependence, age at onset, duration and severity. ARCH Pediatric Adolescent Medicine/Vol 160. Retrieved from *www.archpediatrics.com*.

drunk driving audit report annually. Of all 2010 traffic crash fatalities, 21.8% involved drinking but no drugs, 7.9% involved drugs but no drinking, and 8.4% involved both drinking and drugs. County-level data is available on Michigan OHSP's website, www.michigantrafficcrashfacts.org, and in the MSP Drunk Driving Audit.[38]

[38] Michigan State Police (n.d.). Michigan drunk driving audit. Retrieved from *http://www.michigan.gov/msp/0,1607,7-123-1645_3501_4626-27728--,00.html*.

Table 4 – Michigan Traffic Crash Facts, 2001-2010

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total Crashes	400,813	395,515	391,486	373,028	350,838	315,322	324,174	316,057	290,978	282,075
Total Injuries	112,292	112,484	105,555	99,680	90,510	81,942	80,576	74,568	70,931	70,501
Total Fatalities	1,328	1,279	1,283	1,159	1,129	1,084	1,084	980	871	937
Fatal Crashes	1,206	1,175	1,172	1,055	1,030	1,002	987	915	806	868
Death Rate*	1.4	1.3	1.3	1.2	1.1	1.1	1.0	0.9	0.9	1.0
Fatal Crash Rate**	1.2	1.2	1.2	1.1	1.0	1.0	0.9	0.9	0.8	0.9
Restraint Use, Percent***	47.4%	51.4%	49.8%	51.0%	54.7%	54.9%	54.4%	49.7%	50.4%	51.6%
Percent of Alcohol/Drug-Involved Crashes to total fatal crashes	38.0%	35.8%	34.4%	36.5%	35.0%	39.6%	35.4%	39.0%	40.7%	37.9%
Alcohol/Drug Involved Fatalities	504	463	442	418	408	440	381	379	351	357
Percent of Alcohol/Drug Involved Fatalities to total fatalities	38.0%	36.2%	34.5%	36.1%	36.1%	40.6%	35.1%	38.7%	40.3%	38.1%
OUIL Arrests (all agencies)	58,562	57,782	55,728	55,056	54,036	53,297	49,867	47,251	45,893	41,883
Registered Vehicles (Millions)	8.89	9.00	9.92	9.93	9.69	8.70	8.33	8.38	8.11	8.06
MVMT (Billions)	96.5	96.5	98.2	100.2	101.8	103.2	104	104.6	100.9	95.9
Population (Millions)	9.99	10.05	10.08	10.08	10.11	10.12	10.09	10.07	10.00	9.97

2007 Footnote: Total registered vehicles will be changed from this year forward to subtract the registered trailer plates.
**Death Rate=Persons killed per 100 million MVMT*
***Fatal Crash Rate=Fatal Crashes per 100 million MVMT*
****Restraint Use by deceased occupants of motor vehicles equipped with safety belts*
Source: Michigan Office of Highway Safety Planning, February 2012.

SUBSTANCE ABUSE AND ADDICTION

TEDS indicated that numbers for alcohol treatment, within Michigan's public service delivery system, have varied slightly between 2001 and 2011, but have maintained a decline since 2001, as indicated in Table 5.

Table 5 – Self-Reported Primary Drug of Choice Trend Data, from Treatment Episode Data, at Admission into Michigan Publicly Funded Services

Fiscal Year	Alcohol		Cocaine		Heroin		Other Opiates		Marijuana		Meth		Other Stim		All Others		Totals
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
2001	29,492	49.3%	10,330	17.3%	7,857	13.1%	1,882	3.1%	8,528	14.3%	165	0.3%	108	0.2%	1,459	2.4%	59,821
2002	28,091	50.1%	9,558	17.1%	6,517	11.6%	1,929	3.4%	8,834	15.8%	280	0.5%	81	0.1%	759	1.4%	56,049
2003	31,710	48.4%	11,708	17.9%	7,935	12.1%	2,618	4.0%	10,262	15.6%	506	0.8%	77	0.1%	768	1.2%	65,584
2004	29,927	45.3%	11,765	17.8%	8,726	13.2%	3,246	4.9%	10,893	16.5%	689	1.0%	97	0.1%	742	1.1%	66,085
2005	30,185	43.2%	12,382	17.7%	9,601	13.8%	4,002	5.7%	11,816	16.9%	913	1.3%	92	0.1%	817	1.2%	69,808
2006	30,579	42.1%	13,290	18.3%	9,958	13.7%	4,918	6.8%	12,368	17.0%	707	1.0%	87	0.1%	712	1.0%	72,619
2007	30,488	42.1%	12,895	17.8%	9,931	13.7%	5,603	7.7%	12,264	16.9%	444	0.6%	77	0.1%	759	1.0%	72,461
2008	28,496	42.0%	9,698	14.3%	10,365	15.3%	6,154	9.1%	11,680	17.2%	500	0.7%	93	0.1%	790	1.2%	67,776
2009	28,981	41.5%	7,125	10.2%	12,522	17.9%	7,779	11.1%	11,707	16.8%	502	0.7%	124	0.2%	1,092	1.6%	69,832
2010	26,052	40.1%	6,064	9.3%	11,358	17.5%	8448	13.0%	11,275	17.3%	611	0.9%	120	0.2%	1,101	1.7%	65,029
2011	25,489	38.7%	5,495	8.3%	12,465	18.9%	9,621	14.6%	10,793	16.4%	712	1.1%	168	0.3%	1,137	1.7%	65,880

Note: Does not include private practice data. This table may include duplicate counts of persons if they entered treatment more than one time during the year, either for the same or other substance.
Source: MDCH, BSSAS, February 2012

Data also indicated that during 2008 to 2010, 15.1% of Michigan adults had no health coverage, perhaps influencing a decline in access to care,[39] as shown in Table 6.

Table 6 – Adult Health and Safety Patterns from Michigan Behavioral Risk Factor Survey

Michigan	N Sample Size	Percent	Table
Heavy Drinking	***26,738***	***5.4%***	***13***
Binge Drinking	***26,992***	***16.6%***	***13***
Drove a vehicle after drinking alcohol	***14,906***	***2.7%***	***14***
Always wears seatbelt	***14,863***	***88.3%***	***15***
No Health Coverage	***27,634***	***15.1%***	***9***

Source: Based on 2008-2010 Michigan BRFS, May 2011

DROVE VEHICLE AFTER DRINKING

The combined 2008 to 2010 Michigan Behavioral Risk Factor Survey (MIBRFS) regional and local health department estimates indicated that 2.7% of Michigan adults drove after drinking, as shown previously in Table 6 above. Also notable is the fact that many children reside with parents and caregivers who have substance abuse issues, and are dependent upon them to provide transportation.[40]

Alcohol Consumption – General/Adult

According to the 2010 NSDUH report, there were 4.7 million persons aged 12 or older who had used alcohol for the first time within the past 12 months. Most of these (82.4%) were under 21 at the time of initiation and the mean age of first use in this group was 16.1 years. The 2008 to 2010 MIBRFS regional and local health department estimates, released May 2011, indicate the following consumption patterns for individuals 18 years-of-age and older: 5.4% heavy drinking and 16.6% binge drinking, as shown previously in Table 6.

Alcohol Intervening Variables – General/Adult

SAFETY BELT USE

Michigan's seat belt law became a primary enforcement law on April 1, 2000. Seat belt use has dramatically increased (70% to 98%) from 1998 to 2009, with a

[39] Michigan Department of Community Health, Bureau of Epidemiology. (2011). Regional and local health departments. Michigan Behavioral Risk Factor Survey (BRFS). Contact Chris Fussman at *MiBRFSS@michigan.gov* or 517-335-8144.

[40] University of Maryland, Center for Substance Abuse Research (2009). More than one in ten children in the U.S. live with substance-abusing or substance-dependent parent. CESAR Fax, 18(18). Retrieved from *http://www.cesar.umd.edu/cesar/cesarfax/vol18/18-18.pdf.*

rate of 95.2% in 2010.[41] According to Fatality Analysis Reporting System (FARS) data, during 1998 and 2009 there were decreases in total traffic fatalities (1,366 to 871, respectively), unrestrained fatalities (518 to 168), alcohol-involved fatalities with .01 BAC or higher (502 to 291), and alcohol-involved fatalities with .08 BAC or higher (427 to 246).[42] Increased belt use has contributed to reducing fatalities in alcohol-involved crashes and all crashes; the official National Center for Statistics and Analysis methodology estimates fewer potential "lives saved" as total fatalities decrease but still shows about 500 Michigan lives saved by safety belts every year.[43] Safety belt use is addressed as a health and safety issue by the Michigan OHSP.

STATEWIDE FOCUS OF SPF/SIG ACTIVITIES ON ARTCD

The federal SPF/SIG has afforded dollars to build community capacity to address ARTCD during 2004 to 2010. Community-level needs assessments, capacity building, and strategic plans were completed by sub-state entities for MDCH/BSAAS. Implementation plans and evaluations are continuing. ARTCD and underage drinking remain a focus of statewide prevention planning for 2010 to 2011.

Prescription Drugs Data

Prescription Drug Abuse Consequences – Youth/General/Adult

Prescription drugs are considered misused if taken in amounts or in ways in which they were not prescribed and/or if they are taken by a person other than to whom they were prescribed. Drug overdoses and interactions, accidental poisonings and deaths are consequences of this behavior, as indicated in Table 8.

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41 National Highway Safety Administration, National Center for Statistics and Analysis. (2011). Seat Belt Use in 2010 – Use rates in the States and Territories. Retrieved from http://www-nrd.nhtsa.dot.gov/Pubs/811493.pdf

42 National Highway Safety Administration, National Center for Statistics and Analysis. (2009). Fatality analysis reporting system. Data Resource Website. Retrieved from *http://www-fars.nhtsa.dot.gov/Main/index.aspx*.

43 National Highway Safety Administration, National Center for Statistics and Analysis. (2009). The increase in lives saved, injuries prevented, and cost savings if seat belt use rose to at least 90 percent in all states. Traffic safety facts, research notes. Retrieved from *http://www-nrd.nhtsa.dot.gov/Pubs/811140.PDF*.

Table 8 – Prescription Drug Overdose Death Rates of Michigan Residents by Age and Sex

Annual Overdose rates by age and gender, Michigan, 2007-2009						
Age Category	Males			Females		
	Number	Population	Rate	Number	Population	Rate
<20	9	1,373,851	0.7	4	1,311,664	0.3
20-29	48	673,744	7.1	22	655,089	3.4
30-39	50	637,597	7.9	27	629,216	4.3
40-49	67	741,866	9.1	64	749,960	8.5
50-59	54	692,622	7.7	53	715,789	7.5
60+	18	804,249	2.2	19	1,017,775	1.9
Total	246	4,923,929	5.0	190	5,079,493	3.7

Source: MDCH, Vital Records, and Health Statistics

This category of misuse and abuse is also known as "medication abuse." Violence and extreme risk taking may also become by-products of misuse. According to the 2009 MiYRBS, 25.0% of 9th through 12th graders who had sex in the last three months reported doing so after using alcohol or drugs.[44] Healthy pregnancy outcomes are threatened by drug use. Prescription drug abuse also leads to impaired driving and traffic crashes causing severe injury or death, as shown previously in Table 4.

The most commonly abused prescription drugs:[45]

- **Opioids** – for pain oxycodone (OxyContin), propoxyphene (Darvon), hydrocodone (Vicodin), hydromorphone (Dilaudid), meperidine (Demerol), and diphenoxylate (Lomotil)

- **Depressants** – for anxiety and sleep disorders barbiturates: pentobarbitol sodium (Nebutol); benzodiazapenes: diazepam (Valium), and alprazolam (Xanax)

- **Stimulants** – for narcolepsy, ADHD, and obesity dextroamphetamine (Dexedrine), methylphenidate (Ritalin), and steroids (anabolic/androgenic)

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44 Michigan Department of Education. (2009). Michigan youth risk behavior survey 2009. Contact Kim Kovalchick at *kovalchickk@michigan.gov* or 517-241-4292. Retrieved from http://www.michigan.gov/documents/mde/09YRBSDetail_3271657.pdf.

45 U. S. Department of Health and Human Services, National Institute of Drug Abuse. (n.d.). Research report series - prescription drugs: abuse and addiction. Retrieved from *http://www.nida.nih.gov/researchreports/prescription/prescription2.html*.

Many prescription drugs are addictive to varying degrees and result in the need for substance abuse and addiction treatment. The Drug Enforcement Agency (DEA) evaluates drugs and other substances for the sake of regulations and classifies these drugs into five schedules according to their abuse potential, addictive nature, and whether or not they have accepted medical use for treatment.

ABUSE AND ADDICTION

In looking at Michigan publicly funded treatment sought in 2010 and 2011, where the initial treatment involved prescription drugs, as primary, secondary or tertiary drug of choice, for youth 20 years-of-age and under; treatment decreased from 234 in 2010, to 180 in 2011, as indicated in Table 9. National data is readily available, but state data collection is just beginning and is fragmented. State data collection is considered a gap for the SEOW to focus on, as the problem has escalated nationally and continues to make headlines within the state.

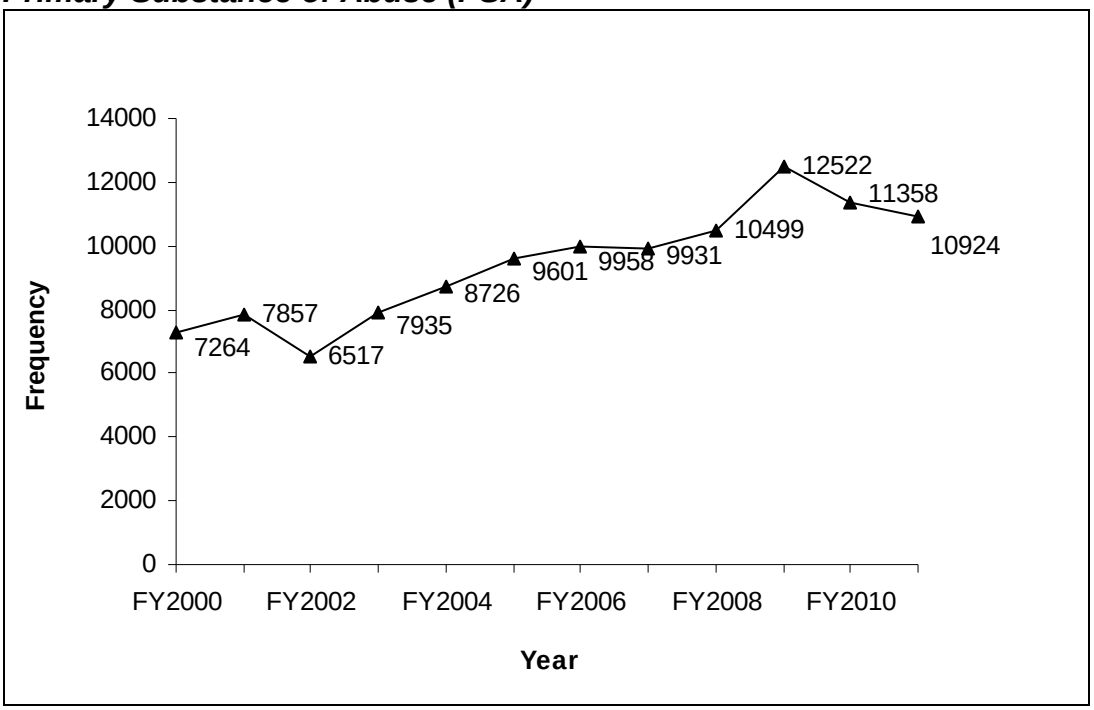
Table 9 – Initially Prescribed Drugs Involved Treatment: Self-Reported as Primary, Secondary, or Tertiary Drug of Choice for Treatment in Michigan Publicly Funded Services, 2010-2011

Age in Years	Client Gender								TOTAL COUNTS	
	Male				Female					
	Count		Percentage		Count		Percentage			
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
< 14	0	0	0.0%	0.0%	0	0	0.0%	0.0%	0	0
14-17	13	18	44.8%	50.0%	16	18	55.2%	50.0%	29	36
18-20	112	82	54.6%	56.9%	93	62	45.4%	43.1%	205	144
21-25	340	298	40.2%	36.2%	506	525	59.8%	63.8%	846	823
26-29	434	468	43.4%	43.8%	566	604	56.6%	56.2%	1,000	1,069
30-35	504	571	45.9%	43.3%	594	747	54.1%	56.7%	1,098	1,318
36-44	406	487	40.8%	44.9%	589	598	59.2%	55.1%	995	1085
45-54	351	400	47.2%	46.7%	392	457	52.8%	53.3%	743	857
55-64	105	134	52.8%	54.9%	94	110	47.2 %	45.1%	199	244
65+	2	4	18.2%	80.0%	9	1	81.8 %	20.0%	11	5
Total	2,267	2,462	44.2%	44.1%	2,859	3,119	55.8 %	55.9%	5,126	5,581

Note: Does not include private practice data. Data may include duplicate counts of persons if they entered treatment more than one time during the year, either for the same or other substance.
Source: MDCH, BSSAS, February 2012

The percentage of treatment admissions for opiate abuse and addiction has increased fourfold from 3.1% in 2001 to 14.6% in 2011, as shown in previously Table 5. Michigan publicly funded treatment involving prescription drug abuse as the primary, secondary, and tertiary drug of choice totaled 5,581 treatment entrances in 2011, with the highest rates in adults 21 to 54 years-of-age, with a sharp increase in rates from 2010 to 2011 among adults 30 to 35 years-of-age, as shown in Table 9 above. Illicit drug use has also increased as it becomes a more affordable option for a person to progress from expensive prescriptions to more affordable illicit substances,[46] as illustrated in Figures 1, 2, and 3.

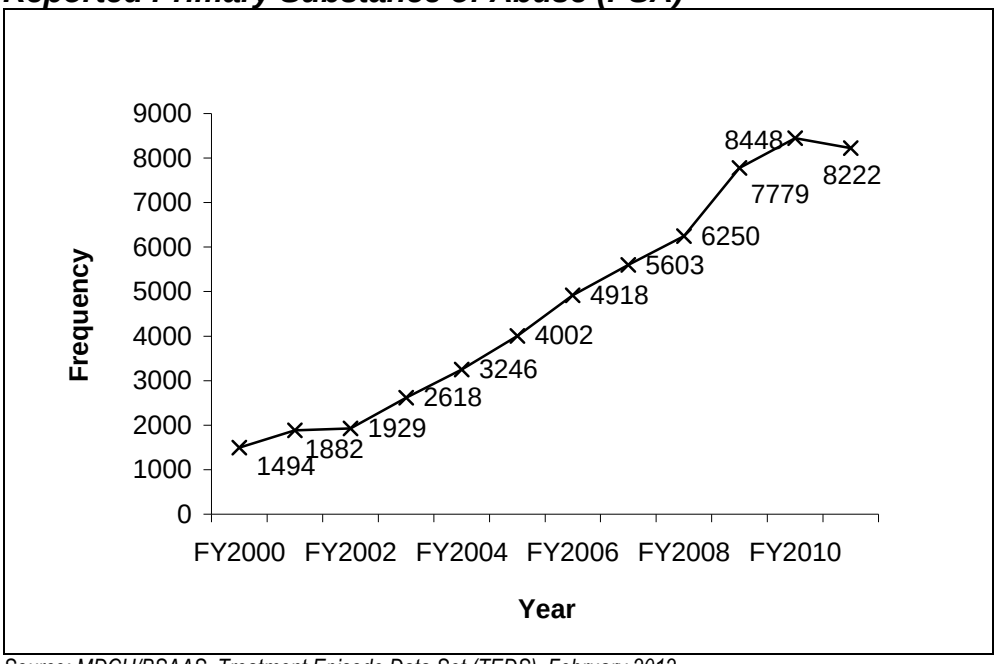
Figure 1 – Heroin Primary Drug of Choice Trend Data, as Self-Reported Primary Substance of Abuse (PSA)



Source: MDCH/BSAAS, Treatment Episode Data Set (TEDS), February 2012

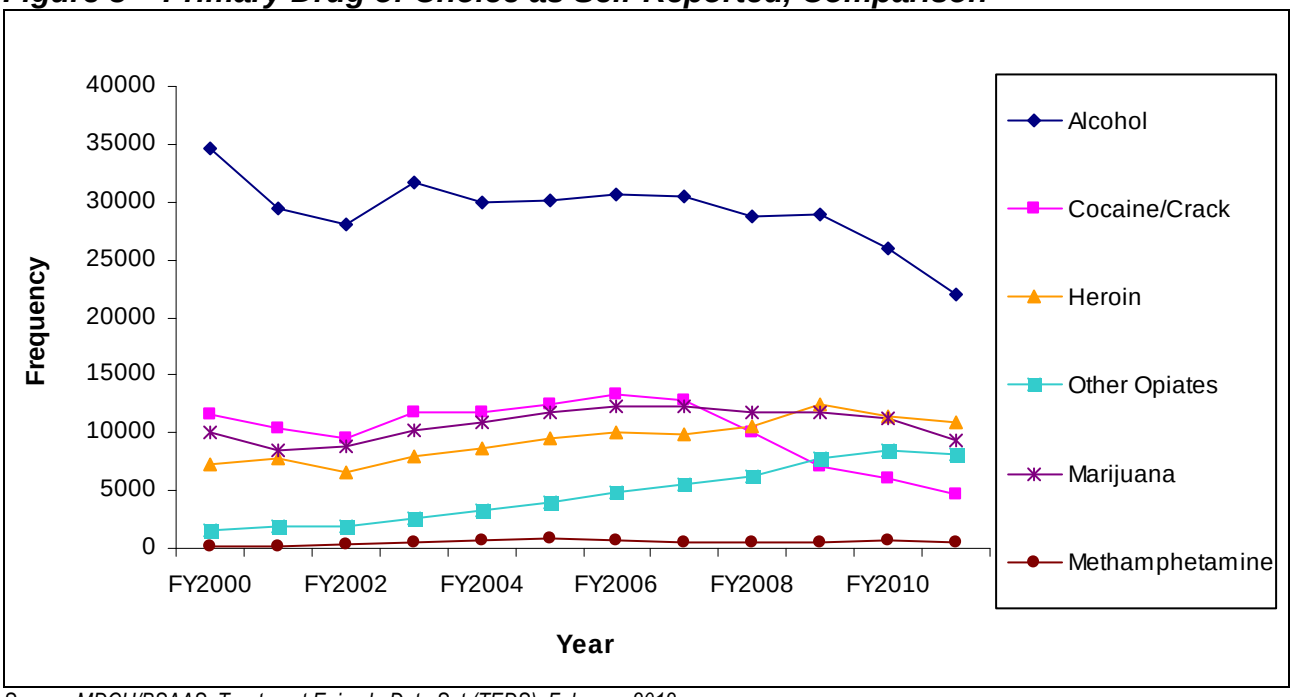
[46] Canfield, M., Keller, C., Frydrych, L., Ashrafioun, L., Purdy, C., & Blondell, R. (2010). Prescription opioid use among patients seeking treatment for opioid dependence. Journal of Addiction Medicine. 4(2), 108-113.

Figure 2 – Other Opiates Primary Drug of Choice Trend Data, as Self-Reported Primary Substance of Abuse (PSA)



Source: MDCH/BSAAS, Treatment Episode Data Set (TEDS), February 2012

Figure 3 – Primary Drug of Choice as Self-Reported, Comparison



Source: MDCH/BSAAS, Treatment Episode Data Set (TEDS), February 2012

TRAFFIC DEATHS AND INJURIES INVOLVING DRUGS

The number of deaths involving drugs slightly increased from 119 in 2009, to 153 in 2010. The number of people injured in crashes involving alcohol and/or drugs decreased from 6,271 in 2009, to 6,175 in 2010. However, drivers injured who had both alcohol and drugs in their system increased from 463 in 2009, to 616 in 2010.[47] Some of the numbers involve illicit drug use, which is often an outcome of progressive addiction to prescription drugs, as noted previously.

Prescription Drug Consumption – Youth/General/Adult

Prescription drug misuse is an emerging trend. According to NSDUH, the prevalence of past year nonmedical use of pain reliever among youth aged 12 to 17 years decreased, but not significantly, from 6.6 percent in 2009 and to 6.2 percent in 2010. Although national data is prevalent, state data is limited. Two questions regarding prescription drug use were asked on the Michigan Profile of Healthy Youth (MiPHY) last school year (2009-10) for the first time.[48] According to the 2009 MiYRBS, illegal drugs were offered, sold, or given on school property to 30% of students within the last year. Six percent of 9th through 12th graders have taken barbiturates without a doctor's prescription in the last 30 days. This rate is significantly higher for Hispanic/Latino students (11%) and eleventh graders (8%). Ten percent of 9th through 12th graders have used barbiturates without a prescription at least once in their life, again with higher rates for Hispanic/Latino students (16%). Nine percent of 9th through 12th graders have used club drugs one or more times during their life, with higher rates for Hispanic/Latino students (16%) and eleventh (13%) and twelfth (11%) graders. Four percent of students have taken steroid pills or shots at least once, and three percent have done so in the last 30 days. The 2009 MiYRBS data also show that 14% of students have sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paint or spray to get high one or more times during their life.[49] Prescription drug misuse is prevalent in the headlines and media. "Pharming" parties are common among youth.

Nationally, nonmedical use of pain relievers in the past year among persons aged 12 or older did not change between the NSDUH 2002 to 2003 and 2008 to 2009 surveys (4.8% in 2002 to 2003 and in 2008 to 2009). The prevalence in Michigan increased but not significantly over this time-period (5.2% in 2002 to 2003 and 5.7% in 2008 to 2009). Declines in nonmedical use of pain relievers

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[47] Michigan State Police, Criminal Justice Information Center. (2011). Michigan annual drunk driving audit. Retrieved from *http://www.michigan.gov/documents/msp/2010_audit_for_web_deployment_357302_7.pdf*.

[48] Michigan Department of Education (2009-2010). MiPHY questions. Retrieved from *http://www.michigan.gov/miphy*.

[49] Michigan Department of Education. (2009). Michigan youth risk behavior survey 2009. Contact Kim Kovalchick at *kovalchickk@michigan.gov* or 517-241-4292. Retrieved from *http://www.michigan.gov/documents/mde/09YRBSDetail_327165_7.pdf.*

were observed among youths 12 to 17 years-of-age, while increases were noted among persons aged 18 to 25.[50]

Prescription Drug Intervening Variables – Youth/General/Adult

ACCESS

Results from the NSDUH indicate that prescription drugs are obtained most commonly free from friends or relatives.[51] Therefore, the home is a point of access for prescription drug abuse. Adults are often ill informed about how accessible their prescriptions are to their family, friends, babysitters, and visitors. Prescriptions are often discontinued before completely used and kept beyond their expiration dates. The DEA has sponsored Nationwide Prescription Drug Take-Back Days to encourage proper disposal techniques of unwanted and unused prescription drugs across communities in all 50 states.[52] Of particular interest is Hydrocodone. During 2010, there were over 5.8 million prescriptions for this Schedule III category drug, accounting for 31.2% of all controlled substance prescriptions in Michigan. Hydrocodone is also dispensed under the names of Vicodin, Lortab, Tussionex, etc.

The number of legitimate prescriptions written has consistently increased, as indicated in Figure 4. The Michigan Automated Prescription Service (MAPS) reported over 18.8 million prescriptions were written in 2010. Prescriptions for Hydrocodone have dramatically increased since 2005, accounting for 31.2% of all controlled substance prescriptions in 2010. Suboxone prescriptions increased 957.6% from 2005 to 2010.[53] Suboxone's patent expired in late 2009 and has been generically available thereafter, which usually spikes prescriptions.

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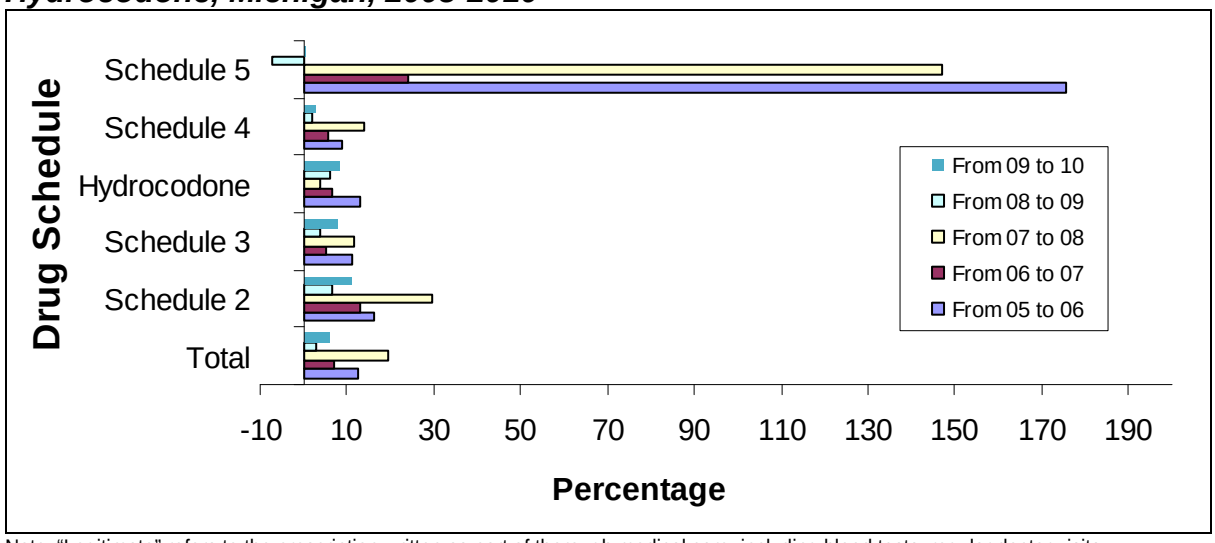
50 SAMHSA (n.d.). State Estimates of Substance Use from the 2008-2009. National surveys on drug use and health. Retrieved from *http://www.oas.samhsa.gov/2k9State/TOC.htm*.

51 SAMHSA (n.d.). Results from the 2010 national survey on drug use and health: summary of national findings. National surveys on drug use and health. Retrieved from *http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm*.

52 U.S. Department of Justice, Drug Enforcement Administration. (2010). American public overwhelmingly responds to DEA prescription drug take-back effort. *Retrieved from http://www.nationaltakebackday.com/toolbox/documents/TakeBackRelease%20Update.docx*.

53 Michigan Department of Community Health, Bureau of Health Professions. (2006-2010). Prescription data. Michigan Automated Prescription System (MAPS).

Figure 4 – Change in Legitimate Prescriptions Filled by Schedule and Hydrocodone, Michigan, 2005-2010



Note: "Legitimate" refers to the prescription written as part of thorough medical care, including blood tests, regular doctor visits, health history, etc. *Source: Michigan Automated Prescription System (MAPS), 2005-2010 Prescription Data, Bureau of Health Professions*

Some highlights from the MAPS data for 2010 include frequency of prescribed controlled substance by NSDUH Use Category: pain relievers at 8.9 million, tranquilizers at 3.5 million, stimulants at 2.1 million, and sedatives at 1.5 million, as shown previously in Table 11. Almost every category of controlled drug has increased in number of prescriptions since 2003. From 2003 to 2010, the biggest increase noted was with Opioid antagonists (Suboxone/Subutex, Schedule III); the number of prescriptions increased rapidly (327 prescriptions in 2003 and 285,059 in 2010), as shown previously in Table 10. Increases shown in Schedule II (stimulants and pain relievers) drug prescriptions from 2003 to 2010 include: oxycodone (113%), methadone (146%), and hydromorphine (275%). Numerous prescriptions decreased from 2003 to 2010 including: methyphenidate 82.4% (Ritalin, Schedule II stimulant), fentanyl 40.8% (Schedule II pain reliever), and propoxyphene 18.1% (Darvocet/Darvon, Schedule IV pain reliever). The most commonly prescribed pain relievers in 2010 were: Hydrocodone (Vicodin, etc., Schedule III) at 5.8 million prescriptions, codeine (Tylenol #3 and #4, Schedule III) at 0.72 million, and oxycodone (OxyContin, etc., Schedule II) at 0.69 million.[54]

MILITARY CONSIDERATIONS

Wartime creates additional stress with deployments, wounds, and loss of lives, for both the veterans and their families. These stressors create a high-risk for all and often increased access. The prevalence of illicit drug use, including prescription drugs, increased from 5% in 2005, to 12% in 2008. The increased prevalence was primarily attributed to the addition of questions that asked for

[54] Ibid.

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usage of prescription medication for non-medical reasons.[55] Stigma has created apprehension about utilizing treatment within the military, with veterans often returning to civilian life with unresolved substance issues.

SOCIAL NORMS

Sharing prescriptions, attitudes about self-medicating for even minor complaints, advertising campaigns, and jovial acceptance in media, all contribute to misuse and abuse of prescription drugs.

PERCEPTION OF RISK

Prescription drugs are often thought safer because they are initially prescribed by a doctor.

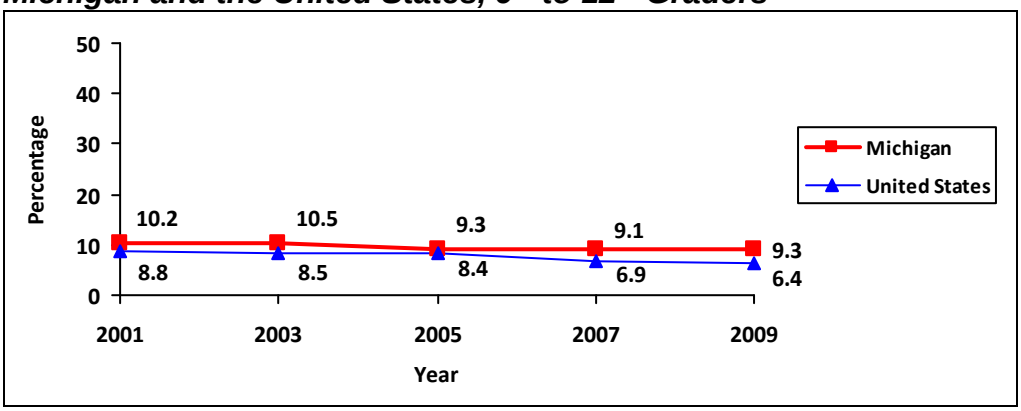
Mental Health Indicators

Suicide Prevalence

ATTEMPTED SUICIDE – YOUTH

In 2009, 16% of Michigan public high school students reported having seriously considered suicide in the past 12 months, compared to 13.8% of youth nationally. About one in every 11 Michigan public high school students (9.3%) reported having attempted suicide one or more times in the past year with three percent of respondents requiring medical attention after an attempted suicide,[56] as indicted in Figure 5.

Figure 5 – Percentage of Youth Who Attempted Suicide in the Past Year in Michigan and the United States, 9th to 12th Graders



Source: MiYRBS and YRBS

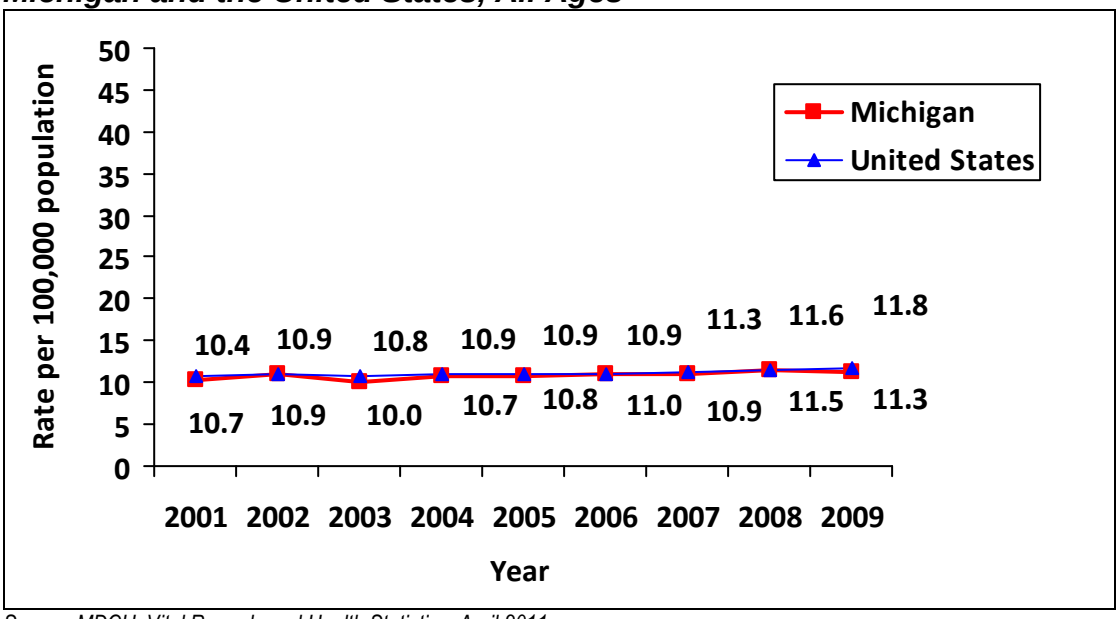
[55] Department of Defense. (2008). Survey of health related behaviors among active duty military personnel. Retrieved from http://www.tricare.mil/2008HealthBehaviors.pdf.

[56] Michigan Department of Education. (2009). Youth risk behavior survey. Retrieved from http://www.emc.cmich.edu/YRBS/2009/2009_YRBS_V_S.pdf.

SUICIDE – GENERAL/ADULT

One objective of Healthy People 2010 is to reduce the suicide rate to 5.0 suicides per 100,000 population. In 2009, Michigan's age-adjusted suicide rate was 11.3 per 100,000 population, which is two times the target and slightly lower than the national rate of 11.8 suicides per 100,000 population as illustrated in Figure 6.

Figure 6 – Rate of Suicide Deaths per 100,000 Population, Age Adjusted in Michigan and the United States, All Ages



Source: MDCH, Vital Records and Health Statistics, April 2011

Since 2001, the U.S. and Michigan suicide rates were virtually equivalent. The rate of death for males in Michigan was approximately four times higher than that of females (18.6 per 100,000 for males, versus 4.7 per 100,000 for females), [57] as illustrated in Figure 7. The leading method of suicide for males was a firearm (55%), while for females it was poisoning (45%).[58]

Four of the five participating SPE CA regional communities have suicide rates higher than the state's overall rate. The two CAs in the Upper Peninsula of Michigan each have one county (local community) that has a suicide rate that is in the highest category in the state. The other CAs have at least one county in the next highest category rate.

[57] Michigan Department of Community Health, Vital Records and Health Statistics Section. (2009). Interview.

[58] Michigan Department of Community Health. (2007). Michigan critical health indicator. Retrieved from http://www.michigan.gov/documents/mdch/Critical_Health_Indicators_2007_198949_7.pdf.

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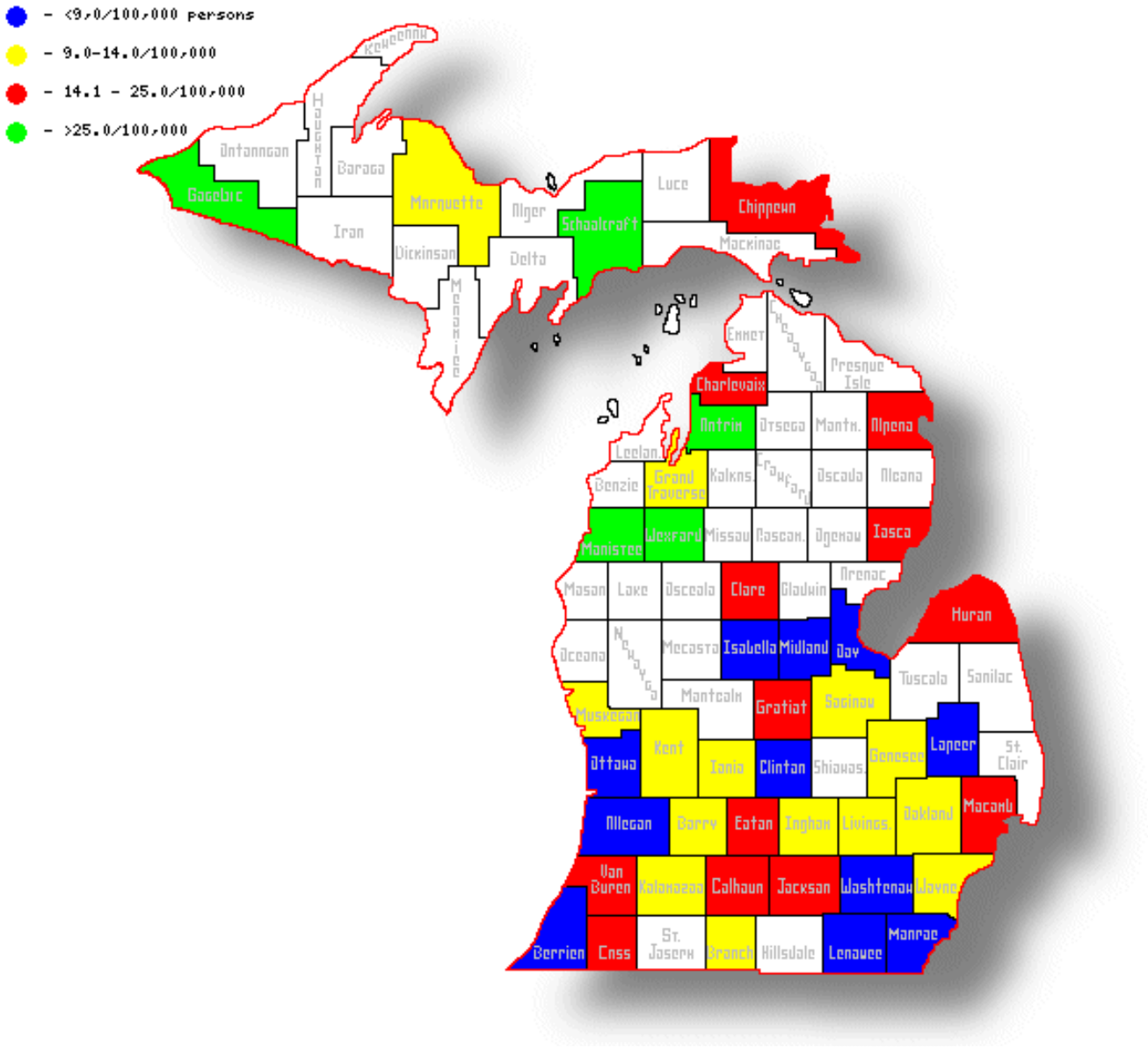
Figure – Michigan's 2009 Suicide Rates by County (state suicide rate – 11.7/100,000 persons rate – this is part of rate shown in yellow.) Note: white indicates too few suicides to calculate rate.

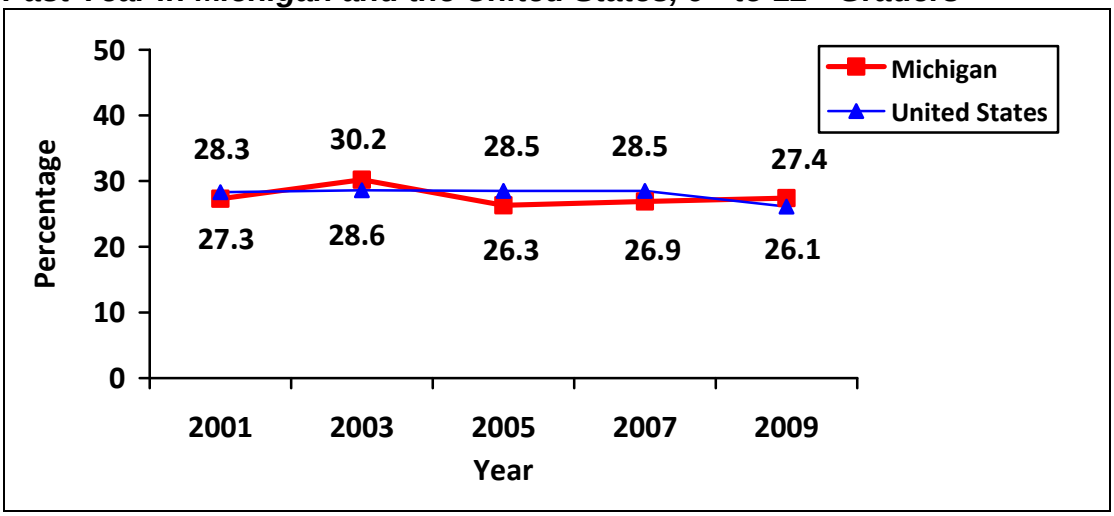


Depression and Serious Mental Illness Prevalence

DEPRESSIVE FEELINGS – YOUTH [59]

While there has been some variability, the rate of past year depressive feelings reported by 9th through 12th graders in Michigan declined from 30.2% in 2003 to 26.3% in 2005. The rate, however, as shown in Figure 8, has slightly increased from 26.9% in 2007 to 27.4% in 2009.[60] Depressive feelings was defined as feeling so sad or hopeless, almost every day for two weeks or more in a row, that the person stopped doing some of their usual activities.

Figure 8 – Percentage of Youth Who Reported a Depressive Episode in the Past Year in Michigan and the United States, 9th to 12th Graders



Source: Michigan Youth Risk Behavior Survey, http://www.michigan.gov/mde/0,1607,7-140-28753_38684_29233_41316---,00.html and Youth Risk Behavior Surveillance System, http://www.cdc.gov/HealthyYouth/yrbs/

CO-OCCURENCE OF DEPRESSIVE FEELINGS AND ALCOHOL CONSUMPTION/ ILLICIT DRUG USE

Similar proportions of Michigan's male and female high school students reported current drinking (36% of males and 37% of females) and binge drinking (23.8% and 22.4% respectively). Past year depression was related to alcohol consumption in addition to increased risk of attempting suicide, as shown in Table 13.

59 Given data source of YRBS, rather than using 'depression', the term 'depressive feelings' for youth is appropriate.

60 Michigan Department of Education. (2009). Michigan youth risk behavior survey. Contact Kim Kovalchick at kovalchickk@michigan.gov or 517-241-4292.

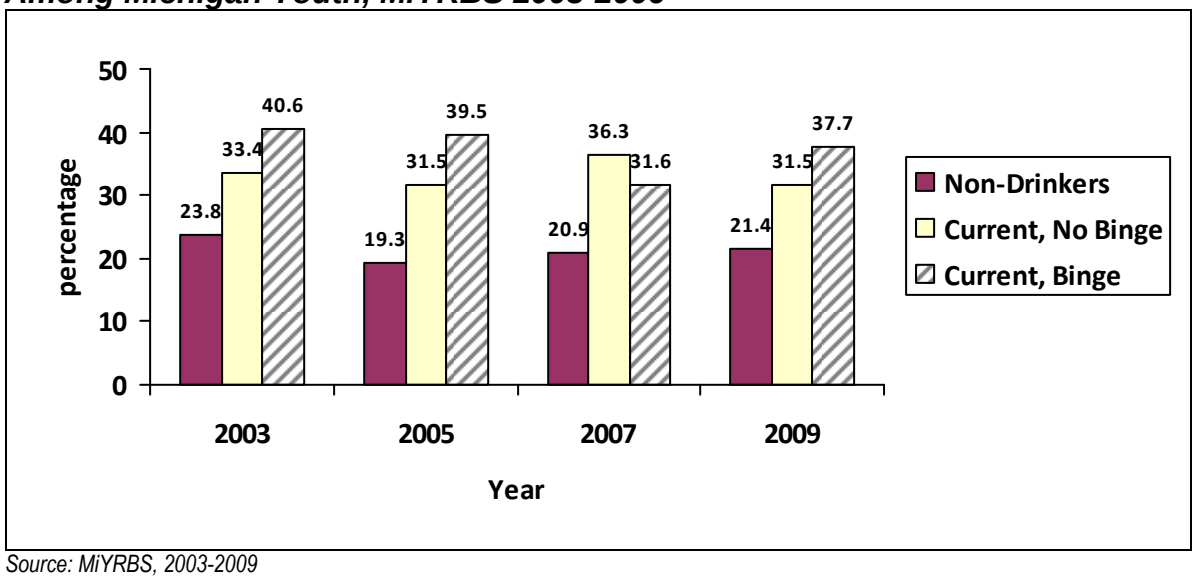
Table 13 – Prevalence of Attempting Suicide and Alcohol Consumption in the Past 12 Months Among Michigan Youth, MiYRBS 2003-2009

Attempted suicide one or more times during the past 12 months				
Drinking Status	2003	2005	2007	2009
Non-Drinkers	*6.3 %*	*5.9 %*	*6.1 %*	*6.4 %*
Current, Not Binge	*13.1 %*	*9.1 %*	*10.5 %*	*9.5 %*
Current, Binge	*15.9 %*	*16.7 %*	*12.4 %*	*11.7 %*

Note: All ***bolded values*** *indicate a significant difference of p≤.05 (χ^2 test) compared to non-drinkers Source: MiYRBS, 2003-2009*

Compared to non-drinkers, binge and current drinkers reported a significantly higher prevalence of feeling sad or hopeless for almost every day during a two week period, which included considering suicide, and making a suicide plan during the previous 12 months,[61] as shown in Figures 9, 10, and 11.

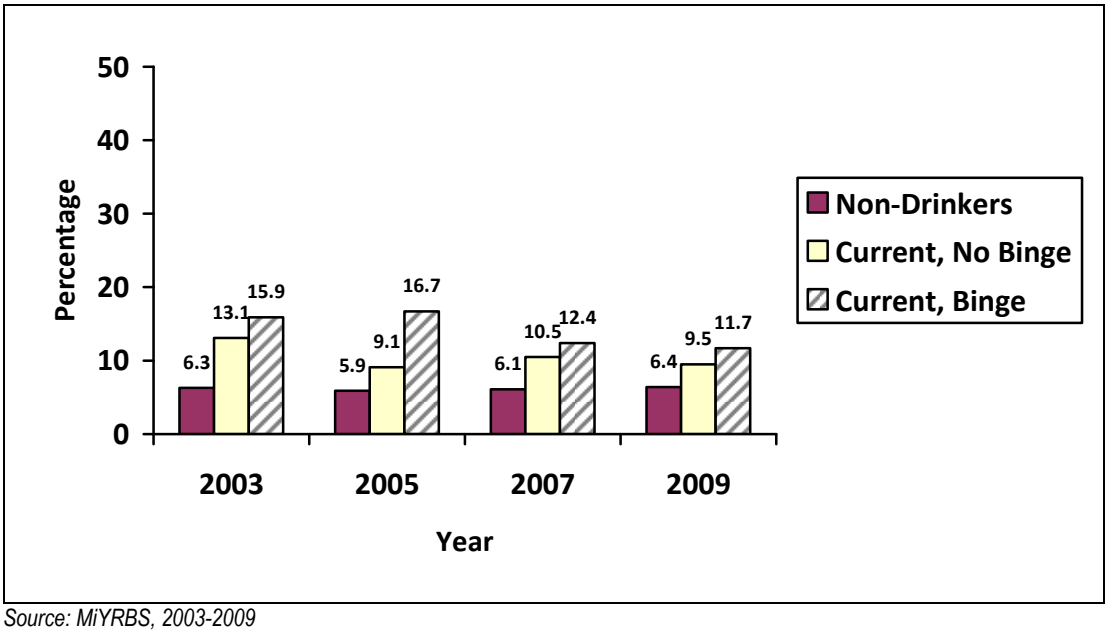
Figure 9 – Prevalence of Depressive Feelings and Alcohol Consumption Among Michigan Youth, MiYRBS 2003-2009



Source: MiYRBS, 2003-2009

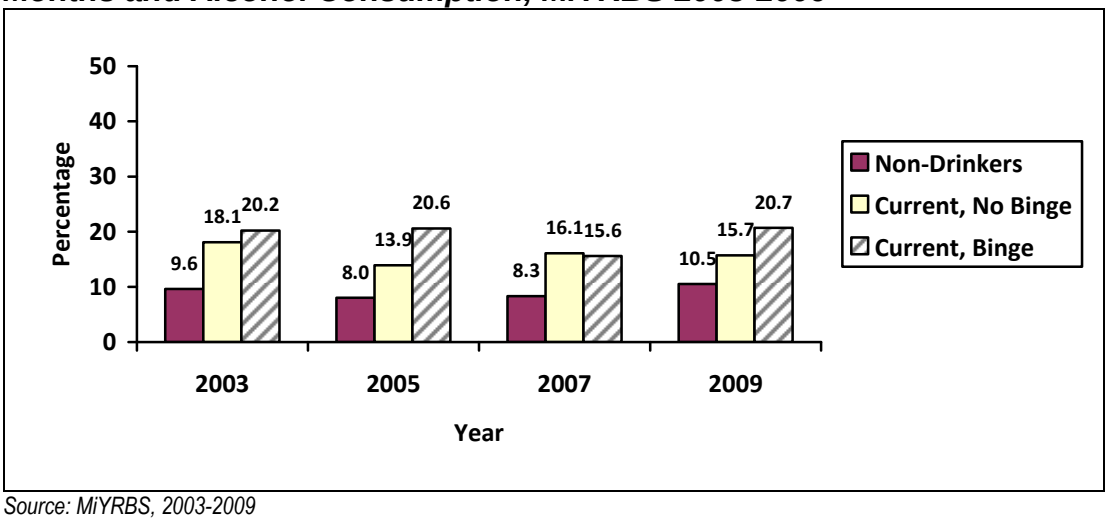
[61] Michigan Department of Community Health, Bureau of Epidemiology, and the Michigan Department of Education. (2010). Violence and mental distress in current and binge drinking mi youth. Michigan alcohol surveillance brief. 1(1). K. Gonzales, K. Kovalchick & L. Cameron (Eds.).

Figure 10 – Prevalence of Students Who Seriously Considered Attempting Suicide during the Past 12 Months and Alcohol Consumption, MiYRBS 2003-2009



Source: MiYRBS, 2003-2009

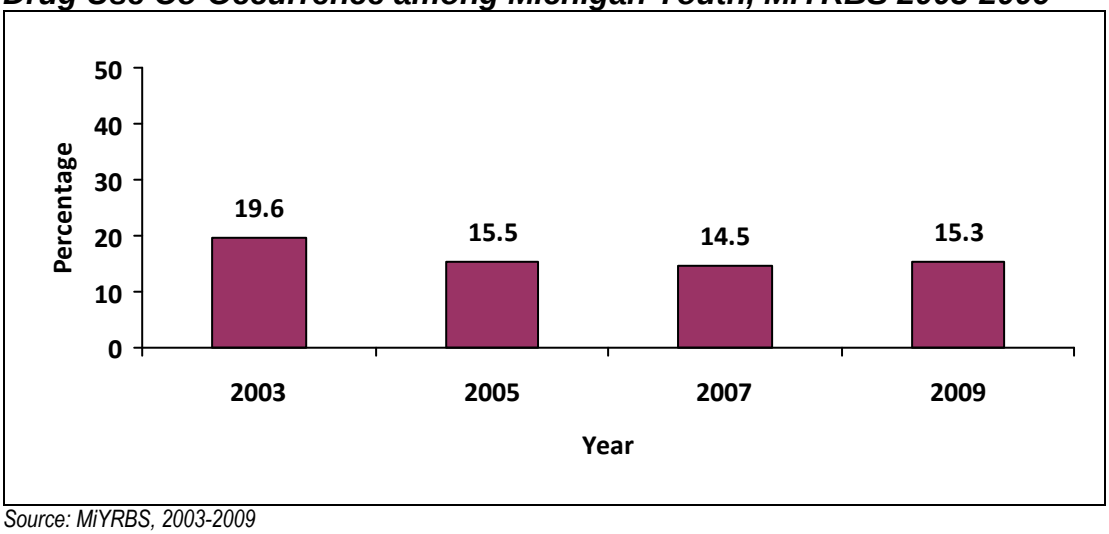
Figure 11 – Prevalence of Students Who Made a Suicide Plan in the Past 12 Months and Alcohol Consumption, MiYRBS 2003-2009



Source: MiYRBS, 2003-2009

The co-occurrence of reported drug use and depressive feelings among Michigan's youth declined during 2003 to 2007, however, the prevalence of reported depressive feelings and lifetime illicit drug use co-occurrence slightly increased from 14.5% in 2007 to 15.3% in 2009, as indicated in Figure 12.

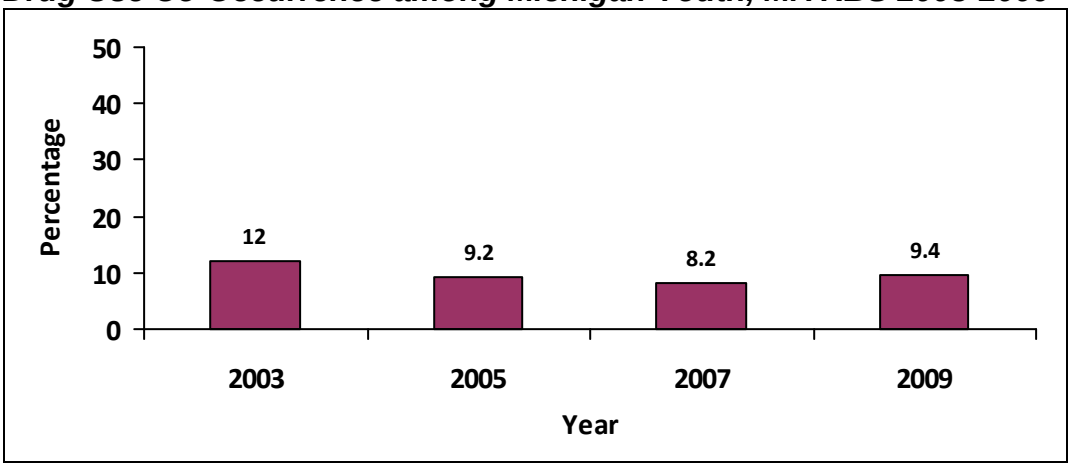
Figure 12 – Prevalence of Past Year Depressive Feelings and Lifetime Illicit Drug Use Co-Occurrence among Michigan Youth, MiYRBS 2003-2009



Source: MiYRBS, 2003-2009

On the other hand, the co-occurrence prevalence of reported depressive feelings and current illicit drug use declined from 12% in 2003 to 9.4% in 2009, as indicated in Figure 13. In 2009, lifetime and current illicit drug use prevalence estimates were significantly higher among Michigan youth reported depressive feelings than those who did not report depressive feelings.[62]

Figure 13 – Prevalence of Past Year Depressive Feelings and Current Illicit Drug Use Co-Occurrence among Michigan Youth, MiYRBS 2003-2009



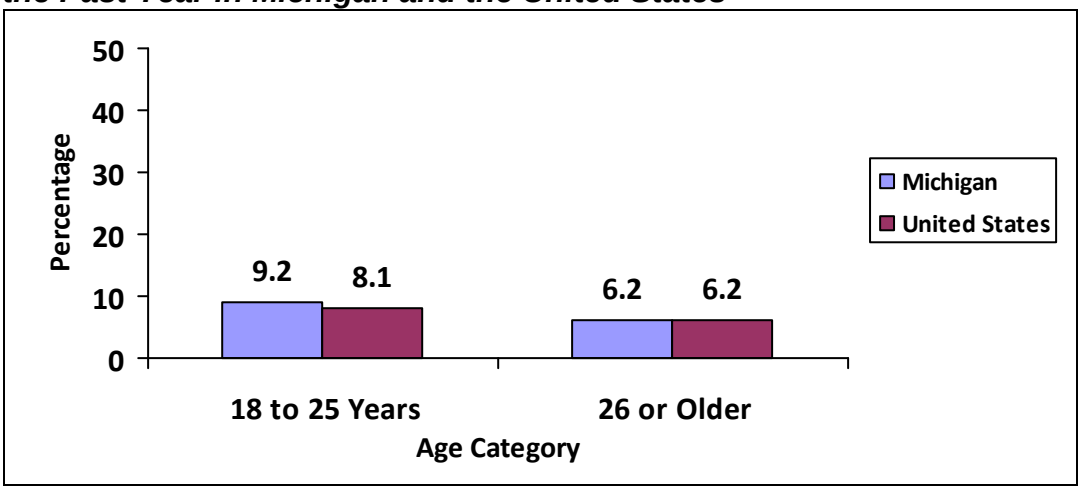
Source: MiYRBS, 2003-2009

[62] Michigan Department of Community Health, Bureau of Epidemiology. (2011). Evaluation of the youth risk behavior surveillance system for monitoring co-occurrence of drug use and depressive feelings among Michigan youth, 2003-2009. K. Hekman, C. Miller & L. Cameron (Eds.).

Depressive Episode and Serious Mental Illness – General Adult

According to NSDUH, young adults between 18 to 25 years-of-age in Michigan showed higher rates of a major depressive episode in the past year, compared to adults 26 or older (9.2% for 18 to 25 years-of age versus 6.2% for 26 years-of age and older) in 2008 and 2009 estimates, as indicated in Figure 15.

Figure 15 – Percentage of Persons Who Had a Major Depressive Episode in the Past Year in Michigan and the United States

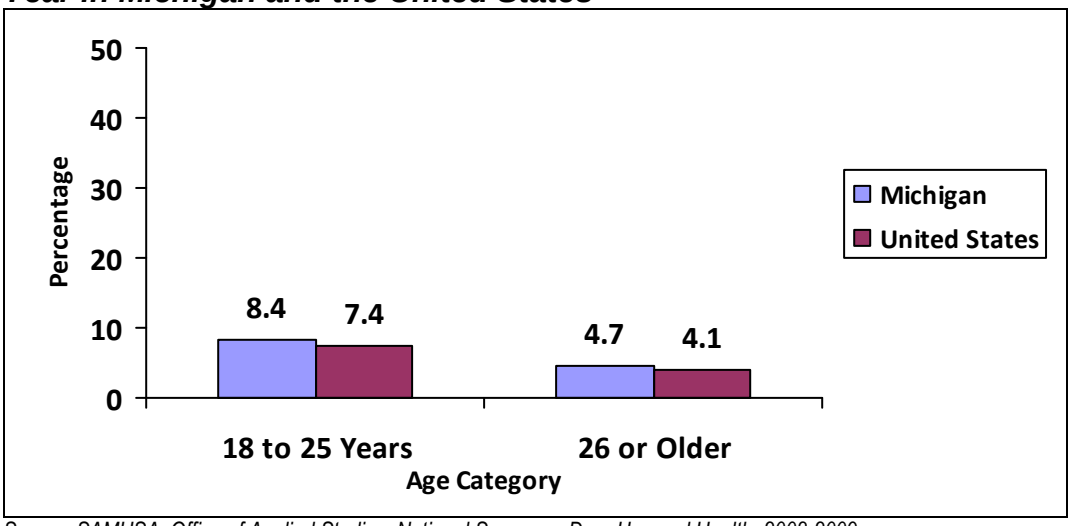


Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2008-2009

In the DSM-IV, a major depressive episode is defined as a period, of two weeks or longer, of either a depressed mood or loss of interest or pleasure, and at least four other symptoms that reflect a change in functioning, such as problems with sleep, eating, energy, concentration, and self-image. Young adults also had higher rates of serious mental illness compared to individuals 26 or older (8.4% for 18 to 25 years-of age versus 4.7% for 26 years-of age and older), as indicated in Figure 16. Serious mental illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a substance use disorder, that met the criteria found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* and results in serious functional impairment.[63]

[63] SAMHSA (n.d.). State estimates from the 2008-2009 NSDUH. Retrieved from http://www.oas.samhsa.gov/2k9State/Ch6.htm#6.1

Figure 16 – Percentage of Persons with Serious Mental Illness in the Past Year in Michigan and the United States



Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2008-2009

REGIONAL AND LOCAL DATA

The following table provides comparisons for the five SPE communities for the 24 ATOD and mental health indicators and 4 social and health indicators provided on pages 14-15. Only significant differences between the indicators for the regions and state are listed below, which are based on 95% confidence intervals.

SPE Community	Region Indicator is Better than State Indicator	Region Indicator is Worse than State Indicator
BABH/Riverhaven	Infant mortality Violent crime	Alcohol-impaired deaths and incapacitating injuries in a motor vehicle crash Perception of great risk of smoking one or more packs of cigarettes per day Suicide deaths
Kalamazoo	Violent crime	Alcohol-induced deaths Binge alcohol use among persons aged 12 to 20 (2002-2004 only) Lung cancer deaths Suicide deaths
Mid-South	Health insurance coverage Infant mortality Violent crime Incidence of lung cancer Drug-induced deaths	Alcohol-impaired deaths and incapacitating injuries in a motor vehicle crash Alcohol and binge alcohol use among persons aged 12 to 20 (2006-2008 only)
Pathways	Infant mortality Violent crime Drug-induced deaths	Alcohol-impaired deaths and incapacitating injuries in a motor vehicle crash Alcohol-induced deaths Alcohol (2002-2004 and 2006-2008) and binge alcohol use (2002-2008) among persons aged 12 to 20 Suicide deaths

SPE Community	Region Indicator is Better than State Indicator	Region Indicator is Worse than State Indicator
Western U. P.	Violent crime Drug-induced deaths Use of marijuana (2002-2004 only)	Alcohol-impaired deaths and incapacitating injuries in a motor vehicle crash Alcohol-induced deaths Alcohol and binge alcohol use among persons aged 12 to 20 (2006-2008 only) Suicide deaths

Data Limitations and Gaps

As is the case in many states, information gaps exist in alcohol, tobacco, other drug (ATOD) and mental health data available within Michigan at the state and local level. These gaps in information may limit the ability to address a complete profiling of population needs, resources, and readiness. The SEOW has identified these information gaps, which are primarily the result of systems issues. Subsequently, these gaps may have impacted the formulation of statewide and local community indicators and need statements, and what has been included in this document.

When assessing data, the SEOW looked at measure, availability, analysis and frequency of data collection as a first tier consideration of whether to include specific data sets. This contributed to the level of confidence in what the data appeared to be showing. Other considerations related to data gaps and limitations included:

- Limited use of available tools in communities. One example of this was the limited number of school districts using the Michigan Profile for Healthy Youth (MiPHY). Through efforts of the SEOW, community coalitions, CAs, the Michigan Department of Education and other stakeholders, attention has been given to community readiness and responsiveness to conducting the MiPHY, and the number of school districts now participating has increased substantially.

- Limited data being collected on specific drugs (e.g. methamphetamine, prescription and over-the-counter drugs, etc.) or specific correlations (e.g. the link between child health and maternal alcohol consumption related to fetal alcohol spectrum disorders [FASD] or potential mental health indicators, the link between substance use/abuse and child abuse and neglect cases, etc.)

- The need for substance use disorder treatment data that is not limited to publicly funded programs (and a disclaimer to be added to current data on this limitation).

- Limitations in data sources available to assess mental health issues in communities, and the link to risk and protective factors, life stressors, and other potential indicators.

- Local level risk and protective factor data related to environment/access, school, community and individual domains, as well as specific populations (e.g., college students, adjudicated youth, the elderly, etc.).

The above examples of gaps in data are acknowledged, and are important for the reader to consider when reviewing this document. Although accomplishments have been achieved in developing and accessing more data in recent years, there is still work to be done. It is expected that as the SEOW work proceeds additional indicators will be added in future reports as data is identified and new linkages are made. The SEOW views this as one of its primary roles. The assistance and support of the Michigan Department of Community Health will be invaluable to this process.

Service Coordination and Integration

Required for inclusion per number 3 in the "Directions for completing the 5-year Strategic Plan." The following section provides essential goals, objectives, and strategies for coordinating services with public and private service delivery systems, including primary health care.

The Michigan Department of Community Health (MDCH) 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 BSAAS functions as the SSA within MDCH. Responsibilities include the administration of federal and state funding for substance abuse prevention, treatment, recovery, and gambling addiction. As explained on p.8, BSAAS allocates Substance Abuse Prevention and Treatment (SAPT) Block Grant (BG) funding through 16 coordinating agencies CAs, whose responsibilities include planning, administering, funding, and maintaining the provision of substance abuse treatment and prevention services for 83 counties in Michigan. All CAs have prevention coordinators (PCs), who receive input from and empower local communities in their response to substance abuse prevention needs.

In fiscal year 2010, $40.4 million was invested at both the state and local level through multi-agency collaborative partnerships. These resources included federal and state funding administered by the Michigan Department of Education (MDE), Michigan State Police (MSP), Office of Highway Safety Planning (OHSP), Michigan Department of Human Services (DHS), and Prevention Network (PN).

In addition to the above multi-agency partnerships, other divisions and sections within MDCH, including Epidemiology, Injury and Violence Control, Adolescent Teen Health Centers, Maternal and Child Health, and the Drug Surveillance Team are strong partners with BSAAS in addressing mutual priorities. Examples of these collaborative efforts include development of underage drinking fact sheets, unintentional drug poisoning overdose death information and conference presentations with MDCH Epidemiology; participation on the Wayne County Drug Surveillance Team that included responding to fentanyl, other prescription drug, and synthetic cannabinoids overdose deaths in the City of Detroit; and collaboration with Maternal and Child Health in relationship to fetal alcohol spectrum disorder (FASD) planning and program implementation.

The Michigan Association of Substance Abuse Coordinating Agencies (MASACA), the Michigan Association of Local Public Health (MALPH), and the Michigan Primary Care Association (MPCA) are other statewide partner organizations and key stakeholders that are important partners in moving forward in service coordination. MASACA and MALPH are statewide organizations whose membership is comprised of the directors of the organizations they represent.

MPCA is the organization in Michigan which provides oversight to federally qualified health centers (FQHCs). These health centers are local, non-profit, community-owned providers of quality primary and preventive health care, and are located in medically underserved communities. Their clients include subpopulations comprised of racial, ethnic, and sexual/gender minority groups vulnerable to health disparities. In Michigan, 32 health centers serve nearly 600,000 patients at over 190 sites across the state and include community health centers, migrant health centers, health care for the homeless centers, and public housing health centers. Each health center's staffing model, facility, scope of service and approaches are tailored to meet the unique needs of its patients and community, and provide culturally appropriate health care that is close to where patients live, at times that are convenient, and in languages the person can understand.

BSAAS has recently established contact with Indian Health Services (IHS)-Central (Bemidji area) region. The Bemidji Area administers several service units which provide care through IHS practitioners. It also administers federally recognized tribal and urban programs which deliver services through health care providers directly hired by the tribes. Many tribal members are geographically isolated from the urban facilities and community health centers, and must rely on tribal and contract providers for their health care needs.

In addition, a strong partnership has been developed over the past two years with the Michigan Army National Guard. Members of this branch of the armed forces are members of both the SPE Policy Consortium and the SEOW, and were active participants as the state's Prescription and Over-the-Counter Drug Strategic Plan was created.

It should be evident from this description that Michigan has strong partnerships at the state level that will help facilitate coordination of services with public and private service delivery systems, including primary health care.

As Michigan moves forward over the next five years, its plan is to focus on system integration at the regional and local level. Emphasis on developing PPCs and successful ROSC will promote coordination of services.

- By the end of 2013 all CAs will have participated in the expansion of the SPE revised training on prevention prepared communities.

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- In FY 2012, BSAAS issued a request for proposals (RFP) to CAs to implement projects that will initiate MI-SBIRT; modeled after the federally funded SBIRT programs. The purpose of this project is to implement MI-SBIRT services for individuals in primary care and/or community health settings, with substance misuse and substance use disorders (SUD). The projects are expected to:

    1. Expand/enhance the continuum of care for substance misuse services and promote behavioral health and primary health integration efforts.
    2. Reduce alcohol and drug consumption and their negative health impact.
    3. Increase abstinence and reduce costly health care utilization.
    4. Promote sustainability and improve treatment outcomes.

MI-SBIRT is designed to expand and enhance the continuum of care in primary care and a mix of other community health settings (e.g., health centers, university health centers, emergency departments, and office-based practices), and support the use of clinically appropriate services for persons at-risk for, or diagnosed with, a SUD. It also seeks to identify and sustain systems and policy changes to increase access to prevention and treatment services in generalist and specialist medical settings. The MI-SBIRT process supports the overall goal of the MDCH to integrate behavioral health and primary care in Michigan while promoting recovery, wellness, and a fulfilling quality of life.

Four CAs (none of these are one of the five SPE CAs) were recipients of these MI-SBIRT project grants. These projects are all in urban settings varying in size and scope. All will be carefully evaluated. It is expected that the SBIRT project grant program will be expanded beginning in 2014 incorporating what is being learned in the four pilot areas.

Michigan is in the process of completing a Training the Trainers for fifteen individuals representing the five SPE communities, the four MI-SBIRT project grants, recovery coaches/the recovery community, school health coordinators, Michigan's training cadre, and community coalitions. The individuals being trained represent every geographical area of the state. This training will be completed in August 2012 and should enable SBIRT training to be provided throughout the state in 2013.

- By 2014 all local communities will have access to webinars on accessing and using data. This is intended to strengthen the measurement of consequences, intervening variables, and the identification and measurement of outcomes.

- Over the next two years trainings on topics of mutual interest to prevention, treatment, mental health, and primary care will be offered widely throughout the state encouraging participants from different sectors to attend training events together (e.g., Trauma in early childhood, SBIRT, QPR-Question, Persuade, Refer Training for Suicide Prevention, and Peer Recovery Coach Training).

- Beginning in 2015 CA Action Plans will reflect new standards for reporting on collaborations and coordination of services. By this date, all local communities

will be collaborating with their county collaborative, local health department, and area primary care providers.

- By 2016, ninety percent of counties will have sufficient school district participation in utilizing the MiPHY (Michigan Profile of Healthy Youth) to be able to use the results to assess substance abuse prevalence and risk and protective factors at the local community level.

- Michigan has about 200 local substance abuse coalitions. By 2017, ninety percent of these groups will be part of PPCs actively supporting ROSC and coordinating prevention services with mental health and primary care providers.

SPE Policy Consortium Oversight

Required for inclusion per number 4 in the "Directions for completing the 5-year Strategic Plan." The following section summarizes the key decision making processes and findings undertaken by the SPE Policy Consortium during the development of the Strategic Plan.

The SPE Policy Consortium was created as a workgroup of Michigan's TSC in December of 2011. Membership in this group includes representatives from the MASACA, MDE, OHSP, the Michigan Army National Guard, the five CA regional communities participating in the SPE grant project, local substance abuse coalitions, faith-based agencies, prevention providers. Additional participants are BSAAS administrators and the Wayne State University evaluator. The consortium has met monthly since its creation.

During the grant funded year its role has been oversight of all SPE activities. The group provided invaluable input into developing and implementing the four mini plans that comprised the capacity building and infrastructure enhancement plan. This was primarily defined by the goal of developing a workforce capable of implementing recovery oriented systems of care in the context of prevention prepared communities.

- The consortium provided guidance on the development of the workforce development scan, the prevention and treatment environmental scan, and the mental health environmental scan. They will also review the primary care scan scheduled to be administered before the end of the grant year.

- It will be the responsibility of the consortium to review, analyze, and incorporate the findings from the scans into on-going prevention enhancement planning.

- The consortium designed and field tested the PowerPoint program currently being used in the state to educate people widely on ROSC and PPCs. This program was included in the trainings of the five regional communities on ROSC and PPCs. See p. 12.

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The PowerPoint will be revised prior to the end of the grant year under the direction of the consortium for use with trainings to expand SPE to the eleven other regional CAs.

- The consortium provided guidance on the development of the above mentioned training on ROSC and PPCs. This included reviewing the agenda and all of the materials used in the trainings.

- The consortium provided guidance on the development of this 5-year strategic plan deciding that expansion to the remaining eleven regional CAs should occur in year one of the plan and shall be done simultaneously with additional training being offered to the original five SPE communities.

The consortium will continue to function as a workgroup of the TSC providing guidance to the implementation of this 5-year strategic plan. It will work actively with TSC to recommend and implement policy changes across state-level partners and stakeholders responsible for SUD prevention and mental health promotion.

Planning Guidelines

Required for inclusion per number 5 in the "Directions for completing the 5-year Strategic Plan." The following section describes in detail the processes, procedures and logic model criteria that are used at the state and community levels including by community coalitions for selecting and implementing evidence-based programs, policies, and practices. This logic model approach requires that communities identify the key risk and protective factors contributing to both substance abuse and its consequences.

The Current "Action Plan Guidelines for Regional Substance Abuse Coordinating Agencies" was published in May 2011 and applies to Fiscal Years 2012-2014. This document applies to both prevention and treatment services administrations and providers.

Included in the action plan guidelines document under the section labeled "Michigan Department of Community Health Priorities" was the following statement,

SAMHSA Strategic Initiatives:

In the 2011 publication, Leading Change: A Plan for SAMHSA's Roles and Actions 2011-14 (http://www.samhsa.gov), SAMHSA lists prevention of substance abuse and mental illness as strategic initiative number one. The promotion of mental health and prevention of SUDs are essential to SAMHSA's mission to reduce the severity of substance abuse, mental illness, and related conditions in communities across the country. Please note the following primary goals under this initiative.

1.1 Build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.

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1.2 Prevent or reduce consequences of underage drinking and adult problem drinking.
1.3 Prevent suicides and attempted suicides among populations at high risk, especially military families; LGBTQI youth; and American Indians and Alaskan Natives.
1.4 Reduce prescription drug misuse and abuse.

The implementation of Prevention Prepared Communities (PPCs) will be the primary objective used to meet these goals. A PPC is a community equipped to use a comprehensive mix of data driven prevention strategies, interventions, and programs across multiple sectors to promote emotional health and reduce the likelihood of mental illness, substance abuse (including tobacco), and suicide among youth, tribal communities, and military families.

During the implementation of the Strategic Prevention Framework State Incentive Grant (SPF/SIG) and Drug Free Communities Support Grants, coordinating agencies (CAs) began the process of building and developing PPCs. Action plans should reflect evidence of the development of PPCs for the prevention of SUDs and mental illness, and the promotion of mental health in support of ROSC implementation. This initial planning marks an evolutionary braiding of inter-agency services that integrates the strengths and resources of each*."*

Directions for community coalitions and CA prevention coordinators include a logic model approach that requires communities to identify "consequences", "intervening variables" (defined as modifiable risk and protective factors), and "evidence-based services/interventions" specific for each targeted intervening variable.

The details of requirements in the "Action Plan Guidelines for Regional Substance Abuse Coordinating Agencies" are contained in Appendix A.

Since the publication of these guidelines CAs have developed and implemented action plans for one funding year, 2012. Five of these CA's have been recipients of capacity and infrastructure development as part of the SPE grant. It is expected that their action plans for 2013 will begin to reflect this greater capacity for developing PPCs that are better positioned to accomplish the above goals.

Beginning with funding year 2013, Michigan will expand the capacity and infrastructure development experienced by the five SPE communities in the grant year to additional CA regions until all are fully able to work with local coalitions and other organizations to effectively establish PPCs throughout Michigan. This expanded capacity should become visible in CA action plans.

Funding Formula Recommendations

Required for inclusion per number 6 in the "Directions for completing the 5-year Strategic Plan."

As agreed upon by the SPE Policy Consortium, Michigan will use the SAMSHA federally approved funding formula for the allocation of state substance abuse prevention resources.

Implementation Plan

Required for inclusion per number 7 in the "Directions for completing the 5-year Strategic Plan." The following implementation plan describes how key prevention strategies will be implemented, a timeline, those responsible for completion and expected completion dates.

Prevent or Reduce Consequences of Underage and Adult Problem Drinking.

Michigan has a long history of addressing underage drinking jointly supporting (with OHSP) the Michigan Coalition to Reduce Underage Drinking for nearly 15 years; creating a Childhood and Underage Drinking (CUAD) Workgroup as part of SPF/SIG; supporting over 200 local community coalitions through the regional CA system; and including it as a required priority in CA action plans for the last four years. It has demonstrated some success as reported earlier in this report.

In 2010 Michigan's CUAD Workgroup completed the "Blueprint for the Delivery of Alcohol and Drug Prevention and Treatment" utilizing the six recommendations outlined in the "Blueprint for the States."[64] Since that time Michigan has passed a keg tracking law and banned alcohol energy drinks. All areas of the state regularly do compliance checks for sales to minors.

BSAAS with assistance from the CUAD Workgroup recently developed a seven minute video titled "Do Your Part" highlighting individuals who share how they are doing their part to prevent underage drinking, and inviting other adults to "Do Your Part." Five 30-second public service announcements targeting parents, coaches, retailers, educators, and law enforcement are available for free distribution as 30 second Public Service Announcements (PSAs) at www.michigan.gov/doyourpart. This video was produced through collaboration with the federal Center for Substance Abuse Prevention (CSAP) Underage Drinking Prevention Education Initiatives (UADPEI).

BSAAS has been collaborating with Dr. Stephen Guertin, MD, Medical Director, Sparrow Children's Center, Lansing, Michigan, around the issue of underage drinking and the link to fetal alcohol spectrum disorders (FASD).

[64] Join Together (2006). *Blueprint for the States – Policies to Improve the Ways States Organize and Deliver Alcohol and Drug Prevention and Treatment*. Retrieved from www.jointogether.org/aboutus/policy-panels/blueprint/order-form.html.

The following goals have been established to guide Michigan in its efforts to further reduce underage and adult drinking.

1. Increase Multi-System Collaboration

   The collaboration at the state level has been well documented here. At the local coalition level the collaboration is primarily with the twelve sectors called for in organizing drug free communities. In almost every case for the community to become an effective PPC these collaborations need to be expanded to include the multi-purpose collaboratives, health departments, hospitals and primary care service agencies, drug and sobriety courts, representatives from the juvenile justice system, community colleges and universities. BSAAS will expand the list that CAs are required to report to as part of the annual action plans.

2. Reduce adult abuse by engaging all segments of the community in establishing ROSC and increase the use of brief interventions.

   - Over the next five years, BSAAS will increase the training for physicians in Screening, Brief Intervention, Referral, and Treatment (SBIRT). See p. 42 for details.

   - In 2013 trainings on developing PPCs will be provided to all CA regions.

3. Engage parents in helping to reduce underage drinking.

   During the next three years, through training and technical assistance and use of AP requirements, encourage local coalitions to

   - offer evidence-based programs that will improve parenting skills such as *Strengthening Families* or *Active Parenting for Teens: Families in Action.*

   - provide strong networks for parents of teens that reinforce no underage use messages.

   - use the recently developed 30-second “Do Your Part” PSA to outreach to parents.

4. Over the next five years, all existing community coalitions will become PPCs and implement at least one environmental strategy.

   - Leadership for strengthening community coalitions to become PPCs will be led by a revitalized CUAD or MCRUD. The *Communities that Care* model program will be widely distributed to inactive or weak coalitions.

   - BSAAS will provide training on the evidenced based program *Community Trials*.

Prevent Suicides and Attempted Suicides Among High-Risk Populations

As part of the SPE planning year BSAAS organized four Suicide Prevention Prepared Communities trainings (p. 14). Through the development and implementation of these trainings it became apparent that knowledge of suicide and suicide prevention varies greatly throughout the state. Participation in suicide prevention groups is more prevalent for mental health professionals than it is for substance abuse prevention professionals. In many communities there are groups working on suicide prevention who have no connection to the local substance abuse prevention coalition. This includes some suicide prevention groups organized by multi-purpose collaboratives.

Most groups are organized around preventing youth suicides often in response to a local youth who has committed suicide. Youth, however, are not the group most at risk for suicide with the exception of LGBTQI youth.

The group who is most at risk are white men between the ages of 35-54 and over 80 (with the latter being by far the most at risk).

Most groups are not systematically connecting to LGBTQI youth or military families. Only in a few instances is there good outreach to American Indians.

The state published a Suicide Prevention Plan for Michigan in 2005. It is scheduled to be reviewed and revised this year. Much of it is still relevant and provides good guidance to the state for what should be happening.

1. BSAAS has a good working relationship with the Injury and Violence Prevention Section of MDCH, participated in the writing of the 2005 Suicide Prevention Plan, and will participate in its review and revision.

2. Coordinating agencies will encourage local community coalitions to collaborate with any existing suicide prevention group in their local area. If there is not an already existing group the coalition should work with appropriate partners to establish one. Local community coalitions will be expected to report to this in their 2013 annual report.

3. By the end of 2015, every county/pairing of counties/or group of counties should have a functioning suicide prevention group that has a local plan to accomplish the following goals:

    - Reduce the incidence of suicide attempts and deaths across the lifespan
    - Develop broad based support for suicide prevention
    - Promote awareness and reduce the stigma

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- Develop and implement community-based suicide prevention programs using the “Best Practices Registry” available from the Suicide Prevention Resource Center (SPRC)
- Promote Efforts to Reduce Access to Lethal Means and Methods of Suicide
- Improve the Recognition of and Response to High Risk Individuals Within Communities
- Improve use of existing surveillance systems

Reduce Prescription Drug Misuse and Abuse

In February 2011, BSAAS established an Rx/OTC Drug Abuse Workgroup. The goal of the workgroup was to develop a strategic plan, including recommendations, for reducing Rx/OTC drug abuse. The strategic plan is to serve as a template for community-level agencies committed to developing local-level action plans. The workgroup membership included representatives of the state- and community-level agencies responsible for the provision of behavioral health care, substance use disorder prevention, education, law enforcement, and environmental quality.

In December 2011, the Rx/OTC Drug Abuse Workgroup distributed a *Community Scan Survey* to community coalitions, CAs, pharmacy retailers, local law enforcement, local public health departments, schools, and substance use disorder treatment and prevention providers. The purpose of the scan was to elicit feedback from community-level stakeholders on their level of capacity to conduct education, law enforcement and prescription drug storage or disposal programs in their respective communities.

Based on feedback from over 400 stakeholders at the 2009 Rx/OTC Drug Abuse Summit and the *Community Scan Survey*, the BSAAS Rx/OTC Drug Abuse Prevention Workgroup identified four goals to be addressed:

1. Increase Multi-System Collaboration

   BSAAS has collaborative relationships with the following key state-level stakeholders and partners, including the Michigan Department of Education, MSP, Michigan Department of Environmental Quality, Michigan National Guard, Michigan Pharmacy Association, the Michigan Primary Care Association, and the Michigan Association of Substance Abuse Coordinating Agencies.

   Over the next two years BSAAS will increase collaboration with the following agencies: Michigan Department of Human Services, Michigan Department of Licensing and Regulation, Michigan Dental Association, Michigan State Medical Society, Michigan Health and Hospital Association, Michigan Broadcasters Association, and the DEA. These agencies include diverse expertise and resources that are essential in combating Rx/OTC drug abuse.

In September of 2012, primary care physicians, dentists, and pharmacists in the five SPE communities will be surveyed to determine their knowledge and attitudes about prescription drug abuse and their willingness to collaborate at the local level to address this issue.

By the third quarter of 2014, BSAAS will work with the Pharmaceutical Associations to develop recommendations for the dispensing of prescription opioids.

2. By the end of 2013, BSAAS will develop statewide media messages to be delivered to the general public, parents, and caregivers. The primary agents for delivering the media messages would be law enforcement, CAs, coalitions, educational institutions, pharmacies, and primary health care agencies.

   Media messages and campaigns should be developed considering the following guidance:

   - Consider existing data when developing a new theme, materials, or suggesting existing messages and materials. Does the message speak to the data?
   - Pinpoint the desired goal of the message and materials. What is desired to be achieved? What is the desired behavior change for the target audience?
   - Consider the audience. Who is the message targeting? Is it culturally sensitive and relevant?
   - Determine the cost and benefit for a target audience behavior modification. What is the motivation for the target audience to change their behavior?
   - Identify existing messages and materials before developing new ones. Are there existing campaign materials and messaging that meet identified needs?
   - Use a multi-pronged strategic approach. How will the campaign educate the public about the effects and prevalence, proper disposal, and where to take unwanted or unused medications?
   - Remember positive messages work better than negative messages and scare tactics.
   - Consider using focus groups to help tailor messaging for specific audiences.
   - Determine if the overall message should be a statewide theme or community specific. What works best?
   - Simple is better. How can it be made easy for the audience to adopt the desired behavioral change?

   Other means of broadening statewide media messages would include the development and dissemination of toolkits distributed statewide. The toolkits would include: educational materials that stress the dangers of using Rx/OTC drugs, a listing of existing resources that will inform the public and patients on safe usage, educational materials on proper storage and disposal of Rx drugs, promotion of existing disposal programs, and educational materials for law enforcement to aid them in identifying and stopping illegal and/or questionable

prescribing practices. Resource materials and toolkit examples can be found at the following websites:

SPONSOR	WEBSITE
Office of National Drug Control Policy	www.whitehouse.gov/ondcp
National Institute on Drug Abuse	www.drugabuse.gov/
U. S. Drug Enforcement Administration	www.justthinktwice.com/
Department of Community Health	www.michigan.gov/mdch-bsaas, see Prevention, RxOTC Drug Abuse
The Mayo Clinic	www.mayoclinic.com/health/prescription-drug-abuse/DS01079/ DSECTION=prevention

3. Broaden Rx/OTC Drug Abuse Education and Use of Brief Screenings

According to the MAPS, the number of legitimate prescriptions written for pain relievers was at 6.3 million in 2003 and 8.9 million in 2010. However, between 2003 and 2010, the number of prescriptions filled for Suboxone, a partial opioid agonist used in treatment addiction, increased rapidly (327 prescriptions in 2003 and 285,059 in 2010). Prescriptions for hydrocodone (e.g., Vicodin) also accounted for 31.2% of all controlled substance prescriptions in 2010.

Over the next five years, BSAAS will increase the training for physicians in Screening, Brief Intervention, Referral, and Treatment (SBIRT). See p. 42 for details.

There was a 369% increase (1,189 to 5,581), from 2000 to 2011 in the number of persons admitted to Michigan's publicly-funded treatment system for addiction to prescription drugs. The primary substance of abuse was opioid based synthetics. This massive increase in the number of persons needing treatment due to their addiction to prescription drugs has placed a considerable strain on the public service delivery system. Since the prescriptions for opioids to treat pain were written in primary care settings, physicians and other healthcare providers are in a position to provide appropriate SBIRT for the patient who is at-risk for developing a dependence on prescribed medications.

Support law enforcement alcohol and drug screening initiatives on the part of the MSP and OHSP to provide the Advanced Roadside Impaired Driving Enforcement (ARIDE) Program and DRE training. There are now 19 DREs in Michigan, with 15 more planned to be trained during FY 2012. In addition, there are currently 500 law enforcement officers around the state who have completed the ARIDE Standardized Field Sobriety Test (SFST) training, with one class being offered each month to train an additional twenty officers each time. OHSP has recommended SFST training to be part of basic training for all officers.

CAs, coalitions, schools, and the military must continue to provide prescription drug education programming that targets grades four through twelve. Evidence-

based programs such as the Michigan Model will prove invaluable for expanding education to this age group.

4. By 2014, increase access to and use of the Michigan Automated Prescription System (MAPS)

   BSAAS will work with the Department of Licensing and Regulatory Affairs (LARA) who should update the MAPS to increase usage by the general public, including users of pain medications, pharmacists, law enforcement, Behavioral Health and Developmental Disabilities Administration (BHDDA), and the BSAAS State Epidemiological Outcomes Workgroup (SEOW).

   It is also recommended that LARA expand MAPS to include a report that identifies current information, and a template for requesting the data and an analysis of that data.

   Additionally, LARA should convene a training conference on the use of MAPS by the end of fiscal year 2013.

At the start of FY 2010, all 16 CAs were required to address Rx/OTC drug abuse in their Action Plan (AP) submissions for prevention. Utilizing a Strategic Planning Framework, each CA developed and implemented a plan to prioritize needs within their region.

These APs will be evaluated and strengthened each year following the four recommendations contained in this plan.

Evaluation Plan

Required for inclusion per number 8 in the "Directions for completing the 5-year Strategic Plan." The following section provides an evaluation plan that identifies baseline and outcomes data as well as processes and procedures for conducting an evaluation at the state and community level. The evaluation plan describes how needs assessment and evaluation data will be used for ongoing adjustments.

There are two types of information that will be used to evaluate the progress of this implementation plan:

1. Reports about activities spelled out in this report that when accomplished should create the capacity to actually reduce underage and adult problem drinking, suicide, and prescription drug abuse.

   These activities at a broad level are building a ROSC and creating a PPC. They fit under goals like "Increase multi-level collaboration." Because Michigan's implementation is happening at a regional and local level more than it is at the state level, tracking all these hundreds of actions becomes very important.

Measuring not only the number of these activities but also the quality helps to explain progress or lack thereof in meeting the outcome goals.

The multi-year action plans and progress reports completed locally and then by the CAs are key to providing the tools for assessment and process evaluation.

2. The other type of information is data that measures consequences (the effects of use, misuse and abuse of a substance on quality-of-life: health, mortality, crime, dependence, accidents, and potential life lost); consumption patterns (prevalence, use, patterns); and intervening variables (positive and negative contributing factors, such as: availability, enforcement and adjudication, promotion, social norms, laws and policies, risk/protective factors, and other mediating resources). Michigan has identified 24 of these measures, not all of which are relevant to this plan.

For the purposes of this document emphasis will be placed on the need indicators that were used to identify the five SPE communities as high-need and others that will be useful at the regional level to measure successful expansion of strategic prevention enhancement: level of past 30-day use of alcohol and binge drinking among youth 12-20 years-of-age; alcohol involved deaths and serious injuries; non-medical use of pain relievers; past year psychological distress; past year major depressive episode; and age-adjusted suicide rates.

While Michigan's epidemiological report is updated every year, not all data is reported out every year and some indicators are best reported for a range of years rather than just a single year at a time. Within the context of these limitations, the following data will be reviewed every year of the plan at the state and regional level:

Indicator	Baseline	Milestone	2017 goals
Past 30-day use of alcohol among youth 9th-12th grades (M-YRBS)	(2011) 30.5%	(2013) 29.0%	(2017) 26.0%
Binge drinking in past month among youth 9th-12th grades (M-YRBS)	(2011) 17.8%	(2013) 17.0%	(2017) 14.5%
Percent of individuals over 18 who are heavy drinkers (NSDUH)	(2008-10) 5.4%	(2012-14) 5.3%	(2014-16) 5.2%
Alcohol involved deaths when at least one driver was 16-20 years-of-age and had been drinking	(Average of 2004-10) 29	(Avg. of 2009-14) 28.5	(Avg. of 2011-17) 28
Alcohol involved serious injuries when at least one driver was 16-20 years-of-age and had been drinking	(Average of 2004-10) 144	(Avg. of 2009-14) 143	(Avg. of 2011-17) 142
Non-medical use of pain relievers by youth aged 12 to 17 (NSDUH)	(2008-09) 7.4%	(2012-14) 7.3%	(2014-16) 7.1%
Non-medical use of pain relievers by youth aged 18 to 25 (NSDUH)	(2008-09) 13.9%	(2012-14) 13.4%	(2014-16) 12.7%
Past year major depressive episode experienced by youth in 9th-12th grades in 2009 (M-YRBS)	(2011) 27.4%	(2013) 29.0*	(2017) 26.4%
Age-adjusted suicide rates 2009	11.3 per 100,000	11.1 per 100,000**	10.8 per 100,000

**This measure is expected to go up before it goes down based on community awareness and capacity to respond.*
***2014*

Individual communities and regions may select additional indicators to monitor on an annual basis, especially those that measure intervening factors that they are targeting as part of a prevention strategy. This would be particularly true for a community implementing the Community Trials model program.

Action/Sustainability Plan

Required for inclusion per number 9 in the "Directions for completing the 5-year Strategic Plan." The following section provides an action/sustainability plan that describes the primary strategies for sustaining the state infrastructure and outcomes, and for implementing the plans developed as a result of this grant.

In developing this plan, BSAAS is utilizing the infrastructure it has in place including its collaborative partners, workgroups like the SEOW and the TSC-Prevention Policy Consortium, and the 16 regional coordinating agencies, so it is highly likely that the systems and expectations already in place will be able to implement and sustain this plan.

The targeted outcomes have been consistently identified and are already incorporated in the Guidelines for Action Plans 2012-2014. Community groups and CAs are well trained in the SPF planning process so they understand the development of data driven needs assessment and data driven goals.

The evidenced based strategies identified here are ones with which many in the prevention field are already familiar and already being implemented in some locations in the state.

The challenges in this plan rest in the variety and quantity of relationships that are required to implement this plan but even this challenge has been part of developing ROSC which has been Michigan's primary focus for the last two years. The emphasis on creating PPCs helps make it more concrete at the local level.

Specific actions that will be taken to insure sustainability are:

1. Maintenance of the SPE Policy Consortium which is a sub-committee of the Transformational Steering Committee. This group will continue to supply oversight to implementation of the plan.

2. Creation of the web-based data repository for use in local and regional planning.

3. Maintenance of the SEOW and the regional epidemiology workgroups.

4. A review will be done of the Action Plan Guidelines to insure that all aspects of the plan are incorporated.

5. A tool-kit will be developed that contains resources for developing a PPC. The extension of SPE to the remaining CA regional communities may be one of the one important actions to sustain this plan because it will have everyone operating from a similar understanding.

6. Maintenance of the state training cadre providing training to the prevention workforce (especially new members) and full utilization of federal training resources including advocating use of new on-line training tools.

7. Secure federal discretionary grants.

Directions for Prevention Coordinators

Prevention programming is intended to reduce the consequences of SUDs in communities by preventing or delaying the onset of use, and reducing the progression of SUDs in individuals. Prevention is an ordered set of steps along a continuum that promotes individual, family and community health; prevents mental and behavioral disorders; supports resilience and recovery; and reinforces treatment principles to prevent relapse. Prevention services are most effective when the services are conducted within a PPC.

ROSC Implementation Plan goal four: 'To enhance our collective ability to support the health, wellness, and resilience of all individuals by developing prevention prepared communities.' That goal underscores the value of PPCs as the cornerstones of a ROSC. It is evident that PPCs are designed to promote behavioral health and wellness, provide the multi-sector infrastructure necessary, and are critical to the successful implementation of a ROSC. This is consistent with SAMHSA's primary strategic initiative of preventing substance abuse and mental illness.

In concert with implementation of the ROSC, SAMHSA's strategic initiative related to PPCs, and MDCH priorities related to obesity and infant mortality, CAs are expected to sustain a SPF process and a service delivery system that will show evidence of working toward community-level change. A role for prevention services directed toward individual behavior change remains for specific high-risk selective and indicated populations.

CAs are expected to employ the six SAMHSA Center for Substance Abuse Prevention (CSAP) strategies to engage individuals and the community to effect population-based change. It is critical to note that, especially in the case of information dissemination and alternatives, multi-component community-based strategies are more effective than single-component strategies. The six strategies are as follows:

- Information dissemination.
- Education alternatives.
- Problem identification and referral.
- Community-based process.
- Environmental.
- Alternatives

This multi-component and strategic approach should cover all age groups including support for children, senior citizens, all socio-economic classes, diverse cultures, minority and under-served populations, service men and women, gender-specific and targeted high-risk groups.

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

Prevention Services Planning Chart for Prevention Prepared Communities:

All CAs must complete a 'Prevention Services Planning Chart for Prevention Prepared Communities' for each of the prevention priorities. Each of these priorities will require a separate planning chart.

The 'Prevention Services Planning Chart' is designed to elicit a logical sequence of information from consequences, through planned outcomes, provider involvement, and training needs. Each chart is expected to represent summary information, and should be limited to two legal-sized pages, per prevention priority.

The preparation of the 'Prevention Services Planning Chart' must show evidence of a data-guided planning process indicative of the collection and analysis of baseline data to validate the selection of primary problems (consequences) for each priority. Evidence of input from a regional community epidemiological workgroup, in concert with a community collaborative (e.g. Drug Free Communities, Community Strategic Prevention Planning Collaborative, etc.), is required. The workgroup and community collaborative must be representative of diverse community sectors.

The content on this chart is described in the instructions that follow:

PREVENTION SERVICES PLANNING CHART FOR PREVENTION PREPARED COMMUNITIES

CA Name: _____ Plan Fiscal Year: _____ Contact Person's Name and Email: _____

Prevention Priority: _____

NOTE: This section looks at how the CA is working toward community involvement.

1. Who are the CA's partners in this prevention priority, and what specific role(s) do the partners play?

2. What partners are missing, and what is the CA's strategy to get additional partners involved?

Consequence(s)/ (Primary Problem)	Consequence Support Data (Include data sources)	Associated Intervening Variable(s) to be Targeted	Primary Federal Strategies (specific) and Evidence-based Services/Interventions (specific) for Each Strategy	Geographic Area Served	Population Type/ Service Population (Specify based on CSAP Priority Populations)	Activity Related - Immediate Outcomes	Performance Indicator – Intended Long-term Outcome, including link to National Outcome Measures (NOMS)	Provider Agency or Coalition Responsible for Activity	Training and TA needs of the CA to implement this plan
1.									
2.									
3.									
4.									

Prevention Services Planning Chart for Prevention Prepared Communities
INSTRUCTIONS

The Prevention Services Planning Chart for PPCs, is designed to elicit a logical sequence of information from associated consequences, through planned outcomes, provider involvement, and identifying training needs for the priorities.
The chart presents information in a horizontal manner. [COLUMN HEADINGS ARE BOLDED IN THESE INSTRUCTIONS.] The **consequence** is identified in the first column (one per box), with all associated information following in the same row. When a box/column is reached in which multiple items may be listed, i.e., **Associated Intervening Variables to be Targeted**, and the information in the following five boxes/columns is directly related to each item in the previous box/column, please align the associated information adjacent to one another and assign a common number to both items of information. Please provide all necessary information in a concise manner.

CA (Coordinating Agency) name and plan fiscal year:
Enter the name of the coordinating agency who is submitting the prevention plan, and indicate which fiscal year the plan is intended.

Contact person's name and email:
Enter the name and email address of the person who is responsible for the plan and responding to any questions or clarification that may arise.

Prevention priority:

Indicate the overall Prevention Priority:

- Each CA must complete separate planning charts for the following priorities that have been identified as statewide priorities:
  1) Childhood and Underage Drinking
  2) Prescription and Over-the-Counter Drug Abuse/Misuse

- A third priority may be identified at the CAs discretion, however this priority must be based on data and may be related to either an emerging trend or known problem already identified in the region.

Who are the CA's partners in this prevention priority, and what specific role(s) do the partners play?

In response to this question, please identify CA partners in addressing this prevention priority. Also indicate what role the partners play in their collaboration with the CA. When completing this section, note that BSAAS is interested in how the CA is involving the community in the prevention planning process for each priority.

What partners are missing, and what is the CA's strategy to get additional partners involved?

In response to this question, please identify community partners, currently absent, who would strengthen the CA region's response to addressing the priority problem and note strategies that have been identified to secure their involvement in the future.

Consequence(s)/ primary problem:

Identify the specific consequence(s)/primary problem in the CA region that relates to the overarching prevention priority. Consequences and primary problems are identified through the analysis of data, and are defined as social, economic and health problems associated with the use of alcohol, tobacco and other drugs (ATOD).

Note: Numerous consequences can be identified within a single prevention priority; however, it is not feasible or effective to address all or many consequences with limited resources. CAs are encouraged to think beyond "consumption only" problems, and look more closely at the negative impact that occurs as a result of consumption. Again, through the use of data, political will and changeability, prioritization of consequences must occur.

Example: Related to prevention priority "Reduce Childhood and Underage Drinking" the consequence/primary problem may be "Alcohol-related traffic crash deaths among young adults between the ages of 16 and 21 in the region have increased."

Each CA may identify and select up to five consequences per identified prevention priority.

Consequence support data:

Enter local, regional or state data that has been identified, compiled and used to support the consequence selection for the regional prevention plan. This answers the question "How does the CA know this is a problem in the region?"

Example: Related to consequence "Alcohol-related traffic crash deaths" the support data may be "Between 2005 and 2010 there were 268 alcohol-related traffic crash deaths in the CA region." Also site the specific data source, including author. For this example, the data source may be 2010 Michigan Traffic Facts for Counties/Communities, Office of Highway Safety Planning.

Associated intervening variables (modifiable risk and protective factors) to be targeted:

Enter modifiable risks or protective factors associated with a consequence. These factors contribute to the conditions, favorable (risk) or unfavorable (protective), to the existence of the consequence. They are factors that "cause" substance-related

consequences and consumption in communities. There can be numerous variables and factors linked to a consequence. This is where individualization of your region (or to specific communities within your region) should be evident. Prioritization and selection of the variables and/or factors must occur based on the interventions you chose to target.

Identify and list, in order of priority, the variables and/or factors you have selected to target, in relationship to your identified consequence.

Example: Related to consequence “Alcohol-related traffic crash deaths” the intervening variables may be: “Availability of substances; Promotion of substances; Social norms regarding use; and Enforcement of existing laws.”

Primary federal strategies (specific) and evidence-based services/ interventions (specific) for each strategy:

List the CSAP federal strategy and the evidence-based services/interventions that have been selected under each strategy that: 1) will impact the prioritized variable/factor and in turn the prioritized consequence; and 2) are appropriate to the target populations. Note: evidence-based services/interventions selected must be consistent with the implementation of the ROSC. For more information on the evidence-based services/intervention efforts linked to ROSC refer to Michigan’s ROSC implementation plan goals (specifically goals III, IV, V, and IX) in Appendix C.

At least 90% of services/interventions being provided must be evidenced-based.

If “Information Dissemination” strategies are used, they must be part of a multi-faceted regional prevention strategy/initiative. Independent or stand-alone information dissemination services are disallowed. In addition, if “Alternative” strategies are used in the region, the service must reflect evidenced-based approaches and best practices, such as multi-generational and adult-to-youth mentoring.

Example: Related to federal strategy “Environmental” the intervention may be “Increase enforcement of existing alcohol sales laws.”

Following are the Center for Substance Abuse Prevention’s (CSAP) six prevention strategies. All prevention services can be categorized under one of these six federal prevention strategies, and the link to the corresponding intervention for each must be made. The federal prevention strategies that should have priority in each region are “Community-Based Process” and “Environmental,” and to a lesser extent “Education” and “Problem Identification and Referral.”

1 Information Dissemination: This strategy provides information about the nature and extent of drug use, abuse, and addiction and its effects on individuals, families and communities. It also provides information on available prevention programs and services. The dissemination of information is characterized by one-way

communication from the source to the audience, with limited contact between the two.

2 Education: This strategy involves two-way communication, and is distinguished from merely disseminating information by the fact that it is based on an interaction between the educator and the participants. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, and critical analysis (e.g., of media messages).

3 Alternatives: This strategy provides for the participation of target populations in activities that exclude drug use. The assumption is that because constructive and healthy activities offset the attraction to drugs, or otherwise meet the needs usually filled by drugs, then the population would avoid using drugs.

4 Problem Identification and Referral: This strategy aims to identify those who have indulged in the illegal use of drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if an individual is in need of treatment.

5 Community-Based Process: This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for substance use disorders. Activities in this strategy include organizing, planning, enhancing the efficiency and effectiveness of service implementation, building coalitions, and networking.

6 Environmental: This strategy seeks to establish or change community standards, codes and attitudes, thereby influencing the incidence and prevalence of drug abuse in the general population.

Geographic Area Served:

If a portion of the CA region has been identified as a prime area related to a consequence, and will subsequently be targeted for prevention services, please identify that portion of your catchment area as a target. Alternatively, if services will be provided region-wide, please indicate that intent.

Examples: East side of the City of Detroit; City of Williamston, Ingham County; Zip Codes 11111, 99999, 55555, and 33333.

Population Type/Service Population:

List by Institute of Medicine (IOM) category the service population(s) for the identified intervention(s) as appropriately selected to impact the consequence (hence the prioritized variable/factor). All selected interventions and related target populations are associated to one of these three categories.

Example: Related to population type “Selective” the service population may be: “Children in homes where substance use is widely accepted.”

The IOM prevention intervention categories are Universal, Selective, and Indicated, and are defined as follows:

Universal: The general public or the whole population group that has not been identified on the basis of individual risk; also the population of a geographic area as a whole.

Selective: Individuals or a subgroup of the population whose risk of developing a substance use disorder is significantly higher than average.

Indicated: Activities targeted to individuals who are identified as being in high-risk environments, having minimal but detectible signs or symptoms foreshadowing a substance use disorder, or having biological markers indicating a predisposition for disorder but not yet meeting diagnostic levels.

Activity Related – Immediate Outcomes:

Cite the intended immediate outcome(s) for each planned intervention. Immediate outcomes are directly related to the service and are immediate or short-term changes achieved by the intervention. An immediate outcome is the initial change in a sequence of changes expected to occur as a result of program implementation. The more immediate the outcome, the more influence the program has over its achievement**.**

There is no right number of outcomes. The number of outcomes selected depends upon the nature and purpose of the program, resources, size and number of constituencies represented.

Example: Related to intervention “Parent education/training programs” the immediate outcome may be: “Changes in participant’s family management skills.”

Performance indicator – intended long-term outcome, including link to NOMS:

Cite the performance indicator(s) – long-term outcomes anticipated to be impacted and/or achieved through the implementation of interventions. Associate the indicator to the relevant intervention(s).

Over time, the change(s) that result from the program or intervention are known as long-term outcomes. A confluence of multi-factored prevention initiatives can, therefore, merge to create impact toward a final outcome. Long-term outcomes can be influenced by a variety of factors in the socio-cultural, political and economic environment. It is expected that multiple intervening variables would need to be targeted in order to lead to an impact on the long-term outcome. CAs are asked to provide direct linkage of all long-term outcomes for the region to a specific NOM, as appropriate for each indicator.

Example: Related to intervention “Parent education/training programs” the long-term outcome may be: “Decreased adolescent alcohol use.”

Provider agency or coalition responsible for activity:

Cite the provider agency responsible for implementing the identified activity or intervention. A provider agency is a subcontracted entity having a written agreement to provide specific activities. A coalition is a representative group of a given community consisting of members, stakeholders, or constituents of that community. This group collaborates and coalesces around common concerns, issues and actions. If a coalition is coordinating, funding or actively involved with the planned activity, they may be cited as the provider.

The aforementioned entities providing programs to impact specific consequences/intervening variables are those that would be cited here, linked to the specific strategy, intervention and population type.

Examples: “Joe’s Agency,” “Organization for Annie,” and “Eastside Coalition.”

Training and technical assistance (TA) needs of the CA to implement this plan:

If the CA has any training or technical assistance needs to help in the implementation of the plan in their region, identify those needs in the last column. These would be trainings provided by BSAAS, by others through the BSAAS training project, or by the CSAP-identified Central Regional Expert Team.

Plan Review Criteria: The ‘Prevention Services Planning Chart’ will be reviewed based on the following criteria:

- Demonstrating use of a consequence-based, data-guided process for the multiple year planning format, including evidence of input from community epidemiological workgroups in concert with a community collaborative (e.g. Drug Free Communities, Community Strategic Prevention Planning Collaborative, etc.), representative of diverse community sectors.
- Identifying priority problems and target populations based on local epidemiological evidence.
- Implementing evidence-based interventions for priorities consistent with the implementation of the ROSC, MDCH priorities and the SAMHSA Strategic Initiative.
- Supporting development of PPCs by strengthening the regional prevention services system, based on the implementation of the ROSC.”

Do Your Part Michigan
Strategic Plan to Reduce Underage Drinking
2016 - 2018

Executive Summary:

Ending the pervasive problem of underage drinking in Michigan may seem like a daunting task. In 2015, the Michigan Department of Health and Human Services (MDHHS) Office of Recovery Oriented Systems of Care (OROSC) contracted with Prevention Network (PN) to convene a team of experts from across the state committed to reducing underage drinking in Michigan. This team developed and submitted a preliminary plan to OROSC, which was then distributed to other key stakeholders in the state not involved in the original efforts for feedback and input: Prepaid Inpatient Health Plans (PIHPs), OROSC Transformation Steering Committee (TSC), and the TSC- Prevention Workgroup. *Do Your Part Michigan: The Strategic Plan to Reduce Underage Drinking 2016-2018*, is a result of these combined efforts.

Four overarching goals have been identified as part of this three-year plan:

1. Increase and strengthen the capacity of our state to reduce underage drinking by promoting quality practices, use of data and planning.
2. Reduce access of alcohol to minors.
3. Educate the public on consequences of underage drinking and provide resources to prevent underage drinking by developing a state-wide media campaign.
4. Evaluate Michigan's efforts to reduce underage drinking.

Ending underage drinking cannot be accomplished by one organization or community. Rather, the solution comes through wide-spread collaboration and engagement with unified goals. It is envisioned this plan will be used by current and potential partners in communities, schools, governments, faith-based groups, and healthcare organizations across Michigan to engage with parts of this plan most applicable to their work. The plan is meant as a guide for PIHPs, community coalitions and other state and community-level partners to use when strategizing efforts to reduce underage drinking across Michigan by aligning with the goals and objectives of this plan. In conjunction with the TSC workgroups, OROSC will lead the effort to review the plan minimally twice per year to measure benchmarks and progress.

It should be noted this plan does not address the growing emphasis on the role of recovery as it relates to prevention and the integration of substance use disorders and mental health conditions. OROSC acknowledges that a three-year strategic plan cannot address all aspects of underage drinking, and that work outside the scope of this plan is being done and can be done to address the problems associated with underage drinking. However, the goals and targets of this plan are designed with all Michigan citizens in mind.

Do YOUR Part. Help reduce underage drinking in Michigan.

DRAFT

The Problem

Underage drinking is a prevalent problem in Michigan. Although the incidence of underage drinking has declined over the two decades[1], in 2013, over 28% of high school students had at least one drink of alcohol in the last 30 days. Of those youth who drank alcohol, 14% reported consuming their first alcoholic drink before the age of 13. [2]

Youth who drink alcohol are more likely to have more absences from school, receive failing grades, get into fights, experience changes in brain development like memory problems, and experience delays in social development. Youth who drink are also more likely to abuse other drugs, are at higher risk for sexual or physical assault, legal problems, car crashes, unintentional injuries and other problems.[3]

These risks are even greater for youth who binge drink. Binge drinking is defined as consuming 4 or more drinks for women and 5 or more drinks for men in an occasion[4]. In addition to the consequences of drinking listed above, youth who binge drink are at increased risk for other health problems including liver disease, alcohol poisoning, sexually transmitted infections, high blood pressure, stroke, and other cardiovascular diseases[5]. Persons reporting first use of alcohol before age 15 were more than 5 times as likely to report past year alcohol dependence or abuse as persons who first used alcohol at age 21 or older[6].

Binge drinking is pervasive at colleges and universities. Drinking heavily and binge drinking is often perceived by students as an integral part of the college experience[7], contributing to findings from the National Survey on Drug Use and Health (NSDUH) that college students are more likely to binge drink than those in the same age group who are not in college[8]. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) reports that nearly 80% of all college students drink[9]. Many of these students come to college with established drinking habits from high school. In 2013, nearly 19% of all full-time college students met the requirements for alcohol dependence, but only 5% sought treatment[10].

The consequences of underage drinking are serious and costly to tax payers. According to a recent report released by the Underage Drinking Enforcement Training Center (UDETC), underage drinking in Michigan leads to traffic crashes, violent and property crime, unintentional injury, and high-risk sex. Due to these crimes, as well as hospital visits, and lost work time, underage drinking cost Michigan tax payers $1.9 billion in 2013[11]. This equates to $192 for every man, woman, and child in the state of Michigan.

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[1] 1997-2011 Youth Risk Behavior Surveillance (YRBS) Trend Report.
[2] 2013 Michigan YRBS.
[3] Centers for Disease Control and Prevention (CDC) Website: Alcohol FAQs.
[4] National Institute on Alcohol Abuse and Alcoholism (NIAAA) Website.
[5] CDC Website: Alcohol FAQs.
[6] National Survey on Drug Use and Health (NSDUH) Report, October, 2004. http://www.oas.samhsa.gov/2k4/ageDependence/ageDependence.htm.
[7] 2013 NIAAA College Fact Sheet.
[8] 2013 NSDUH.
[9] 2013 NIAAA College Fact Sheet.
[10] 2013 NIAAA College Fact Sheet.
[11] 2015 Underage Drinking, The Facts. Underage Drinking Enforcement Training Center (UDETC).

Funding

The importance of funding is implicit in the work to reduce underage drinking in Michigan. Current and potential partners are encouraged to use this plan when preparing budgets, grant applications, and requests for funding proposals.

Many goals are accomplished with limited resources every day, but with a more robust funding stream, our reach across the state will be greater and the reality of sustaining prevention programming and ending underage drinking is more possible.

Goals

After assessing the data, and discussing prevention strategies that state and local agencies are successfully implementing in communities across Michigan, the plan's initial team arrived at four goals to accomplish by the end of 2019:

1. Increase and strengthen the capacity of our state to reduce underage drinking by promoting quality and evidence-based practices, use of data and planning.
2. Reduce access of alcohol to minors.
3. Educate the public on consequences of underage drinking and provide resources to prevent underage drinking by developing a state-wide media campaign.
4. Evaluate Michigan's efforts to reduce underage drinking.

In order to accomplish each goal within a three-year time frame, objectives were chosen with short (by 2016), medium (by 2017), and long-term (by 2018) target deliverables. Some deliverables are on-going and some are time-limited. All will ensure measurable progress and are described in detail in the matrix provided at the end of this document. The matrix provides overarching deliverables needed. As champions or agencies are identified for the different objectives, more detailed and specific work plan timelines will be established to provide benchmarks to be achieved each year.

Goal 1: Increase and Strengthen the Capacity of Our State to Reduce Underage Drinking by Promoting Quality Practices, Use of Data and Planning

Institutes of Higher Education (IHEs) play a vital role in preventing underage drinking. Many institutions are already working diligently to create safe environments within their campus communities, and our aim is to bring individual IHEs together to reduce underage drinking. This includes working with students who are in recovery from alcohol and other drug addiction, promoting Screening, Brief Intervention and Referral to Treatment (SBIRT) in all campus health centers, to ultimately measure the effectiveness of campus prevention efforts, and replicate best practices across the state.

There is the hope to bring together the breadth of expertise and experience to strengthen our state. For this reason, training and organizing volunteers is vital to the mission of reducing underage drinking in Michigan. There is also the hope to collaborate more effectively with primary care practitioners, such as those individuals working in family medicine, hospitals, federally qualified health centers, student health systems at colleges and universities, and the networked health system within public schools. Creating networks and opportunities to share ideas, best practices and outcomes with one another will strengthen Michigan's response to reducing underage drinking.

- *Objective 1: Establish a higher education prevention network.*

- *Objective 2: Create and maintain a system to educate and support volunteer groups in their local efforts to reduce underage drinking.*
- *Objective 3: Integrate primary care practices with community-based prevention of underage drinking.*

Goal 2: Reduce Access of Alcohol to Minors

In Michigan, in 2013, 33.1% of surveyed high school students who drank alcohol obtained it from someone giving it to them[12]. According to the 2013 NSDUH, among current underage drinkers who did not pay for their own alcohol the last time they drank, the most common source was from an unrelated person aged 21 or older (36.6%). Parents, guardians, or other adult family members provided the last alcohol to 24.5% of nonpaying underage drinkers.[13]

By limiting access of alcohol to underage youth, the incidence of underage drinking will likely decline[14]. Achieving measurable outcomes for Goal 2 by educating parents and local municipalities about what they can do to reduce access of alcohol to minors is possible.

- *Objective 1: Reduce social availability[15] of alcohol by parents and other adults.*
- *Objective 2: Assist municipalities in gaining more control over liquor licenses in their communities, including temporary licenses.*
- *Objective 3: Conduct a study to determine the potential benefits and feasibility of systematically increasing the price of alcohol across the state.*
- *Objective 4: Assist retailers in their efforts to identify responsible alcohol sales and service practices.*

Goal 3: Educate Public on Consequences of Underage Drinking and Provide Resources to Prevent Underage Drinking By Developing a State-Wide Media Campaign

Education is crucial in reducing underage drinking in Michigan. According to the NSDUH trend report from 2012, nearly two-thirds of high school students do not perceive great risk from binge drinking[16]. In 2011, 38.7% of high school students in the United States reported drinking alcohol in the past 30 days[17]. In contrast, a national study of parents with teenagers, aged 13-17, found that only 10% of parents believed their teenager drank alcohol in the last year[18]. This underestimation of parent's perception of their teens' alcohol use, and the consequences of use, is addressed in this plan through education and providing resources.

- *Objective 1: Strengthen and continue promoting "Do Your Part" state media campaign.*

[12] 2013 Michigan YRBS.
[13] 2013 NSDUH. http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.htm
[14] The Community Guide. http://www.thecommunityguide.org/alcohol/supportingmaterials/AFAlcoholDensity.pdf
[15] We are defining "social availability" as non-commercial sources of alcohol (http://www.udetc.org/documents/accesslaws.pdf).
[16] 2012 NSDUH Trend Report.
[17] 2011 YRBS.
[18] 2011 C. S. Mott Children's Hospital National Poll on Children's Health (NPCH). http://mottnpch.org/reports-surveys/parents-say-other-teens-drink-and-use-marijuana-my-kids-dont

- *Objective 2: Continue ongoing support for appropriate local or regional underage drinking prevention media campaigns.*

Goal 4: Evaluate Michigan's Efforts to Reduce Underage Drinking

To date, there is no public examination of the effectiveness of laws, policies, enforcement initiatives, and implemented strategies to reduce underage drinking in the state of Michigan. Although many programs implemented across the state are certified by the National Registry of Evidence-based Programs and Practices (NREPP), there is no specific state-wide data on the effectiveness of these programs to reduce underage alcohol use. The aim with this goal is to identify the most effective strategies communities across the state can use to combat underage drinking and replicate them across the state.

- *Objective 1: Develop an evaluation plan to assess the relationship between underage drinking and non-traditional on-premise outlets*[19].
- *Objective 2: Review and evaluate data from results of local evidence based prevention strategies addressing underage drinking.*
- *Objective 3: Identify and secure funding to evaluate state laws and policy changes relevant to underage drinking and their impact.*

[19] This document uses the term "non-traditional on-premise outlet" to signify locations such as movie theatres, spas, farmer's markets, grocery stores, or any other venue where alcohol is served that is not primarily a bar or restaurant.

Consequence and Supporting Data	Goal	Objectives	Agency Responsible	Immediate Outcomes (2016)	Intermediate Outcomes (2017)	Long Term Outcomes (2018)
According to NSDUH (2013), rates of current underage drinking increase with age, with 11% of 14-25 year olds identifying drinking, 25% of 16-17 year olds, and 49% of 18-20 year olds. Adults who had their first drinking of alcohol at age 14 or younger were 7 times more likely to be classified as alcohol dependent or abusive drinking. In addition, 62% of college students (18-22 years old) identified as current drinkers. 42% of current drinkers in college identified as binge drinkers and 13% were heavy drinkers.	1. Increase and strengthen the capacity of Michigan to reduce underage drinking utilizing a multi-prong approach including promoting quality practices, use of data and planning.	1. Improve alcohol policies and practices at Institutions of Higher Education (IHEs) in Michigan (colleges, universities, community colleges, etc.) through the establishment of a Higher Education Network	Prevention Network	Identify key personnel* at Michigan IHEs and inventory interest in participating in a state-wide Higher Ed Network to reduce Underage Drinking. **Person who is responsible for any prevention, intervention, adjudication, and recovery for alcohol use services.*	Inventory capacity and needs of individual IHEs related to a state wide network. This would include IHE's involvement with Prepaid Inpatient Health Plan (PIHP) or other formal IHE-community relationships.	In partnership with key IHE personnel, invite other IHE partners to begin building network structure and identify best practices, model policies, trainings, and other resources to introduce and replicate in Michigan through the Higher Ed Network. Some examples of these best practices would be Screening Brief Intervention and Referral to Treatment, collegiate recovery networks, and campus community coalitions.
				Identify potential funding sources for a state wide network.	Apply for/request funding to support staff person to implement strategies identified by inventory, and address emerging trend issues related to underage drinking.	Create sustainability plan for continuation of Higher Ed Network beyond state, federal, or foundation support.
		2. Create and maintain local systems to educate and support volunteer groups in their efforts to reduce underage drinking.	Prevention Network	Identify funding to increase the capacity of Michigan Coalition to Reduce Underage Drinking (MCRUD) as a network of volunteer and professional groups working to reduce underage drinking.	Identify best practices and effective strategies to share with local volunteer groups to increase their capacity to address local issues.	Create sustainability plan for continuation of MCRUD beyond state, federal, or foundation support.

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According to the 2013-2014 Child and Adolescent Health Centers (CAHC) Dashboard Report, implementation of CAHC's improves the learning environment and health outcomes in schools with medically underserved students. A part of improving health outcomes is increasing confidence in refusal and negotiating skills, decreased substance abuse, and increased intention to abstain from substance abuse. These indicators result in lower rates of underage drinking.[20]		3. Integrate primary care practices with community-based prevention of underage drinking.	OROSC/ Regional PIHPs	Identify primary care providers including Federally Qualified Health Centers, local public health departments, and CAHCs who are already partnering with local agencies and coalitions.	In conjunction with regional PIHPs, Department of Education and local coalitions, identify qualifying schools to implement best practices, effective interventions and new CAHC's to increase capacity to address underage drinking in their communities.	Develop sustainable solid partnerships between local coalitions and CAHC's.
				Identify which prevention strategies are being implemented.	Identify gaps in current prevention strategies and build upon existing strengths to implement best practices and effective interventions.	Disseminate information to primary care providers on the benefits of and ways to collaborate with community-based organizations and coalitions to address the prevention of underage drinking; encourage implementation of effective and evidence-based strategies in their practice.
Over one-half of all underage drinkers get their alcohol from an adult[21].	2. Reduce access of alcohol to minors.	1. Reduce social availability of alcohol by parents and other adults.	TBD	Explore options for a state wide public awareness campaign regarding legal consequences for hosting and providing alcohol to minors.	Develop and disseminate campaign.	Evaluate and refine campaign.

[20] Michigan Department of Health and Human Services. "Child and Adolescent Health Centers 2013-2014 Dashboard Report: Measuring Quality, Effectiveness, and Outcomes". http://www.michigan.gov/documents/mdch/FY_14_Dashboard_488062_7.pdf.
[21] 2013 NSDUH.

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			MDHHS/OROSC; Regional PIHPs	Create and disseminate "Do Your Part" branded materials for agencies to use as part of their educational efforts at the local level, i.e. flyers, table tents, posters. Host these materials at the "Do Your Part" website.	Evaluate "Do Your Part: materials.	Develop and present report on effectiveness of "Do Your Part" materials. Incorporate findings into future revisions.
Increased areas of alcohol outlet density is directly related to higher incidence of excessive drinking, as well as higher rates of injury, crime, and violence[22].		2. Assist communities and municipalities in gaining more control over liquor licenses in their communities, including temporary licenses.	TBD	Identify state-wide partners, such as the Michigan Township Association, who advise municipalities. Inventory them regarding knowledge of their authority related to permanent and temporary liquor licenses. Include their involvement with PIHP funded and other formal agency/coalitions.	Identify best practices implemented by municipalities that interact with and approve temporary licenses, such as approval process, enforcement, etc.	Develop information piece and training for municipalities that includes model local ordinances and server training recommendations.
				Identify & increase awareness of MLCC materials and resources available to municipalities regarding this issue.		
				Interview and survey current Liquor Control Commissioners to identify the criteria or process for revocation, or suspension of local liquor licenses.	Share this information to local municipalities through training.	
There was a 26% decrease in alcohol-related fatal car crashes after an increase in alcohol tax was implemented in Illinois.[23] Increasing the price of alcohol is an effective method for		3. Conduct a study to determine the potential benefits and feasibility of systematically increasing the price of alcohol across the state.	TBD	Study the relationship between alcohol cost increase and reduction of alcohol related consequences specific to Michigan.	Survey public to determine level of support for systematic alcohol cost increase based on study findings.	Identify appropriate partner to facilitate broad based state-wide coalition to identify and implement best practices to increase cost, with the goal of reducing consequences.

[22] Campbell, et. al. 2009.
[23] Wagenaar. 2015.

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preventing excessive and underage drinking.[24]						
Data on retail sales of alcohol to underage individuals {STILL NEED—Su Min is working on gathering from MLCC}		4. Assist retailers in their efforts to identify responsible alcohol sales and service practices.	TBD	Identify retail partners who share an interest in responsible alcohol sales and service.	In collaboration with retail partners, identify specific issues that can be addressed by retailers and trade organizations, i.e. theft, product placement, false or confusing identification cards, etc.	In collaboration with retail partners, identify and/or create best practices, tools, and resources to address the identified issues. Identify or create a system to share findings with the retail sector.
Nearly two-thirds of high school students do not perceive great risk from binge drinking.[25] Parents of 13-17 year olds overestimated teen substance use on a national level, while underestimating their own teens' alcohol use.[26]	3. Educate the public on consequences of underage drinking and provide resources to prevent underage drinking by developing a state-wide media campaign.	1. Strengthen and continue promoting "Do Your Part" state media campaign.	TBD	Identify media/public relations partners that can evaluate and strengthen underage drinking prevention component.	Create materials based on advice of media partners.	Develop additional "Do Your Part" public service announcements to run state-wide.
				Identify materials appropriate to include as downloads on Do Your Part web site.		
				Assess successful underage drinking media campaigns from across the nation.	Improve marketing and dissemination strategies for "Do Your Part" materials based on successful elements of other underage drinking media campaigns previously assessed.	
		2. Continue ongoing support for appropriate local or regional underage drinking prevention media campaigns.		Include "Do Your Part" web site links to local underage drinking prevention media campaigns.		
There has been no public examination of the effectiveness of laws, policies, enforcement	4. Evaluate Michigan's efforts to reduce underage	1. Develop an evaluation plan to assess the relationship between underage drinking and non-	TBD	Monitor and track the number of non-traditional on-premise outlets, in order to establish an increase or decrease in the number of non-traditional	Convene stake-holders to discuss results of monitoring and tracking non-traditional on-premise outlets and provide recommended next steps.	

[24] Wagenaar, et.al. 2008.
[25] 2003-2012 NSDUH.
[26] 2013 National Poll on Children's Health (NPCH).

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initiatives, and implemented strategies to reduce underage drinking. Although many programs implemented across the state are certified by the National Registry of Evidence-based Programs and Practices (NREPP), we do not have state-wide data on the effectiveness of these programs to reduce underage alcohol use in Michigan.	drinking	traditional on-premise outlets		outlets.		
				Survey the public about their attitudes of non-traditional licensed outlets.		
		2. Review and evaluate data from results of local evidence based prevention strategies addressing underage drinking		Identify appropriate partner or hire staff to create a cross-site evaluation tool.	Implement cross-site evaluation.	Develop and present report on effectiveness of programs. Incorporate findings into future planning.
		3. Identify and secure funding to evaluate state laws and policy changes relevant to underage drinking and their impact		Convene stake-holders to identify state laws and policies to study effects on underage drinking.	Partner with researchers to study the effects chosen policy(ies) have on underage drinking in Michigan.	Develop report based on findings and incorporate into future planning and education.

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Your Role is Vital to this Plan

It is imperative that all Michigan residents work together to achieve the goals of this plan. In this section, specific roles are outlined that key community leaders can take to make this plan successful.

Special Role for Families…

- If you have alcohol in the home, be sure to monitor it and have it locked away.
- Set and enforce a curfew.
- When your teen is staying over at a friend's house, be sure to call the other parent to verify that they are safe.

Special Role for Businesses and Retailers…

- Be sure to check IDs for anyone looking under age 40.
- Have strong policies against selling to minors and intoxicated individuals.
- Be sure to train your employees on checking IDs and laws related to alcohol sales and service.
- Require all managers and staff to participate in server training.

Special Role for Law Enforcement…

- Prioritize enforcement of underage drinking laws.
- Conduct alcohol compliance checks in your community and share results with the Michigan Liquor Control Commission and other stakeholders.
- Educate retailers on relevant underage drinking and other alcohol laws.
- Get involved in your local community coalition if one exists.

Special Role for Faith-Based Organizations…

- Through a sermon, raise your congregation's awareness of underage drinking and other alcohol related problems.
- Provide an alcohol free, safe place for afterschool activities.
- Periodically include information on underage drinking in your Sunday bulletin.
- Get involved in your local community coalition if one exists.

Special Role for Nonprofit Organizations and Substance Abuse Prevention Providers…

- When planning interventions, enhance your impact by creating new partnerships.
- Be sure to evaluate each intervention and share your findings at conferences, workshops, through journal articles and websites.
- Join a community coalition or create one if none exist.
- Connect with your local Child Adolescent Health Center.

Special Role for the State…

- Continue to collaborate with state departments, local coalitions, and other agencies in efforts to reduce underage drinking.
- Make the reduction of underage drinking a priority by providing additional funding opportunities for prevention programs and strategies.

Special Role for Volunteers and Volunteer Groups…

- Partner with local businesses and nonprofit organizations that will support the work you want to do around underage drinking prevention.

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- Enhance your skills by participating in trainings.
- Get involved with your local community coalition. If one does not exist, partner with an organization and create one.

Special Role for Institutions of Higher Education…

- Share your efforts to reduce underage drinking with your community, as well as other Institutions of Higher Education.
- Work with your recovery community and provide a safe place for students recovering from alcohol and other drug addiction.

Special Role for High School Students…

- Do your part by not participating in underage drinking.
- Educate yourself and others on the dangers of drinking alcohol at a young age.
- Participate in mentoring programs, sports, art and music.
- Get involved with your local community coalition.

Special Role for Media…

- Provide more opportunities for Public Service Announcements.
- Connect with your local community coalition.
- Be involved in community events and promote positive, healthy messages.

Special Role for Healthcare Providers…

- Screen underage patients presenting with alcohol-related illnesses for alcoholism.
- Offer and/or attend trainings on alcohol screenings, counseling, motivational interviewing, and brief interventions.
- Support and participate in community efforts to reduce underage drinking.

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The Initial PN Work Team and Planning Process

This strategic plan to prevent underage drinking is a product of collaboration between several different partnering agencies, all with the same purpose: to prevent and reduce underage drinking in the state of Michigan.

The process of creating this plan was modeled after the Strategic Prevention Framework (SPF), developed by the Substance Abuse and Mental Health Services Administration (SAMHSA). This five-step planning process was further guided by sustainability and cultural competency[27]. The initial PN work team met a total of 7 times over the course of 6 months. Additionally, a small workgroup met to consolidate the assessments, brainstorms and goals of the larger committee into one cohesive plan. With input from the larger work team and a consensus on the final product, PN submitted the plan to OROSC in July, 2015. The Michigan Prevention Association, Allied Liquor Stores of Michigan, Prosecuting Attorneys Association of Michigan, Michigan State Police Office of Highway Safety Planning, Michigan Alcohol Policy Promoting Health and Safety, Michigan Liquor Control Commission, and many others supported this effort. The following individuals are gratefully acknowledged for their input and efforts:

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[27] SAMHSA. http://captus.samhsa.gov/prevention-practice/strategic-prevention-framework.

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Resources

Centers for Disease Control and Prevention Prevention Status Reports	http://www.cdc.gov/psr/state_reports.html
The Community Guide	http://www.thecommunityguide.org/
Fetal Alcohol Spectrum Disorders (FASD)	http://www.michigan.gov/fas
John's Hopkins School of Public Health The Center for Alcohol Marketing and Youth	http://camy.org/
Michigan Liquor Control Commission	http://www.michigan.gov/lara/
Revoking a Liquor License	http://www.michigan.gov/documents/lara/Local_authority_on_objections_to_renewal_and_revocations_2_383196_7.pdf
SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)	http://www.nrepp.samhsa.gov/
Screening, Brief Intervention and Referral	http://www.integration.samhsa.gov/clinical-practice/SBIRT#general http://bha.dhmh.maryland.gov/SitePages/SBIRT.aspx
Motivational Interviewing "Motivational Interviewing-Risk Assessment" Free Online Training. Course Catalog ID: MI-0001-2014	https://courses.mihealth.org/PUBLIC/cm0682/home.html
Michigan Coalition to Reduce Underage Drinking (MCRUD)	http://www.mcrud.org/
Alcohol Justice	https://alcoholjustice.org/
Community Anti-Drug Coalitions of America (CADCA)	http://www.cadca.org/

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Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required 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 1915b/c 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. 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. 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 provide 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 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 trainings 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, co-IDDT/ACT; Individual Placement and Support, and Family Psychoeducation.

Another area of best practice being implemented in Michigan that crosses programs is the infusion of Motivational Interviewing (MI) as an approach to various treatments and interventions. MI is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal. MI represents a philosophy as well as a set of skills for effectively engaging and assisting Michigan's behavioral health system's service recipients facing one or more areas of difficult behavior change about which they may be ambivalent. In FY17, a pilot project for implementing MI in Opioid Treatment Programs was implemented with plans to expand across the state in the coming years.

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 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 contract with 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 individuals 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 centers, 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 behavioral health 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%	317,937
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.

Adults with SMI: Michigan’s estimated population was around 9,935,116 persons as reported by the 2016 United States Census Bureau. Of that number 74% were over the age of 18, constituting an estimate of 7,342,677 adults. Per the 2014-2015 data set provided by the National Survey on Drug Use and Health (NSDUH), 4.33% (317,937) of Michigan’s adult population are estimated to have serious mental illness. There were 236,291 adults served through the Michigan mental health services in 2016 per the SAMHSA URS data set. This information, used in conjunction with other URS data showing demographics and characteristics of those served in the prior year, coupled with estimated penetration rates from NSDUH, helps guide planning to assure those most in need of publicly funded services are reached.

Children with SED: According to 2016 US Census figures, Michigan has approximately 2,194,154 child residents (ages 0-17.) Prevalence data supplied by SAMHSA's 2013 National Outcome Measures Prevalence Report suggests 6-12% of the 1,184,104 children from ages 9 to 17 in Michigan could be identified as having a serious emotional disturbance (SED). That means anywhere from 71,046 to 142,092 children ages 9 to17 may have been eligible for services in the public mental health system in 2013 alone. However, data compiled by MDHHS for FY15 indicates 44,514 children (ages 0 through 17) with SED were served in the public mental health system in Michigan. Using this data, Michigan can make a case for continued focus on identifying and engaging children who may be in need of mental health services from the public mental health system.

Narratve Question

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

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

Describe your state's targeted services to rural and homeless populations and to older adults

Older adults are eligible for the same service array as younger adults within the public behavioral health system. In FY16 over 7,734 older adults (65 and over) received public behavioral health services, which is approximately 3% of the total number of adults served. Approximately 2,527 of these individuals had an Intellectual/Developmental Disability, 2,527 had a mental illness, and 1,083 had both. MDHHS continues to partner with universities such as Eastern Michigan University's Alzheimer's disease and Education Program, and colleges like Lansing Community College, Mental Health and Aging Project (MHAP), to provide a variety of seminars and workshops related to both mental illness and dementia. An annual Mental Health and Aging Conference and regional seminars focus on the mental health needs of elders. Other partnerships include collaborative work with the Michigan Assisted Living Association, providing materials, curriculum, and training on dementia care to staff of facilities whose residents include over half persons with dementia.

One way in which MDHHS/BHDDA is targeting efforts to reach the rural population in the state is through the piloting of a safe transport project. In FY16, MDHHS implemented this pilot project in NorthCare Network, PIHP Region 1 (Upper Peninsula of Michigan) to allow the development of infrastructure for providing safe transports for the individuals served at critical transitions in their care in rural areas. This was due in part to transportation being identified as an unmet need that is undermining care at critical times in an individual's life. Part of the issue is the lack of a consistent regional approach to blended funding for transportation. MDHHS (human services) holds the dollars per contract for transportations and rarely have adequately trained volunteers so they cannot provide transporters themselves in the behavioral health system. Further, the current MDHHS human services position is they will not reimburse CMHSPs for those transports. Law enforcement struggles to meet requests for "voluntary" transports and occasionally is able to assist but correctly require payment for those voluntary transports. As budget cuts continue, local law enforcement have fewer and fewer officers to help with this need. The intent is after two years of monitoring performance outcomes of this pilot project, other rural areas of the state will be provided the opportunity to implement similar initiatives.

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. One specific 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.

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; Supported Employment / 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. More specific information on each of these projects is available in Step 1 Assess Strengths and Needs of the Service System portion of this application.

Footnotes:

Environmental Factors and Plan

11. 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) Are you considering any of the following:

Targeted services for veterans	◉ Yes ○ No

c) Expansion of services for:

(1)	Adolescents	◉ Yes ○ No
(2)	Other Adults	○ Yes ◉ No
(3)	Medication-Assisted Treatment (MAT)	◉ Yes ○ No

Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 9. Primary Prevention-Required SABG.

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. Either directly or through and arrangement with public or private non-profit entities make pernatal care available to PWWDC receiving services? (●) 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 Are you considering 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, custody issue (●) 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 contract PPW programs annually and any issues and concerns are discussed with the Women's Treatment Specialist, as well as 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 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 — (●) Yes ( ) No
- **e)** Monitoring requirements as outlined in the authorizing statute and implementing regulation — (●) Yes ( ) No

2. Are you considering 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 (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.

OROSC monitors compliance for admission via the Priority Population Wait List Deficiency Reports and 90% Capacity Reports. In addition, the State Opioid Treatment Authority 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.

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. Are you considering 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. During site reviews, MDHHS staff will record compliance of PIHPs with a Community Disease policy to include requirements related to appropriate services for persons with or at risk of contracting TB and other communicable diseases.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery? — ( ) Yes ( ) No

2. Are you considering 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 — ( ) Yes ( ) No

with HIV/AIDS

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 SABG funds to provide counseling and case coordination types of services to PWID individuals who use local Syringe Services 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. Are you considering 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 service 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. Are you considering 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, e.g. 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. Are you considering any of the following:

- **a)** Notice to Program Beneficiaries — ○ Yes ◉ No
- **b)** Develop an organized referral system to identify alternative providers — ○ Yes ◉ No
- **a)** Develop 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. Are you considering 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. Are you considering 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 include 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 on-line. 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. Are you considering 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) Develop 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, e.g., 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) [x] Commission on the Accreditation of Rehabilitation Facilities

ii) [x] The Joint Commission

iii) [x] Other (please specify)

Accreditation Association for Ambulatory Health Care
National 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. Are you considering 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 opertunity 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)** Preformance-based accountability ○ Yes ◉ No
- **d)** Data collection and reporting requirements ◉ Yes ○ No

2. Are you considering 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

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, which govern the Mental Health and Substance Use Disorder Programs.

http://www.michigan.gov/lara/0,4601,7-154-63294_72971---,00.html
http://www.michigan.gov/lara/0,4601,7-154-72600---,00.html

Footnotes:

Environmental Factors and Plan

12. 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 2016-FFY 2017? ○ Yes ◉ No

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

None at this time.

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

No technical assistance is needed at this time.

Footnotes:

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma [60] 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 behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. 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 behavioral health 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[61] paper.

60 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.*
61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health 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 behavioral health providers? (●) Yes ( ) No

3. Does the state have a plan to build the capacity of behavioral health 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.

The Children's Trauma Initiative collaborative participants attend a 3-4 day training with topics focused on Complex Trauma and Trauma Informed Assessment measures, including assessment to determine child/parent readiness for TFCBT and/or other potential treatment strategies, as well as TFCBT principles, practices, implementation. They participate in coaching conference calls, twice per month for clinicians/supervisors and monthly coaching calls with supervisors to address supervisory issues and attend follow-up trainings to review cases, assessments/assessment processes, TFCBT implementation, and evaluation. They also complete monthly evaluation metrics to assure fidelity which are entered on the online training site.

In addition, conference calls with senior leadership (CMHSP Children's Services Directors, Executive Directors) and TFCBT faculty regarding system implementation and potential agency barriers to implementation are facilitated by MDCH staff.

This initiative has been supported with block grant funding for several years and has resulted in the participation of 43 out of 46 CMHSPs in Michigan. The initiative continues with the goal of expanding statewide.

As part of the Children's Trauma Initiative, participating CMHSPs utilize Trauma Informed Screening and Trauma Informed Assessment (Trauma Symptom Checklist for Young Children and the Northshore UCLA PTSD) as part of the intake process for children and youth with serious emotional disturbance (SED). Each CMHSP that participates in the Children's Trauma Initiative have clinical staff, supervisors and parent support partners trained to implement each component of the initiative. The components are: the Trauma Informed Screening and Trauma Informed Assessment (Trauma Symptom Checklist for Young Children and the Northshore UCLA PTSD) as mentioned above; for those determined to be appropriate after assessment, trauma treatment through the implementation of the evidence-based Trauma Focused Cognitive Behavioral Therapy (TF-CBT) is available; and finally, caregiver education for biological, adoptive, and foster parents is available through the Resource Parent Training curriculum. This curriculum is also used to train community partners. The training is provided by clinical staff and parent partners. The focus of the Children's Trauma Initiative is to provide clinical staff and their supervisors with the skills needed to provide trauma-informed care and trauma treatment to children with SED and their families to ensure appropriate clinical intervention to a population that has a high probability of trauma.

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

No technical assistance is needed at this time.

Footnotes:

Environmental Factors and Plan

14. 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.[62]

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.[63]

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 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.

[62] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. **OJJDP Model Programs Guide**

[63] **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 behavioral health 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, behavioral health 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 behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health 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 behavioral health 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?

Through the Governor's Mental Health Diversion Council, continuing efforts to divert the mentally ill out of jails and prisons and into treatment (when appropriate) remains a top priority for this administration. Currently there are 11 pilot initiatives throughout the state that are addressing jail diversion and intervention at all points across the Sequential Intercept Model that include:

- Pilots- CIT/CITY, Diversion Centers, In jail assessments, Mental Health Courts, In jail services, Boundary Spanners, Pre/Post Release Treatment (warm handoffs), Longer term housing, Probation/Parole Intervention
- Kevin's Law Revamp (Assisted Outpatient Treatment) – Implementation
- Implementing Michigan Juvenile Justice Assessment System
- Stepping Up Initiative (Statewide Summit)
- Universal Release Form
- Youth Mental Health First Aid Training Statewide
- Guardianships both Adult and Juvenile
- Implemented Crossover Youth Practice Model

- Suspending Medicaid Services in Jail (Completed)
- Juvenile Competency Mental Health Examiner Training
- Juvenile Competency Restoration Provider Training
- Juvenile Urgent Response Team RFP
- Intercept "0" (Treatment before interaction with the law)

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. 62

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. 63

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 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 Mental Health Block Grant and Substance Abuse Prevention and Treatment Block Grant 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.

62 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform
Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide
63 http://csgjusticecenter.org/mental-health/

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

No technical assistance is needed at this time.

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

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], and 49[4].

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.

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)** [x] Methadone
- **b)** [x] Buprenophine, Buprenorphine/naloxone
- **c)** [ ] Disulfiram
- **d)** [ ] Acamprosate
- **e)** [x] Naltrexone (oral, IM)
- **f)** [x] 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?

(1) In four of Michigan's PIHP regions a Vivitrol Pilot with the Department of Corrections (DOC) is taking place. Candidates from the Women's Prison and some entering the Detroit Re-Entry Program are taking part. This project will include medication, counseling, and peer support services. Identified PIHP contracted programs will work in collaboration with DOC to ensure these services as well as providing assist in obtaining additional community supports that may be needed.

(2) A training pilot is being designed/developed that will interweave critical elements of effective treatment of Opioid Use Disorders (OUD) with Medication Assisted Treatment (MAT). This pilot will take place within an Opioid Treatment Program (OTP), the target audience will be all types of staffing within an OTP, and the content will focus on the use of motivational language and interviewing with individuals who have a co-occurring disorder of OUD and mental health disorder who are receiving MAT treatment. How using these elements will enhance recovery oriented care, reduce episodes of triggering symptomatology of the co-morbid disorders that would detract from the quality of OUD treatment, and improved retention in and of medication and counseling services.

(3) Opioid State Targeted Response (STR) Grant – Michigan is the recipient of $16.3 million to address opioid prevention and treatment. Detailed information on the activities has been provided to SAMHSA in grant required and related documents. Briefly, STR initiatives include but are not limited to: MAT Peer training, training on motivational interviewing, opioids and pain management, suboxone dosing technical assistance, prison re-entry treatment/counseling/peer supports, expansion and enhancement of MAT/OUD treatment services, media campaign, and more.

Please indicate areas of technical assistance needed to this section.

None at this time.

**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.*

Footnotes:

Environmental Factors and Plan

16. Crisis Services - Requested

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 behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.[64] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[65],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

[64] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[65] Practice Guidelines: Core Elements for Responding to Mental Health Crisis. 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 respond to the following items:

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)** ☐ WRAP Post-Crisis
- **b)** ☐ Peer Support/Peer Bridgers
- **c)** ☐ Follow-up Outreach and Support
- **d)** ☐ Family-to-Family Engagement

- **e)** ☐ Connection to care coordination and follow-up clinical care for individuals in crisis
- **f)** ☐ Follow-up crisis engagement with families and involved community members
- **g)** ☐ Recovery community coaches/peer recovery coaches
- **h)** ☐ Recovery community organization

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

Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual?s mental or substance use disorder. 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, and strive to reach their full potential.
In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders**.
States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

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?

The MDHHS contracts with the 10 Prepaid Inpatient Health Plans require that each area develop and implement a survey on recovery practices in their local areas. As part of the contract requirements each area must report on recovery outcomes and processes. Several areas continue to implement the Recovery Enhancing Environment survey while others have selected the Recovery Self-Assessment (RSA). Both of these instruments have individuals who receive or have received services involved in applying the instruments and serving in advisory capacities to evaluate the results and develop action plans.

A survey of consumer run drop-in members was conducted by peer support specialists with approximately 1,400 responses. Outcomes included community integration and recovery. The survey showed less hospitalizations because of drop-in center attendance and less isolation by developing friends and relationships.

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 supports and services are woven into all areas of the service delivery system for persons with mental health conditions. Programs are based in recovery. One example is the continuum of peer services including Certified Peer Support Specialist, Certified Recovery Coach, parent support partners, and youth mentors who serve as Medicaid providers. In addition, we have built strong partnerships with advocacy organizations to promote and expand the integration of recovery throughout the state. Michigan Peer Specialists United is a statewide organization that has individuals with lived experience designated in local communities across the state. This strong informal network has strengthened the array of recovery services available. A variety of consumer and advocacy organizations in the state work closely with providers and provide technical assistance from the individual and family perspective.

Approximately 7,000 individuals with serious mental illness are attending the estimated fifty consumer run drop-in centers in Michigan. The services provided at these centers emphasize freedom from isolation, community inclusion, and development of recovery-focused relationships. Peer support specialists work throughout the drop-in networks and through their training emphasize cultural diversity, recovery, and peer leadership.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

The state continues to strengthen the foundation of a Recovery Oriented System of Care (ROSC) in Michigan. As such, OROSC has submitted a draft policy regarding Peer Recovery Coach Certification to the MDHHS Medical Services Administration for review and approval. Prior to approval, the draft policy will be distributed for public comment. PIHPs, providers, Peer Recovery Coaches and recovery and advocacy organizations will be encouraged to respond. The policy will formalize standards for training, certification, practices and employment for Peer Recovery Coaches. Peer Recovery Coaches from across the state contributed to the development of the policy draft. The proposed effective date of the policy is November 1, 2017.

The Transformation Steering Committee (TSC) meets quarterly and develops guidance to regions and statewide on recovery practices and outcomes to share best and promising practices. Individuals with SUD are also members of the Behavioral Health Advisory Council, which is involved in the planning and evaluations of services and the review of the state plan for block grant services.

5. Does the state have any activities that it would like to highlight?

From a BRSS TACs grant 45 individuals in two prisons in the state were trained as Certified Peer Support Specialists. These individuals received additional training in the areas of Wellness Recovery Action Planning, Whole Health Action Management, motivational interviewing, and ethics. The program at Women's Huron Valley has grown substantially with multiple groups running each week and services being provided in a variety of settings. Data being collected demonstrates a high level of

satisfaction of individuals receiving peer services. Recently a two-day training on the role of peers in trauma informed care was provided with skills and knowledge to run groups and provide individual peer to peer support. In 2018, women incarcerated will be trained as Certified Recovery Coaches to address the large population of person with SUD and co-occurring disorders.

Beginning in 2016 a three-year Veteran and Military Members Strategic Plan was developed by BHDDA. One of the objectives of this plan is to identify, train and embed Veteran Navigators/Liaisons into the publicly funded behavioral health care system throughout the State of Michigan. In addition to providing Veteran Navigators within each of the ten PIHP regions across the state, it also includes the identification of 'buddies" for one-on-one match-ups through collaboration with the Buddy-to-Buddy program administered through the University of Michigan.

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

No technical assistance is needed at this time.

Footnotes:

Environmental Factors and Plan

18. 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 behavioral health 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 behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office 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.

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

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

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.

Footnotes:

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health 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[66]. 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[67]. 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[68].

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[69]. 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[70].

According to data from the 2015 Report to Congress[71] 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 behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (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).

[66]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[67]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.

[68]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.

[69]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[70]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 **http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010**

[71] **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 behavioral health 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 behavioral health 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 co-occurring disorders (COD). All public mental health providers in Michigan utilize a standard definition of SED and uniform access standards, as outlined in an attachment to the Michigan Department of Health and Human Services (MDHHS – former MDCH) contract with the 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 the former MDCH (Now MDHHS) requires CMHSPs to provide an assessment of their local SOC and how they plan to move forward to improve outcomes for children with SED and their families and children with developmental disabilities and their families. MDHHS continues to work individually with PIHPs to provide technical assistance regarding progressing to more comprehensive SOCs. CMHSPs 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. In FY18 MDHHS will sponsor a Motivational Interviewing training for PIHP/CMHSP staff that work with youth and families, supported with mental health block grant funds. 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, and 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 2018-2022. As a result, providers who serve adolescents and transitional age youth will be receiving training and coaching in identified evidence based practices, a youth and family/caregiver network will be developed to help support those entering treatment and working on sustaining recovery, and outreach strategies will be developed to bring more adolescents and transitional age youth into treatment at a younger age.

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 FY18-19. 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 seven 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. 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. 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. A really exciting development that has been supported by the merger of MDCH and MDHS, is the child welfare residential transformation process that MDHHS has embarked upon with consultation from children's mental health staff. MDHHS is also consulting 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 two urban 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. FY18-19 appears to bring additional opportunities for collaborative efforts in the areas of juvenile justice, screening, identification and treatment of social/emotional/mental health issues in home and community-based environments, 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 continues to support the Children's Transition Support Team (CTST), who operate out of the only state children's psychiatric hospital (Hawthorn Center) but travel statewide to assist in and support the success of the transition of children/youth with very complicated behavioral health needs back into their communities. The CTST has served nearly 70 youth in three years and with their assistance, those youth have experienced an average increase of 70% in time spent stable in their communities compared to pre-CTST intervention. Hawthorn Center has also recently added a step-down transition unit that works to prepare youth and families for transition back to their communities and the CTST now works with all the children/youth that graduate to that unit. 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. Now that MDHHS encompasses physical health, behavioral health, child welfare and juvenile justice in one department, collaboration at the state level should be better. Additionally, Michigan has been awarded

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. In FY17, MDHHS sponsored a Mobile Crisis Response Conference to introduce this approach to the PIHP/CMHSP system and provide examples if national models and teams that are already up and running in Michigan. MDHHS is currently in the process of requiring mobile crisis response as a part of the Medicaid continuum of covered services for youth.

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 FY18-19. 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.

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

Please see the information provided above.

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

None.

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention - Required 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 behavioral health 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 through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health 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.

MDHHS has a state youth suicide prevention grant from SAMHSA (cohort 9), which is in its third of five years. A number of activities are taking place under that grant including:
A pilot suicide risk screening program for youth entering foster care.
A pilot follow-up program for youth discharged from a pediatric psychiatric emergency department
School-based suicide prevention programming
Introductory training on the Zero Suicide Model for Health and Behavioral Healthcare
Implementation of the Zero Suicide Model in two local health departments and one large community mental health agency
Implementation of the Michigan Zero Suicide Network to support implementation of the model across the state
Availability of ASIST (Applied Suicide Intervention Skills Training) and AMSR (Assessing and Managing Suicide Risk) workshops for communities statewide.
An annual Suicide Prevention Community Technical Assistance meeting open to anyone interested in suicide prevention at the local level.

Additional activities are outlined in the existing Statewide Suicide Prevention Plan located on The Michigan Association for Suicide Prevention's website at masponweb.org .

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 2016-FFY 2017 plan was submitted? ◉ Yes ○ No

If so, please describe the population targeted.

The pilot programs described above were initiated after the previous plan was submitted.
Target population for foster care screening program: youth ages 10-18 entering foster care placement in three counties.
Target population for psychiatric ED discharge follow-up: youth ages 10-18 being discharged from a specified large pediatric psychiatric emergency room.
These programs are intended to address two of SAMHSA's priorities for youth suicide prevention.

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

Please see above.

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

None.

Footnotes:

Environmental Factors and Plan

21. Support of State Partners - Required 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 behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please 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?

Although the “development” of new partnerships are not necessarily needed, Michigan plans to continue building and enhancing partnerships currently in place. These partnerships include with the Michigan Department of Education; Michigan Developmental Disabilities Council; Michigan Licensing and Regulatory Affairs; Michigan Rehabilitation Services; Michigan State Police; and various Medicaid Health Plans.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

The Behavioral Health and Developmental Disabilities Administration (BHDDA) carries out responsibilities specified in the Michigan Mental Health Code (Public Act 258 of 1974 as amended) and the Michigan Public Health Code (Public Act 368 of 1978 as amended). It also administers Medicaid Waivers for people with developmental disabilities, mental illness, serious emotional disturbance, and it administers prevention and treatment services for substance use disorders. The administration establishes the policy directions and standards for the statewide system including Community Mental Health Services Programs (CMHSP) services to children and adults, Substance Abuse prevention and treatment, Autism Services to Children and families, problem gambling addictions services and State Hospital Centers.

BHDDA services and supports in Michigan are delivered through county-based community mental health services programs (CMHSPs). Michigan Department of Health and Human Services (MDHHS), along with 46 regional CMHSPs and 10 Prepaid Inpatient

Health Plans (PIHPs), contracts public funds for mental health, substance abuse prevention and treatment, and developmental disability services. Medicaid funds, which are paid on a per Medicaid-eligible capitated basis, are contracted thru PIHPs, three of which are single county PIHPs and seven of which are regional entities. Substance Abuse services are purchased through the 10 PIHPs and delivered through local Recovery Oriented Systems of Care.

Each region is required to have an extensive array of services that allows for maximizing choice and control on the part of individuals in need of service. Individual plans of service are developed using a person-centered planning process for adults and family driven and youth guided services for children. Outpatient mental health services are available through Medicaid Health Plans (MHPs) for persons who are not eligible for Medicaid Services through PIHPs and their CMHSP networks. These efforts are coordinated with others at the state and local level to maximize efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes for individuals to function in the community.

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

In terms of services provided under IDEA, in June, 2016, a Memorandum of Understanding (MOU) related to Transition to Employment of Students and Youth with Disabilities was signed by the Michigan Department of Education, Michigan Rehabilitation Services, Michigan Bureau of Services for Blind Persons, MDHHS/BHDDA, Michigan Workforce Development Agency, and Michigan Developmental Disabilities Council. The vision of the MOU is identified as 'through strong interagency collaboration, students with disabilities will exit school with competitive integrated employment and/or a connection to post-secondary education intended to lead to employment. It is believe preparation for competitive integrated employment should take place throughout secondary education and extend through transition to the workforce or post-secondary education. Together with Michigan's Employment First Executive Order No. 2015-15, the MOU recognizes that Michigan starts with the presumption that everyone, with the appropriate preparation and support, can be employed in a competitive integrated job; and that all signers share in a common responsibility, philosophy and goal of increasing the number of transition age students and youth with disabilities who successfully transition from school to such employment. Per the Workforce Innovation and Opportunities Act (WIOA), students with a disability are between the ages of 16 and 21 who are eligible for and receiving IDEA services. In Michigan, these services may extend through age 25, which is beyond the federal requirement of age 21. Goals, mutual responsibilities, individual party responsibilities, and resolution of conflicts are outlined as portions of this MOU.

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

No technical assistance is needed at this time.

Footnotes:

Environmental Factors and Plan

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

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating 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 a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance 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 BHPC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[72]

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 behavioral health 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.

[72] **http://beta.samhsa.gov/grants/block-grants/resources**

Please respond to the following items:

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

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 (FY16 – FY17), that includes priority focus areas including:

Children: Improve outcomes for children (youth and families) by:
- Reducing underage drinking
- Reducing youth access to tobacco and illegal sales to minors
- Reducing fetal alcohol spectrum disorder births
- Reducing the impact of substance use in families by enhancing and improving access to treatment

Adults 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 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: Transform the healthcare system by:
- Continuing the implementation of a recovery oriented system of care
- 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 illness to self-direct their services and supports
- Promoting and strengthening the role of consumer run programs
- Treating addiction as a chronic disease
- Improving behavioral health outcomes while leveraging efficiencies in cost and societal consequence

Workforce: Strengthen Workforce and Economic Development by:
- Providing statewide training in best-practice behavioral health services including prevention, treatment and recovery technology
- Providing training and continuing education to enhance credentials and employment opportunities for Certified Peer Support Specialists and Certified Peer Recovery Coaches

- Expanding employment opportunities for Peer Recovery Coaches and Peer Support Specialists in primary and integrated care settings

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i — ◉ Yes ○ No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linquistic, rural, suburban, urban, older adults, families of young children)? — ◉ Yes ○ No

3. Please indicate 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 bylaws will be undergoing a required four-year review during the second half of 2017. The BHAC membership includes people in recovery, family members, advocates, and other individuals who are important to this diverse council.

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

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

The BHAC will have an important new project to tackle, as the State Legislature has deemed that the Council is to receive regular progress reports on major pilot programs being implemented regarding integration/coordination of behavioral and other health care for Medicaid beneficiaries.

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

The Council would benefit from technical assistance on public policy activity, including analysis, advocacy, prioritization of issues, and consensus-building for action.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[73]

[73]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.

Footnotes:

Behavioral Health Advisory Council
Meeting Minutes for June 16, 2017

Members Present: Julie Barron, Ricardo Bowden, Linda Burghardt, Karen Cashen, Mary Chaliman, Sara Coates, Norm DeLisle, Erin Emerson, Kevin Fischer, Deborah Garrett, Greg Johnson, Arlene Kashata, Lauren Kazee, Mark Maggio, Michelle Mull, Chris Flores for Paula Nelson, Stephanie Oles, Jamie Pennell, Neicey Pennell, Eva Petoskey, Mark Reinstein, Ben Robinson, Kristie Schmiege, Larry Scott, Jane Shank, Patricia Smith, Sally Steiner, Jennifer Stentoumis, Jeff Van Treese, Brian Wellwood, Mark Witte

Members Absent: Benjamin Jones, Kevin McLaughlin, Malkia Newman, Marcia Probst, Cynthia Wright

Others Present: John Addis, Glenn Cornish, Jamie Estep, Lorianne Fall, Kim Gaedeke, Tom Renwick, Alyson Rush, Brenda Stoneburner, Haley Winans, Lynda Zeller

Welcome and Introductions: Mark Reinstein called the meeting to order and introductions were made.

Review and Approval of Minutes: The Council reviewed the meeting minutes from March 3, 2017. Chris moved and Sally seconded, minutes approved with one typo correction on page 2.

MDHHS/BHDDA Updates - Tom Renwick

1115 Waiver – CMS' approval of the 1115 Waiver is still in process and there has been no change since the last meeting. CMS is not yet ready to approve the waiver as written. CMS needs to make some decisions about how certain services are handled across the country and until those decisions are made they will not approve Michigan's waiver. Therefore, no 1115 Waiver language will be included in FY18 PIHP/CMHSP contracts with MDHHS as these contracts are already being finalized. There will have to be additional work on contracts once the waiver is approved.

Combined Block Grant Review – MDHHS has not received a report back from SAMHSA regarding the review and MDHHS was not given a time frame as to when to expect this report. MDHHS will review any recommendations included in the report when it is received.

Shortage of Inpatient Psychiatric Hospital Beds – Discussions continue in many different venues about this issue. There is now a MIPAD (Michigan Inpatient Psychiatric Admissions Discussion) group working on this with a deadline for recommendations by October 1st. Karen will email the BHAC a list of the members of the group and how people can make suggestions and comments to the group. The point of this group is to identify as many avenues that exist to try to remedy the problem from

every possible area (hospitals, licensing, BHDDA, etc.). The BHAC discussed their concerns regarding this issue of accessing inpatient psychiatric services.

Healthy Michigan – There has been some discussion about having to re-evaluate Healthy Michigan rates. There is also some concerns that there are changes to a person's Medicaid eligibility that may originate at the local MDHHS level at annual eligibility determination that are impacting Medicaid reimbursement rates. MDHHS is looking into this, as this may be more related to assignment of former "DAB" Medicaid to HMP or TANF.

Governor's Recognition of Excellence – Lynda Zeller, Tom Renwick & Brenda Stoneburner

Lynda presented Karen Cashen with a Governor's Recognition of Excellence coin. This is a very prestigious honor for Karen. Brenda nominated Karen for all her very important and expansive work for BHDDA.

Section 298 and Promoting Integration of Behavioral Health in Primary Care – Mark Reinstein

Section 298 - The conference committee on the MDHHS budget has agreed on some recommendations to include in the final budget language for section 298. The language is vague regarding the recommended pilot in Kent County but a pilot is named and allowed in Kent County. They also recommended 1 to 3 pilots where the Medicaid Health Plans are given "first dollar control" of all Medicaid money. They also recommended a change in number of PIHPs but this may not end up in the final version of the language. The pilots are to last two years and have an evaluation component that is to start 18 months into the pilots. Advocacy groups have already begun contacting Governor Snyder asking him to veto this portion of the MDHHS budget.

Lynda reminded the BHAC that this current language is regarding financial models only. There is also work continuing on the other policy recommendations that came out of the 298 Workgroup's report. This budget process has been different than previous years and there are a lot of rumors flying around but the language on 298 is not final yet.

Ben asked about how the duals projects are being considered in this process. Erin Emerson indicated that the evaluation of the duals project is in full swing right now and they don't have results to report at this time.

Jane expressed her ongoing concern with the proposed language and moved that the BHAC have a formal response to this, Michelle seconded. Jane reiterated that she feels the MDHHS did hear the voices of consumers and families in policy recommendations but that the legislature did not. Chris Flores indicated that private providers lost their voice along the way as the focus became only CMHSPs. Ricardo indicated that his experience with an affinity group was that people did not want the mental health system privatized. Mark R. asked what the specific action is that the BHAC should take. Jane amended her motion to be that the BHAC send a letter, to be written by Mark R., to the Governor that spells out the BHAC members concerns with

298. Michelle seconded the amended motion. The group discussed this new motion. It was clarified that the letter will be modeled after the letter from the advocate groups that was already sent to the Governor minus the request for veto. The BHAC voted; 15 yes and 1 no with 9 abstaining. All State of Michigan employees present abstained. Motion approved. Mark will email a copy of the letter to the group.

Promoting Integration of Behavioral Health in Primary Care Grants
These are joint efforts between MDHHS, Michigan Hospital Association, CMHSPs/PIHPs, and FQHCs. The grant applications asks for projects in 3 communities to integrate behavioral health into primary care setting. MDHHS expects to hear whether we are chosen for funding in September.

Improving MI Practices Presentation – John Addis
John gave a presentation on the improvingMIpractices.org website. Allyson Rush from MDHHS asked for the BHAC's help in reviewing trainings on the website that were transferred over from the VCE in Wayne County. If BHAC members have expertise in any of the content areas of the trainings, please let Allison know if you would like to help in reviewing them. Information that was presented will be emailed to BHAC members as members who joined by webinar could not see the presentation.

FY18 – FY19 Combined Block Grant Application – Karen Cashen
A part of the feedback MDHHS did receive from SAMHSA is that the BHAC would like to be more actively involved in the block grant application process. BHAC members clarified that they really just wanted more time to review and provide input. Karen explained the application process and indicated that there are areas of the application that members of the BHAC do have expertise in and if members who have that expertise would like to contribute they certainly can. Karen indicated that she will likely be reaching out to those folks individually for input.

The BHAC members discussed their experience with the SAMHSA Block Grant review meeting. Some recollections members had were that they would like to have more time to review the application and getting technical assistance from SAMHSA for the Council and as a whole. The technical assistance issue was not clearly communicated to MDHHS by SAMHSA. Karen can request technical assistance from SAMHSA whenever the Council wants. Karen asked the Council to think about specific technical assistance requests and this will be added to the August BHAC agenda. It is also time to review the BHAC by-laws. Sally will lead this group. Please contact Sally if you want to participate in this review. Some volunteers were identified at the meeting.

Michigan Automated Prescription System (MAPS) – Kim Gaedeke and Hailey Winans
Kim and Hailey from LARA gave a presentation on the MAPS project. The BHAC members received a PowerPoint handout on the project. Karen will email the presentation to the BHAC.

Michigan Opioid State Targeted Response Grant – Larry Scott
The state received a $33 million dollar grant to reduce prescription drug and opioid misuse and overdose. There were 2,400 opioid overdose deaths in Michigan in 2016. This is a very serious issue in Michigan. The first year money is guaranteed but the second year is not. MDHHS has released a request to all the participating agencies to obtain information for this project. There are also collaborative agreements in place between state agencies. This money will be used for: a statewide opioid media campaign; statewide training in the Iowa Model (an EBP to address opioid misuse and overdose); to fund the expansion of MAPS; to fund the statewide expansion of the Red Project (a prevention initiative); to expand the Michigan OPEN Project (training doctors on proper prescribing, specifically surgeons); to fund inter-tribal participation in prevention; to expand funding for motivational interviewing; to increase medication assisted treatment programs in areas where there are none; to fund transportation to clinics and psychiatric treatment and medications to participants in MAT; to fund a program to provide peer recovery supports and MAT to people re-entering society from prison; to fund a hospital-based SBIRT model using peers (Project Assert); and to fund the Angel Project (provides Narcan to police officers and law enforcement offices and assists people in accessing SUD treatment). This grant is very comprehensive and innovative and the hope is there will be some great outcomes that result from this work.

Public Comment
Stephanie Oles asked that all BHAC member agencies, especially state department representatives, keep the chronic homeless population in mind when looking at mental health initiatives.

Announcements
Deborah Garrett – There are 12 officially recognized recovery organizations in Michigan. There is a rally on Belle Isle on September 9th. There was a regional recovery organization training that was recently held in Lansing.

Brain Wellwood – The annual Support Group Conference is July 20th at LCC West.

Mary Chaliman – Will be attending a regional opioid crisis meeting in Indiana as part of a Michigan team as the child welfare representative.

Jane Shank – The ACMH Statewide Conference is at the Lansing Radisson on September 21st.

Michelle Mull – Elmer is back to work some and he continues to make progress.

Mark adjourned the meeting.

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.

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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.

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Behavioral Health Advisory Council
Meeting Minutes for August 18, 2017

Members Present: Ricardo Bowden, Linda Burghardt, Karen Cashen, Mary Chaliman, Norm DeLisle, Erin Emerson, Kevin Fischer, Deborah Garrett, Greg Johnson, Benjamin Jones, Lauren Kazee, Mark Maggio, Kevin McLaughlin, Elmer Cerano for Michelle Mull, Malkia Newman, Stephanie Oles, Marcia Probst, Mark Reinstein, Ben Robinson, Kristie Schmiege, Larry Scott, Jane Shank, Patricia Smith, Sally Steiner, Jennifer Stentoumis, Jeff Van Treese, Brian Wellwood, Mark Witte, Jennifer Hirst for Cynthia Wright

Members Absent: Julie Barron, Sara Coates, Arlene Kashata, Paula Nelson, Jamie Pennell, Neicey Pennell, Eva Petoskey,

Others Present: Glenn Cornish, Jamie Estep, LoriAnne Fall, Adam Rondeau, Brenda Stoneburner, Jon Villasurda, Lynda Zeller

Welcome and Introductions: Mark Reinstein called the meeting to order and introductions were made.

Review and Approval of Minutes: The Council reviewed the meeting minutes from June 16, 2017. Sally moved and Ricardo seconded, minutes approved unanimously.

Section 298 Update – Mark Reinstein

No big developments in this area since the last meeting except that the budget has now been finalized for fiscal year 2018. The BHAC is supposed to receive updates on the developments in the 298 process as part of the boilerplate.

MDHHS/BHDDA Updates – Lynda Zeller

Section 298 – The Department is currently speaking with potential facilitators. One of the most important first tasks of the facilitator will be to establish methods of communication with various players and stakeholders, including BHAC who is named in the boilerplate. At this time, the evaluator is also being selected. Then the work of identifying and implementing pilots will begin, along with working with the 10 PIHPs to implement the 71 policy recommendations that came out of the 298 Workgroup. The department will work with facilitator to engage conversations and official processes to help CMHs with considerations about whether to express willingness to be part of a pilot. Lynda emphasized the importance of common vision and willing partners to the success of any integrated financing models. There is still a lot of work to be done on quality of life metrics to determine if any system, new or old, is providing what individuals need with better outcomes. BHAC will be consulted as these metrics are being developed, though the exact process for interface will be clearer once facilitator is chosen and project plans have time to develop.

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Elmer moved that the BHAC communicate to MDHHS that MH, SUD, tribal nations, kids and families, and consumers with lived experience be involved at every level of the process as it moves forward, Malkia seconded. The BHAC voted, 16 yes and 0 no with 8 state employees abstaining. Mark will work with BHAC members to develop a letter to the Department on this issue.

MIPAD Activities – The 100-day sprint to develop recommendations to address the crisis of adults and children being unable to access inpatient psychiatric beds has begun. The MIPAD group is currently in the process of identifying the things that are currently missing in the system that are creating this crisis. This is also a national issue.

State Targeted Response (STR) Grant – The grant is in full swing to address the opioid crisis.

Stepping Up Summit – The summit in November is to provide education and information on the over-representation of adults with mental illness and/or addiction in prisons and jails.

Lynda reiterated the need for the BHAC's important feedback on the 298 evaluation process.

FY18-19 Combined Block Grant Application – Karen Cashen, Jennifer Stentoumis, and Larry Scott

The application is due September 1, 2017. A draft of the application was provided electronically to the BHAC prior to the meeting. Karen reviewed the sections of the application on the WebBGAS online system. Mark R. suggested that a short paragraph be added to the application describing what the boilerplate says about the 298 process. Lynda Z. indicated that will be added. Elmer suggested that information about the Home and Community Based Services Rules be added as well. This will be added. Jennifer reviewed the Children with SED information. Larry reviewed the SA Prevention and Treatment information.

Kevin M. voiced his concerns about the Recovery Coach Certification process set to be put in place as of October 1st. Mark Witte indicated that his understanding was that the workgroup trying to address this issue was not really heard. Kevin indicated that there is a lot of confusion surrounding this issue and what is included in the application may not be accurate in describing what is happening. The confusion is directly impacting the field. Larry will investigate this issue further and update this information in the application as necessary. Kristie echoed what Kevin and Mark indicated. Jeff V. reported he was part of the process and things are still subject to change. Deborah indicated there were some disconnects in the participation and communication. There are additional concerns surrounding this issue that need to be addressed outside of the block grant application.

To see the application as it unfolds members can go to www.BGas.SAMHSA.gov. The user name is citizenMI and the password is citizen.

Karen will send out the above access information to the BHAC. Karen reviewed the BHAC specific application sections with the group. The application will go online for public comment shortly.

Mark R. indicated that the BHAC needs to submit a letter with the application from the BHAC. Norm moved and Mark W. seconded to provide the letter. BHAC voted unanimously to provide the letter for the FY18-19 Combined Block Grant Application.

By-Law Report – Sally Steiner and Mark Reinstein
An ad hoc group of the BHAC met to review the BHAC by-laws. Their work is ongoing. They hope to have a draft of the revised by-laws for review at the November BHAC meeting. There may still need to be revisions made after the draft is presented in November.

House CARES Task Force – Mark Reinstein
So far, two community meetings have been held, one in Livingston County and one in Grand Rapids. This task force is comprised of 14 legislators (7 democrats/7 republicans). Improving MH and SUD services is the reported purpose of the task force. They seem to have a very broad scope. The upcoming community meetings are: 8/21 Harrison; 8/29 Oakland Community Health Network; 9/7 Lansing. Mark attended the meeting in Livingston and was less than impressed. There was no consumer, family, or advocacy representation. It was simply presentations by service providers with no chance for questions. Elmer went to the Grand Rapids meeting and it was similar to the Livingston meeting. No focus on the people being served. It seemed pointless to him and not likely to result in anything meaningful. The task force indicates that they want to have recommendations ready by January. Representative Kesto's office provides a weekly update on the task force and anyone can get on the list to receive it if they contact his office.

Areas of SAMHSA Technical Assistance Request – Mark Reinstein and Karen Cashen
Mark and Karen have a call with SAMHSA to talk about TA needs. Mark had to complete a short questionnaire to help provide SAMHSA with some preliminary information about TA needs. BHAC members were asked to contribute ideas about TA if they had any additional information.

Community Network Services Anti-Stigma Program – Malkia Newman
Malkia presented on the CNS Anti-Stigma Program. A PowerPoint was distributed to the group.

Public Comment – No public comment.

Announcements
Norm – MDRC fundraiser is August 27th at Moriarty's in Lansing from 3:00 – 7:00 p.m.
Ben - Rosehill Center is celebrating 25 years on Thursday, October 19th at Townsend Hotel with speaker Muriel Hemingway.

Kevin M. – Recovery Palooza is September 22th in Grand Rapids. For more information visit recoveryallies.us.
Linda B. – Area Agencies on Aging Association of Michigan's annual conference is October 5 – 6th at the Kellogg Center.
Patricia – Public Health received another grant, this one for opioid overdose morbidity and mortality surveillance.
Jane – ACMH Conference is September 21st at the Lansing Radisson Hotel. The theme is, "There's No Place Like Home".
Brenda – The 18th Annual Substance Use and Co-Occurring Disorder Conference is September 25 – 26th at the Lansing Center. Information is on the MACMHB website www.macmhb.org.
Kevin F. – NAMI Walk is September 23rd at Belle Isle, Detroit.
Ben J. – September is National Recovery Month. Belle Isle Recovery Month Celebration is on September 9th.
Ricardo – Day in the Park Event is this Sunday, August 20th, at the Bay City State Park from 1 – 5 p.m. On September 29th, another recovery event at the Unity Club in Saginaw.
Marcia - Wellness and Recovery Fair is September 21st at Bronson Park in Kalamazoo.

Mark adjourned the meeting.

DRAFT

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

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)		6150 W. Michigan Ave., L2 Lansing MI, 48917 PH: 517-775-8727	barron@ceicmh.org
Ricardo Bowden	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1614 McKinley Bay City MI, 48708 PH: 989-415-2049	ricardobowden@chartermi.net
Linda Burghardt	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1907 Atherton Way Okemos MI, 48864 PH: 517-347-1077	lburghardt@comcast.net
Karen Cashen	State Employees	Michigan Department of Health and Human Services	320 S. Walnut, 5th Floor Lansing MI, 48913 PH: 517-335-5934	cashenk@michigan.gov
Mary Chaliman	State Employees	Michigan Department of Health and Human Services	235 S. Grand Ave., Grand Tower, Suite 514 Lansing MI, 48933 PH: 517-898-0707	chalimanm2@michigan.gov
Sara Coates	Others (Not State employees or providers)	Michigan Primary Care Association	7215 Westshire Drive Lansing MI, 48917 PH: 517-827-0875	scoates@mpca.net
Norm DeLisle	Others (Not State employees or providers)	Michigan Disabilty Rights Coalition	3498 E. Lake Lansing Road, Suite 100 East Lansing MI, 48823 PH: 517-333-2477	ndelisle@mymdrc.org
Erin Emerson	State Employees	Medical Services Administration	400 South Pine Street Lansing MI, 48933 PH: 517-284-1132	emersone@michigan.gov
Kevin Fischer	Others (Not State employees or providers)	NAMI Michigan	921 N. Washington Avenue Lansing MI, 48906 PH: 517-853-0951	kfischer@namimi.org
Deborah Garrett	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		29601 Little Mack Avenue Roseville MI, 48066 PH: 586-634-2316	dgarrett@recovery4detroit.com
Greg Johnson	State Employees	Department of Corrections	3201 Bemus Road Ypsilanti MI, 48197 PH: 734-434-4068	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	Federally Recognized Tribe Representatives		2815 Hilltop Court 204 Traverse City MI, 49686 PH: 231-735-0491	a_kashata@hotmail.com
Lauren Kazee	State Employees	Department of Education	608 W. Allegan Street, 2nd Floor Hannah Building Lansing MI, 48933 PH: 517-241-1500	kazeel@michigan.gov
Mark Maggio	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1106 Ethel Ave. Hancock MI, 49930 PH: 906-281-1909	markmaggio88@yahoo.com
Kevin McLaughlin	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2673 Oakleigh Rd. Middleville MI, 49333 PH: 616-262-8531	kevin@recoveryallies.us
Michelle Mull	Others (Not State employees or providers)	Michigan Protection & Advocacy Service, Inc.	4095 Legacy Pkwy., Suite 500 Lansing MI, 48911 PH: 517-487-1755	mmull@mpas.org
Paula Nelson	Providers	Sacred Heart Rehabilitation Center, Inc.	400 Stoddard Road Memphis MI, 48062 PH: 810-392-2167	pnelson@sacredheartcenter.com
Malkia Maisha Newman	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		279 Summitt Dr. Waterford MI, 48328 PH: 248-342-9921	mnewman@cnsmi.org
Stephanie Oles	State Employees	Michigan State Housing Development Authority	735 E. Michigan Avenue, P.O. Box 30044 Lansing MI, 48912 PH: 517-241-8591	oless@michigan.gov
Jamie Pennell	Parents of children with SED		211 Butler Street Leslie MI, 49251 PH: 517-589-9074	jpennell00@yahoo.com
Neicey Pennell	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		211 Butler Street Leslie MI, 49251 PH: 517-703-4486	ncypennell@gmail.com
Eva Petoskey	Federally Recognized Tribe Representatives		2848 North Setterbo Road Peshawbestown MI, 49682 PH: 231-357-4886	epetoskey@centurytel.net
Marcia Probst	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2030 Portage St. Kalamazoo MI, 49001 PH: 269-364-6987	mprobst@kazoocmh.org
Mark Reinstein	Others (Not State employees or providers)		3 Medford Circle Ann Arbor MI, 48104 PH: 734-646-8099	msrmha@aol.com
Ben Robinson	Others (Not State employees or providers)		5130 Rose Hill Boulevard Holly MI, 48442 PH: 248-531-2411	brobinson@rosehillcenter.org

Kristie Schmiege	Family Members of Individuals in Recovery (to include family members of adults with SMI)		37450 Schoolcraft Rd., Suite 110 Livonia MI, 48150 PH: 810-965-2675	kschmiege@hegira.net
Larry Scott	State Employees	MDHHS Office of Recovery Oriented Systems of Care	320 S. Walnut St., 5th Floor Lansing MI, 48913 PH: 517-335-0174	scottl11@michigan.gov
Jane Shank	Others (Not State employees or providers)	Association for Children's Mental Health	6017 W. St. Joe Highway, Suite 200 Lansing MI, 48917 PH: 231-383-1595	acmhjane@sbcglobal.net
Patricia Smith	State Employees	Michigan Department of Health and Human Services	P.O. Box 30195 Lansing MI, 48913 PH: 517-335-9703	smithp40@michigan.gov
Sally Steiner	State Employees	Michigan Department of Health and Human Services	333 S. Grand Ave.,, P.O. Box 30676 Lansing MI, 48909 PH: 517-284-0164	steiners@michigan.gov
Jennifer Stentoumis	State Employees	MDHHS Office of Recovery Oriented Systems of Care	235 S. Grand Ave. Lansing MI, 48909 PH: 517-335-6258	stentoumisj@michigan.gov
Jeff Van Treese	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		665 136th Avenue, Suite 100 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 Street Lansing MI, 48933 PH: 517-371-2221	brwellwood@yahoo.com
Mark Witte	Providers	Allegan County CMH Services	3283 122nd Ave. Allegan MI, 49010 PH: 269-673-3384	mwitte@accmhs.org
Cynthia Wright	State Employees	MDHHS - Michigan Rehabilitation Services	Michigan Rehabilitation Services Lansing MI, 48917 PH: 517-281-2738	wrightc1@michigan.gov

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

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)	9	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	1	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	7	
Total Individuals in Recovery, Family Members & Others	**20**	**58.82%**
State Employees	11	
Providers	3	
Vacancies	0	
Total State Employees & Providers	**14**	**41.18%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	
Federally Recognized Tribe Representatives	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?

The Behavioral Health Advisory Council (BHAC) reviewed and discussed the application at the June 16 and August 18 meetings. BHAC members asked several questions and suggested edits/additions to various sections of the application. At the end of the August 18 discussion, the BHAC voted unanimously to include a letter of support with the application.

There are three diverse racial, ethnic, or LGBTQ members of the BHAC. They were included in with the nine individuals listed at the top 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.

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,** , 2016 (P.L. 114-113) signed by President Obama on December 18, 2015[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 a SSP other than to purchase sterile needles or syringes. However, directing FY 2016 SABG funds to SSPs will require a modification of the 2016-2017 SABG Behavioral Assessment and Plan (Plan). States interested in directing SABG funds to SSPs must provide the information requested below and receive approval on the modification 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 modifying the 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 when requesting a modification to the state?s 2016-2017 Behavioral Health Assessment and Plan.

Please follow the steps listed below to modify the Plan:

- Request a Determination of Need from the CDC
- Modify the 2016-2017 Plan to expend FFY 2016 and/or FFY 2017* 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
- Obtain State Project Officer Approval
- Collect **all** SSP information on **Table B** listed below to be reported in the FFY 2019 SABG report due December 1, 2018

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 2016 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 an amendment to its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan amendment is applicable to the FY 2016 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 persons who inject drugs (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, 2016 (P.L. 114- 113)

[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 a 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 of 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 a 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 a 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.

Footnotes:

June 25, 2016

Mr. Joe Coyle
Viral Hepatitis Unit Manager
Michigan Department of Health and Human Services
Capitol View Building, 201 Townsend Street
Lansing, Michigan 48913

Dear Mr. Coyle,

The Michigan Department of Public Health and Human Services submitted a determination of need request to the Centers for Disease Control and Prevention (CDC) with data examining whether the jurisdiction is experiencing or at risk for an increase in viral hepatitis or HIV infection due to injection drug use. Consulting with CDC on this data is a requirement in the process of seeking approval to use of federal funds to support syringe services programs (SSPs). All such requests are reviewed by a panel of CDC subject matter experts who evaluate submitted data in accordance with the *U.S Department of Health and Human Services (HHS) Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016.*

After careful review of your submission, CDC concurs that Michigan is experiencing an increase in viral hepatitis or HIV infections due to injection drug use. The submitted data provide sufficient evidence to determine a need for SSPs within the jurisdiction. Specifically, the requestor presents statewide data on increases in acute HCV infections and total HCV infections, and that a predominance of new cases are attributed to injection drug use. Epidemiologic trend data in other areas (deaths from heroin and prescription opioids as well as heroin substance abuse treatment admissions) indicate increases in unsafe injection of drugs consistent with risk for a significant increase in viral hepatitis or HIV.

The requestor also provided data from a published study (Suryaprasad AG et al. *Emerging Epidemic of Hepatitis C Virus Infections Among Young Nonurban Persons Who Inject Drugs in the United States, 2006–2012.* Clin Infect Dis. (2014) 59 (10): 1411-1419) in which the state of Michigan participated. In this study, young persons (<30 years of age) newly diagnosed with HCV were interviewed. Among Michigan participants, 94% of interviewees reported a history of injecting drugs, 92% reported a history of using heroin, 37% reported sharing needles, 47% reported sharing cookers, 53% reported sharing cotton, and 65% reported sharing a water source for drug use and preparation.

This notice may be used by state, local, territorial, or tribal health departments or eligible HHS-funded recipients to apply to direct federal funds to support SSPs. As there is no expiration date for this notice, Michigan may elect to either (1) immediately request to direct FY 2016 funds to support SSPs or (2) delay requests to direct funds to support SSPs until a subsequent fiscal year. Michigan is strongly encouraged to discuss plans to direct funds for SSPs with their respective federal funding agency.

Only CDC directly-funded, eligible awardees should submit a request to CDC to direct funding for SSP activities.

Thank you for your interest in the public health implications of injection drug use in Michigan. If you have any questions or require further technical assistance, please do not hesitate to send an email to SSPCoordinator@cdc.gov.

Sincerely,
CDC SSP Determination Panel

Jurisdiction is EXPERIENCING a significant increase in viral hepatitis or HIV infections due to injection drug use

REQUEST FOR DETEMRINAITON OF NEED

Requesting Jurisdiction: Michigan

Geographic area for which the determination is requested: State of Michigan

Point of Contact: Joe Coyle
Viral Hepatitis Unit Manager
coylej@michigan.gov
(517) 335-8165

We are submitting evidence for consultation with CDC to demonstrate our jurisdiction is **EXPERIENCING significant increases in viral hepatitis or HIV infections due to injection drug use**

Outcome(s)	Data source	Geographic area	Baseline period	Assessment period	Percent change between baseline and assessment
Acute HCV	Michigan Disease Surveillance System (NNDSS)	State of Michigan	Month: Jan-Dec Year: 2009 Value: 0.28 Units: acute HCV cases per 100,000 persons	Month: Jan-Dec Year: 2015 Value: 0.85 Units: acute HCV cases per 100,000 persons	>200% increase in the number of acute HCV diagnoses per year between 2009 and 2015 In 2015, where data was available, 60% of cases report a history of IDU within the last 2 weeks to 6 months

Chronic HCV Diagnoses (18-29 year old age group)	Michigan Disease Surveillance System (NNDSS)	State of Michigan	Month: Jan-Dec Year: 2000 Value: 59 Units: new HCV diagnoses	Month: Jan-Dec Year: 2015 Value: 1,444 Units: new HCV diagnoses	>2300% increase in the number of chronic HCV diagnoses per year in individuals aged 18-29 between 2000 and 2015 In 2015, where data was available, approximately 90% of chronic HCV cases between the ages of 18 and 29 reported a lifetime history of IDU
Prescription Opioid Deaths	MDHHS Vital Records	State of Michigan	Month: Jan-Dec Year: 2000 Value: 74 Units: Deaths	Month: Jan-Dec Year: 2014 Value: 481 Units: Deaths	550% increase in overdose deaths as a result of prescription opioids (without other drugs) between 2000 and 2014
Heroin Overdose Deaths	MDHHS Vital Records	State of Michigan	Month: Jan-Dec Year: 2000 Value: 89 Units: Deaths	Month: Jan-Dec Year: 2014 Value: 520 Units: Deaths	484% increase in overdose deaths as a result of heroin (with or without other drugs) between 2000 and 2014
Heroin Substance Abuse Treatment Admissions	SAMHSA Treatment Episode Data Set (TEDS)	State of Michigan	Month: Jan-Dec Year: 2000	Month: Jan-Dec Year: 2015	>100% increase in the number of substance abuse treatment

			Value: 9,023 Units: substance abuse treatment admissions with mention of heroin	Value: 19,728 Units: substance abuse treatment admissions with mention of heroin	admissions with mention of heroin

Part A2: Summary of Evidence

Data submitted to the CDC for the State of Michigan indicated a 200% increase in the rate of acute HCV infections between 2009 and 2015. Where risk information was ascertained on these cases, 60% reported injection drug use 2 weeks to 6 months prior to onset of symptoms.

Data submitted to the CDC for the State of Michigan indicated a 2300% increase in the number of chronic HCV diagnoses per year between 2000 and 2015 in individuals aged 18-29. Where risk information was ascertained on these cases, approximately 90% reported a history of ever injecting drugs.

Other data sources also suggest that the majority of these infections are related to the concurrent epidemics of prescription opioid abuse and heroin:

- Prescription opioid deaths have increased 550% in Michigan between 2000 and 2014
- Heroin overdose deaths have increased 480% in Michigan between 2000 and 2014
- Substance abuse treatment admissions have increased over 100% in Michigan between 2000 and 2015
- Suryaprasad AG et al. Emerging Epidemic of Hepatitis C Virus Infections Among Young Nonurban Persons Who Inject Drugs in the United States, 2006–2012. *Clin Infect Dis.* (2014) 59 (10): 1411-1419.
    - Michigan was an active participant in this study which found an increase in HCV cases associated with injection drugs among youth, particularly in non-urban settings.
    - For the entire study, 77% of interviewees reported a history of injecting drugs (among Michigan interviewees the proportion was 94%)
    - For the entire study, 61% of interviewees reported a history of using heroin (among Michigan interviewees the proportion was 92%)
    - Among Michigan interviewees 37% reported sharing needles, 47% reported sharing cookers, 53% reported sharing cotton, and 65% reported sharing a water source for drug use and preparation

- The CDC's high vulnerability study recently identified 11 Michigan counties in the top 5% of counties in the United States at greatest risk for rapid dissemination of HCV and/or HIV infection among persons who inject drugs
    - Michigan has the fifth most "vulnerable counties" among the 50 states (only behind Kentucky, Tennessee, West Virginia, and Missouri)

Geographic Area

All data mentioned in the table above (counts and rates) are available geographically by county, local health jurisdiction, and public health preparedness region. Indicators of heroin use are prevalent in Detroit and surrounding suburban areas while signs of prescription opioid abuse tend to be more pervasive in areas further removed from Detroit, where heroin is not as readily available.

The highest rates of acute HCV cases and chronic HCV cases among persons aged 18-29 are generally in the rural Northern Lower Peninsula (perhaps not coincidentally, the counties that CDC identified as highly vulnerable) and the Upper Peninsula. On the other hand, the greatest number of these cases are found in suburban southeast Michigan. As such, we are requesting this determination of need for the entire State of Michigan to allow geographical flexibility in our ability to redirect funds for syringe service programs as we perceive many areas of the state to be experiencing and at risk for rapid dissemination of HCV and/or HIV.

Division of HIV & STD Programs
Syringe Services
Program Guidelines

2018

Syringe Services Program (SSP) Start Up Guidance

This manual is designed to outline the process of developing and starting a Syringe Service Program (SSP). The National Alliance of State and Territorial AIDS Directors (NASTAD) and the Urban Coalition for HIV/AIDS Prevention Services (UCHAPS) have been strong proponents of increased access to sterile syringes for people who use injection drugs as a critical intervention for decreasing HIV transmission among this population. Drawing from a field of SSP expertise that has existed in the U.S. since the late 1980s, these program implementation guidelines have been developed by NASTAD and UCHAPS to further assist state and local health departments to plan and implement SSPs as a part of their prevention portfolios.

MDHHS Division of HIV & STD Programs is making this resource available to Local Health Departments and other partners considering the implementation of a syringe services program (SSP). For questions about SSP programs in Michigan, contact: Andre Truss at trussa@michigan.gov The original guidelines can be found at www.nastad.org (https://www.nastad.org/sites/default/files/055419_NASTAD-SSPGuidelines-August-2012_0.pdf).

Your program is a PILOT Program, and this resource is being made available to you to guide you through the process of SSP program development in your specific area. The document goes into extended detail about each area in terms of program establishment.

The drug paraphernalia law does not apply to a state or local government agency, or a person authorized by them, that give out syringes for the purpose of preventing blood born pathogens. So, state and local government agencies can conduct SSP programs without any specific authorization. Agencies that are not government need to get permission. Additionally, for agencies starting SSP programs, Harm Reduction Training could be provided. There is an agency that currently provides Syringe Services that would be willing to provide Harm Reduction Training to those agencies requesting it.

The National Alliance of State and Territorial AIDS Directors (NASTAD) and the Urban Coalition for HIV/AIDS Prevention Services (UCHAPS) recommend collecting three minimum essential data elements for every syringe transaction occurring at SSPs, without regard to the type of service delivery model. They are:

• number of participant contacts (i.e., duplicated participant counts);
• number of syringes distributed; and
• estimated number of syringes returned for disposal

Community partners who have developed SSP programs in Michigan, indicate process monitoring that is inclusive of these elements has proven to work best for them. Upon establishment of your program, your monthly process monitoring report, which is to be submitted via email, should include the following:

1. Number of Presentations
2. To Whom they were provided
3. Clients Served
4. Needles Distributed
5. HIV Tests performed

In areas where SSP participants receive legal protection for needle possession as a result of being formally enrolled in the SSP, ID cards can be a useful tool. Using ID cards can also facilitate transactions once participants have been enrolled in the program. Similar to other enrollment procedures, the use of ID cards should be instituted only if there is a clear benefit to the participant, such as legal protection. However, using ID cards may cause concerns about the lack of anonymity for program participants. If ID cards are used, it is recommended that the program construct unique codes using non-identifiable information the participant can easily recall, such as a combination of mother's maiden name initials and their month and year of birth. Similarly, some ID cards incorporate the following:

- ✓ ID Cards which contain codes

Program ID codes are different and utilize a combination of numbers and letters

Syringe Services Program (SSP) Development and Implementation Guidelines for State and Local Health Departments

August 2012

NASTAD™
NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

UCHAPS
Urban Coalition for HIV/AIDS Prevention Services

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Introduction

Despite significant reduction in the transmission of the human immunodeficiency virus (HIV) and other blood-borne viral infections among injection drug users (IDUs) over the past two decades, injection drug users (IDUs) still account for approximately 16 percent of new HIV infections in the United States,[1] and almost one half (48 percent) of newly reported hepatitis C virus (HCV) infections are IDU related.[2] To help address this continuing public health problem, the White House Office of National AIDS Policy (ONAP) released the *National HIV/AIDS Strategy* (NHAS)[3] in July 2010. An integral step to reaching the NHAS goals to (1) reduce new HIV infections, (2) increase access to care and improve health outcomes for people living with HIV, and (3) reduce HIV-related health disparities is to prevent HIV transmission among substance users through HIV screening programs and other comprehensive HIV prevention services coupled with substance abuse treatment. Similarly, the Department of Health and Human Services (HHS) released *Combatting the Silent Epidemic of Viral Hepatitis: Action Plan for the Prevention, Care & Treatment of Viral Hepatitis* in May 2011. Chapter five of the Action Plan is dedicated to reducing viral hepatitis caused by drug use behavior. Congress passed and President Obama signed the Consolidated Appropriations Act 2010, which included language modifying the ban on the use of federal funds for syringe exchange programs (SEPs), for (HHS) programs. These programs are designed to reduce the likelihood of transmission of blood-borne diseases by providing sterile injection equipment to IDUs and reducing the potential of sharing syringes among this population. HHS released "Implementation Guidance for Syringe Services Programs" (SSP) (July 2010) to set forth guiding principles for using federal funds for SSPs. Fundamental to these principles is that SSPs are part of a comprehensive service program that includes, as appropriate, linkage and referral to substance abuse prevention and treatment services, mental health, HIV prevention, HIV care, HIV treatment and other support services. Concurrently, the Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA) provided interim guidance to grantees for the use of Fiscal Year (FY) 2010 funds for SSPs. Subsequently, the Consolidation Appropriations Act 2012 reinstated the ban on the use of federal funds to syringe exchange programs.

The National Alliance of State and Territorial AIDS Directors (NASTAD) and the Urban Coalition for HIV/AIDS Prevention Services (UCHAPS) have been strong proponents of increased access to sterile syringes for people who use injection drugs as a critical intervention for decreasing HIV transmission among this population. For nearly 20 years many U.S. states and cities have been operating SSPs to prevent disease and protect public safety through increased access to and proper disposal of sterile syringes. They have accomplished this effort through the use of private, local, and state funds and have seen marked reductions in HIV rates among IDUs since the inception of SSPs. In August 2011, NASTAD released a *Statement of Commitment Promoting Injecting Drug User Health* calling for more attention to HIV/AIDS and viral hepatitis health risks and challenges that IDUs continue to face. In May 2012 UCHAPS issued a best practices policy brief "Syringe Access" encouraging the removal of legal and legislative barriers to syringe access. In addition, NASTAD and UCHAPS are strong national advocates for increased and targeted resources and expanded federal investment for disease and overdose prevention, care and treatment programs.

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Drawing from a field of SSP expertise that has existed in the U.S. since the late 1980s, these program implementation guidelines have been developed by NASTAD and UCHAPS to further assist state and local health departments to plan and implement SSPs as a part of their prevention portfolios.

1.1 Purpose and Use of the Guidelines

These guidelines provide assistance to state and local health department jurisdictions that wish to support SSPs for IDUs to prevent transmission of HIV and other blood-borne viruses such as HCV and to link IDUs to vital prevention, medical and social services. For health departments currently implementing SSPs, these program implementation guidelines provide information that can be used to enhance or expand services. For health departments interested in initiating an SSP, these guidelines address key issues to be considered before implementing an SSP.

1.2 Organization of the Guidelines

These guidelines are designed to provide an overview of the core components of, and issues related to, implementing and maintaining SSPs.

Section 2 presents background on SSPs, including the epidemiology of HIV, HCV and overdose among IDUs.

Section 3 describes the structural elements that need to be considered before SSP implementation.

Section 4 explains the philosophical underpinnings and operating principles of SSPs.

Section 5 describes a range of existing SSP delivery models.

Section 6 presents suggestions for monitoring SSPs.

Section 7 outlines how to address capacity building needs for SSP implementation and maintenance.

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Background

This section provides background information on syringe services programs (SSPs) and injection drug users (IDUs), including the definition of SSPs; the demographic characteristics of IDUs; epidemiology of HIV, HCV and overdose among IDUs; a discussion of how SSPs benefit IDUs; and the history and evolution of SSPs in the U.S.

2.1 Definition of SSPs

SSPs are programs that provide syringe access, disposal and/or exchange to IDUs, while also referring and linking IDUs to HIV and viral hepatitis prevention services, substance abuse treatment, and medical and mental health care. Various types of SSPs provide syringe services to IDUs, including syringe exchange programs (SEPs), pharmacies, physician prescription and health care services.

2.2 Demographics of IDUs in the United States

The national data on demographics of IDUs in the U.S. are scarce. SAMHSA conducts the annual National Household Survey on Drug Use and Health. Combined data from 2006 to 2008 indicate that an annual average of 425,000 persons aged 12 or older (0.17%) used a needle to inject non-prescribed drugs during the past year.[4] The prevalence of past-year injection drug use was highest among persons aged 18 to 34 (Table 1). Males were more likely than females to have injected drugs in the past year. The prevalence of past-year injection drug use by race/ethnicity varied widely.

2.3 HIV, HCV and Overdose among IDUs

HIV: As of 2009, 26 percent of HIV infections among females and 13 percent among males were attributable to injection drug use in the U.S.[5] An additional seven percent of cases among males occurred among IDUs who have sex with men (MSM). These figures only partially represent the scope of IDU-associated HIV infections, because injection drug use also contributes to heterosexual HIV transmission, which is responsible for 11 percent of infections among males and 74 percent among females living with HIV.[5] Among females, over half of HIV infections are acquired either by injecting drugs or having sex with an IDU.[6] A recent study found that, among non-IDU heterosexuals in a New York community, those individuals with IDU sex partners had two-fold odds of being HIV infected.[7] Furthermore, data from the CDC-funded National HIV Behavioral Surveillance System (NHBSS) indicate that a third of IDUs shared syringes in the past year.[8] These findings underscore the need for continued and enhanced efforts to address syringe-related risk among IDUs.

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Table 1. Past-Year Injection Drug Use among Persons Aged 12 or Older, by Selected Demographic Characteristics: 2006 to 2008	
Demographic Characteristic	**Percentage**
Age Group	
12 to 17	0.09
18 to 25	0.28
26 to 34	0.26
35 to 49	0.19
50 or older	0.11
Gender	
Male	0.24
Female	0.11
Race/Ethnicity	
Two or more races	0.35
American Indian/Alaska Native	0.24
White	0.18
Hispanic or Latino	0.18
Black or African American	0.14
Native Hawaiian or Other Pacific Islander	0.02
Asian	0.02

Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *The NSDUH Report: Injection Drug Use and Related Risk Behaviors*. Rockville, MD: SAMHSA; October 29, 2009. Available at: http://www.oas.samhsa.gov/2k9/139/139IDU.htm.[4]

HCV: Currently, the majority of the 2.7 to 3.9 million HCV infections among people in the U.S. are attributable to injection drug use.[2] HCV is much more readily transmitted than HIV through multi-person use of injecting equipment, including drug preparation equipment (cottons, cookers, and rinse water).[9, 10] In the U.S., HCV prevalence among IDUs is generally between 60 percent and 90 percent; length of injecting career is the strongest predictor of being HCV seropositive.[11, 12] **Overdose** is the leading cause of death among IDUs[13] and the second leading cause of accidental death in the U.S.[14] Prevalence of nonfatal overdose among opioid users is up to 60 percent among injection heroin users.[15] Other urban heroin users have lifetime overdose prevalence of 29 percent to 68 percent.[16,17,18,19]

2.4 Prevention of Blood Borne Viruses through SSPs

Blood borne viruses are those viruses that are transmitted from the blood of one person to the blood of another person. Of particular concern are HIV and HCV. IDUs are at especially high risk for HIV and HCV through sharing injection equipment, particularly syringes, for one or multiple substances such as heroin, cocaine, amphetamines, hormones, and/or steroids. IDUs are also at high risk for HIV and other sexually transmitted infections through unprotected sex.

Therefore, the HIV- and HCV-specific public health benefits of SSPs arise from (1) removing potentially infectious syringes from the community, (2) providing IDUs with sterile syringes and other clean injection equipment, and (3) distributing condoms. Several studies have found that SSPs

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reduce HIV incidence among IDUs.[20,21,22,23] Most studies of injection-related HIV and HCV risk have found SSPs to be associated with a lower likelihood of syringe sharing or reductions in syringe sharing.[24,25,26,27,28,29,30,31,32,33,34] Ecological studies have found that locales with SSPs tend to have lower HIV seroprevalence among IDUs,[35,36,37,38] and one study reported that closing an SSP resulted in increased prevalence of HIV risk behaviors among IDUs.[39] In addition, the reach of SSPs can extend beyond its primary participants by using social networks of IDUs to deliver and dispose of syringes through secondary or peer exchange models.[40,41,42] Other public health benefits of SSPs include the linkage of IDUs to critical services and programs and promoting integrative care among drug treatment programs, HIV/AIDS prevention and treatment services, HCV prevention and treatment programs, and social and mental health services. The evidence for the public health benefits of SSPs is strong and consistent over time.

2.5 History of SSPs in the United States

The history of SSPs in the U.S. is primarily the history of SEPs. The first SEPs in the U.S. began in the late 1980s in Boston, Massachusetts; Tacoma, Washington; and San Francisco, California. With a few exceptions, these SEPs were primarily activist-initiated programs without support from governmental sources.[43,44,45] The North American Syringe Exchange Network (NASEN) has provided both a national organizational framework for existing SEPs and technical start-up assistance for new programs since the 1980s. Researchers from Beth Israel Medical Center and NASEN have conducted annual surveys of SEPs since the 1990s. Table 2 shows the growth of SEPs in the U.S. from the mid-1990s to 2008.[45] A period of rapid growth among SEPs occurred during the mid-1990s through the early 2000s; however, since then the growth has been incremental. The 123 SEPs participating in the 2008 survey reported operating in 98 cities in 30 states (including the District of Columbia). A total of 120 SEPs reported budget information for 2008. The reported budgets for these 120 SEPs totaled $21.3 million, 79 percent of which came from public (nonfederal) funding.

Table 2. Syringe Exchange Programs Participating in Beth Israel Survey

Numbers of….	1994–95	1996	1997	1998	2000	2002	2004	2005	2006	2007	2008
SEPs known to NASEN	68	101	113	131	154	148	174	166	188	186	184
SEPs participating in survey (%)	60 (88%)	87 (86%)	100 (88%)	110 (84%)	127 (82%)	126 (85%)	109 (63%)	118 (71%)	150 (80%)	131 (70%)	123 (67%)
Cities with SEPs participating	44	69	78	77	98	97	88	90	113	100	98
States with SEPs participating*	21	29	33	33	36	32	32	29	32	31	30
Syringes exchanged (millions)	8.0	13.9	17.5	19.4	22.6	24.9	24.0	22.5	27.6	29.5	29.1
Total of SEP budgets (in millions of dollars)	6.3	7.3	8.4	8.6	12.0	13.0	11.6	14.5	17.4	19.6	21.3
Total of SEP budgets (in millions of dollars, adjusted to 2008 standard)	10.8	11.6	13.0	12.9	16.8	16.6	13.6	16.3	18.8	20.3	21.3
Percentage of total budget from public funding	62	62	67	69	74	67	76	74	79	73	79

Note: NASEN = North American Syringe Exchange Network
*This category includes the District of Columbia and Puerto Rico.
Source: Centers for Disease Control and Prevention. Syringe Exchange Programs—United States, 2008. *MMWR* 2010;59(45):1488-1491. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5945a4.htm.

Four types of SSPs increase syringe access for IDUs in the U.S.: SEPs, pharmacies, physician prescription and health care services. SEPs are community-based programs with a specific mission to increase access to sterile or clean syringes and facilitate disposal of unsterile or used syringes. In many states, pharmacies simply sell needles and syringes without requiring a prescription. Many pharmacies also have some provisions for collecting used syringes, including kiosks and drop boxes.

Participation by pharmacies is voluntary rather than mandatory. Physician prescription of syringes and provision of syringes in health care services are rare.[46,47,47] Yet these models take advantage of instances in which IDUs may be in contact with health care providers and may be very important in creating trusting relationships between IDUs and health care providers.

Laying the Groundwork for Program Implementation

This section discusses the various factors that health departments will need to consider as they plan and implement syringe services programs (SSPs) in their jurisdictions, including the importance and necessity of assessing the community's need and readiness for SSPs, ways of working with law enforcement and strategies for building strong community relationships. General principles of community inclusion and creating programs and policies that are culturally, and linguistically appropriate and reflect the makeup of the community should be incorporated.

All SSP programs should be designed in a manner that enables funded agencies to effectively serve culturally diverse communities. Specifically, all program components, materials and marketing messages should reflect the history and culture of the target population and be linguistically-appropriate. Further, as is standard procedure, all materials should be reviewed and approved by a content review panel prior to use to ensure community support for the appropriateness of the materials. Additionally, funded agencies should employ a culturally competent workforce, including a diverse management team, have organizational policies that support the delivery of culturally competent services and care and a process for establishing if cultural competency goals have been met.

3.1 Assessing the Community's Need for SSPs

The first step in considering whether to implement an SSP is to determine whether the need exists in the health department jurisdiction. Health departments and/or HIV prevention planning groups (HPPGs) may identify IDUs as a target population by using assessments of key epidemiological factors including HIV and/or HCV prevalence and demographics of risk groups, and select SSP as an appropriate intervention.[48]

After the needs assessment is complete, health departments may work with HPPGs and other partners to (1) identify ways to tailor services based on the specific needs of special risk subgroups of IDUs in the community, (2) select the types of syringe distribution and service delivery models most appropriate given resources and context and (3) identify potential locations for SSPs. Health departments may need to educate HPPGs and other partners about IDU-related epidemiological data and the importance of SSPs as an intervention to further address the shared goal of reducing HIV in the community.

3.2 Assessing Community's Readiness for SSPs

This section of the guidelines discusses the importance of assessing the legalities and community support for implementation of SSPs by the state or local health department.

3.2.1 Legalities Surrounding the Operation of SSPs

Once the health department has determined that a SSP is needed to address the HIV prevention needs of IDUs, the next step is to assess whether the community is "ready" or receptive to an SSP. A starting point is to review the laws and ordinances that currently govern SSPs within the health department jurisdiction. Although some states have explicit laws governing SSPs (e.g., New Mexico

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and Hawaii), most do not. States usually have one or more provisions dealing with the delivery and possession of syringes, but these were typically enacted to deal with profit-driven criminal activity. Law enforcement agencies may have their own interpretations of laws governing SSPs, as well as differing priorities. Consequently, laws that appear similar may be enforced differently depending on the locale.

For a health department interested in implementing a new SSP or funding an existing SSP, the challenge is to resolve any confusion about the types of interventions that are legal in a particular community. Resolving this confusion requires a clear vision of the best approach to achieve desired public health outcomes, combined with a willingness to work with health department legal advisors to reconcile any uncertainties. The legal advisors help the health department achieve its goals in a legally responsible manner. For each SSP model (see Section 5), health departments' legal advisors should identify and analyze the laws that govern syringe access.

3.2.2 Building Community Support for SSPs

Providing sterile syringes to IDUs has been shown to reduce sharing of syringes (see Section 2.4). But like other important public health interventions, in order to successfully implement SSPs, there must be an enabling environment consistent of support from key stakeholders such as selected public officials, other government agencies, the general public and consumers. Building community support for SSPs is an integral part of successful SSP implementation. A careful and systematic process can help build community support for SSPs, including assembling the facts and intervention options, assessing stakeholder knowledge and attitudes, and developing an action plan.[49] As described below, several steps can be taken to successfully implement SSPs.

Assemble the Facts and Intervention Options

Start by assessing the characteristics of the local IDU epidemic and identifying current modes of syringe access. SSPs take many forms, and depending on the spatial distribution of IDUs, the accessibility of pharmacies or other health care facilities, and other relevant factors, more than one approach may be worth considering. Having identified potential SSP models (see Section 5), health departments will also need to consult with legal advisors and other stakeholders to discuss the viability of each prospective SSP option for the specific jurisdictions.

Assess Stakeholder Knowledge and Attitudes

Identify key stakeholders and assess their knowledge of and attitudes toward SSPs. Even a legal SSP may fail if elected public officials do not support it, the media frames it negatively, or communities resist it. Police, prosecutors, and public defenders can be engaged to ensure that SSP staff and participants are not mistakenly treated as lawbreakers. Pharmaceutical industry support is crucial to SSPs that work through pharmacies.

3.3 Working with Law Enforcement

This section of the guidelines discusses the public law under which the use of federal funds for SSPs is authorized, certification requirements, and strategies for collaboration between SSPs, health departments and law enforcement.

3.3.1 An Opportunity for Collaboration

Law enforcement is an essential partner for health departments to achieve beneficial public health outcomes. Law enforcement officials, prosecutors, the judiciary, and correctional officials are all

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coping with the societal challenges that can result from public health problems such as HIV, HCV, substance abuse, and mental illness.[50,51] Efforts to develop more effective, coordinated responses include law enforcement crisis intervention teams, courts that address drug and mental health issues, correctional drug abuse treatment programs and transitional services for people leaving jail and prisons. Health departments can work with other social service agencies to improve the overall system response to these common health threats and link individuals to appropriate services.

There may be concern that law enforcement officials who oppose SSPs will object to any proposed location as a way of preventing an SSP from being implemented. However, law enforcement officials may be willing to generally support implementation of an SSP without providing written approval for a specific location. It is important to negotiate with law enforcement officials and receive their approval because of the effect law enforcement can have on injection behavior and SSP utilization. The language in Public Law 111-117 provides an opportunity to further develop more formal partnerships with law enforcement. Research and experience show that law enforcement will understand, accept, and support SSPs.[52,53]

Addressing the occupational risks to law enforcement officers is good public health practice, and it demonstrates the benefits of SSPs. Law enforcement officials and other first responders may need education and services to reduce their own occupational health risks and better understand the public health benefits of SSPs. For example, law enforcement officers may experience and worry about needlestick injuries during encounters with IDUs.[26, 27] SSPs are associated with reduced risk of needlestick injuries to law enforcement officers.[28] Law enforcement may also benefit from, and appreciate, access to protective training and equipment from SSPs, as well as to prophylaxis after an injury.

3.3.2 Taking Action

Like other large organizations, law enforcement organizations can be diverse, decentralized and challenged in the uniform implementation of policies. One metropolitan area may have numerous law enforcement agencies, many district legal attorneys and multiple correctional facilities with varying levels of support for SSPs. Support at the organizational top level does not guarantee the same level of support at the street level, and vice versa. In this section, we describe recommended approaches for working with law enforcement organizations.

Importance of Top-Level Support

Claims that SSPs encourage drug abuse and/or crime have been proven unfounded.[29, 30] Open and unambiguous public support for SSPs among political and social leaders, including the local media, reinforces the need to work with law enforcement officials. Winning support from law enforcement unions and peer organizations such as fire and rescue departments can also help. For example, if the district attorney's office will not prosecute syringe possession or drug residue arrests, law enforcement officials are less likely to make these types of arrests. Addressing related issues, such as access to drug abuse treatment, syringe disposal, and drug overdose, can broaden the base of community support for SSPs. Top-level support within the political and law enforcement leadership may also help ensure that clear messages about the value and legality of SSPs are transmitted to mid-level law enforcement managers and it will provide SSP staff with points of contact regarding issues of law enforcement interference.

Importance of Support from Law Enforcement Officers on the Street
Although street-level law enforcement officers often have considerable experience interacting with and observing IDUs, some law enforcement officers may not be aware of the public health aspects of drug use and infectious diseases, such as HIV. Health departments and SSP staff play a pivotal role in communicating the public health benefits of SSPs, and can provide guidance, as needed, on ways to decrease health risks to law enforcement personnel when interacting with IDUs or handling syringe equipment on the streets. Formal training can be challenging both financially and logistically for SSP operators. Consequently, it is important to build good relationships with police on the street and mid-level commanders, and to consider these activities in SSP budgets.

Open Dialogue between Law Enforcement and SSPs
Building good relationships with law enforcement usually takes time, and the results may vary. Health departments can act as a liaison between SSPs and law enforcement to ensure that communication between these two entities is effective. Most SSPs have a Community Advisory Board or a Board of Trustees. By including law enforcement representatives on these boards, health departments can also help build support and ensure that communication flows both ways.

3.4 Building Community Relationships

SSPs operate best in a supportive community environment. Staff, volunteers, and SSP participants should be involved in community engagement programs. Several strategies have proven effective across a broad range of programs and locations, including: (1) building relationships with community leaders, officials, opinion leaders, law enforcement, public health officials, religious leaders and groups, and businesses most affected by SSP site location; (2) educating the community about drug use, SSPs, and safe syringe disposal; (3) framing messages about SSPs to emphasize the community benefits, including reduced HIV and HCV infection rates, proper syringe disposal and cost-effectiveness; (4) understanding and addressing the concerns of resistant stakeholders in the community; (5) recruiting staff and volunteers who represent the community where the site is located; and (6) involving IDUs in the SSP planning process so their voices and concerns are heard.

This section discusses ways to build relationships with neighborhood groups, potential program participants, pharmacies and pharmacists, and waste management organizations.

3.4.1 Neighborhood Groups

Neighborhood groups can facilitate or impede the location of new SSP sites or maintenance of existing sites. Thus, it is important to partner with the following groups: medical and social service providers, neighborhood and/or homeowners associations, business owners, schools and faith-based groups.

A good way to work with neighborhood groups is to first meet with their boards and ask to participate in or present at larger group meetings. It also can be helpful to become a member of neighborhood groups when possible; however, membership requires that SSP staff members consistently attend and participate in group activities. If appropriate, including both a staff member and an SSP participant in the neighborhood groups may be helpful. IDUs' concerns should be kept in mind when participating in community meetings.

Presentations to community groups ideally convey the community-level benefits of SSPs, such as reduced HIV and HCV infection rates, proper syringe disposal, and cost-effectiveness. Presentations

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are opportunities for education and open dialogue, and it is helpful to anticipate concerns within the community and to come prepared with data and answer difficult questions.

3.4.2 Reaching Potential SSP Participants

To reach potential program participants, outreach workers need to have the IDU community's support and trust. Contacting IDUs initially may require time and patience but will help build a good foundation for the outreach effort. When outreach workers first approach potential SSP participants, they should introduce themselves and indicate the agency in which they work. Initially, outreach workers should be sensitive to any cues the potential participant provides to indicate she/he is not interested in talking at that moment. They can simply let people know what services are provided and when they are offered. It is important for outreach workers to develop a comfortable relationship, while also keeping outreach and service delivery as priorities. Maintaining potential SSP participants' confidentiality is of the utmost importance, especially when program staff are talking with people in groups and people's personal information might be overheard. As they build a relationship with participants, outreach workers can discuss safer injection methods and health matters with them in a way that does not seem threatening. Furthermore, culturally competent outreach practices consider the distinct needs of IDU subpopulations (e.g., MSM, women, youth and transgender persons) and also help build support for the program within the community.

Another good resource for conducting street outreach is peers, because they have access to social networks of IDUs. Since they are a part of the IDU community, they may be able to gain peoples' trust faster than non-peer workers. In addition, peers often know the best locations for outreach efforts, can foresee potential challenges to getting IDUs into the program and can help outreach workers assess situations and offer solutions.

When an agency engages in street outreach, it is important to consider the safety of outreach teams, including secondary exchangers (see Section 5.3); culturally appropriate personnel and attire; culturally relevant educational materials and supplies; training and materials for safe syringe disposal; outreach worker training in overdose prevention, recognition and response; and procedures for documentation of outreach activities, including any adverse incidents.

3.4.3 Emergency Departments

For some IDUs seeking health care services for detoxification, wound infections, abscesses and overdose, emergency departments may serve as access points to locate and recruit IDUs for SSPs. Emergency departments can refer IDUs to SSPs for not only sterile syringes, but also for wound care and overdose prevention education, HIV and STD screening, and substance abuse treatment services. SSPs can provide information about the partnering medical facility and refer IDUs for medical care. Other potential partnership strategies may include having a medical practitioner imbedded within a fixed site or mobile-based SSP, and SSP staff accompanying IDUs to emergency departments to better facilitate access to medical care.

3.4.4 Pharmacies and Pharmacy Organizations

Pharmacies and pharmacists can not only provide sterile syringes to IDUs, they can also be a good resource and a strong ally for other SSP modalities. As health care providers who generally work with large and highly diverse populations, pharmacists may be willing to speak directly with their colleagues about SSPs. Professional pharmacy organizations, most of which are registered with their state pharmacy governing body, and pharmacy schools have regular meetings and conferences that can be important venues for presentations on issues related to community health. To reach

pharmacists working at large chains, contacting the pharmacist supervisor at the parent company and offering to work with them on strategies to get information to other pharmacists within the company are often good strategies.[54,55]

After determining the geographical reach of the SSP, the SSP can easily locate all of the pharmacies through the telephone book or the internet. It is recommended to telephone or approach pharmacists in person and schedule times to come in and talk to them about the SSP.[56] Successful SSP outreach to pharmacists should include information and handouts about: (1) the local program(s), including the available services, target population demographics, and the location and hours of sites; (2) local laws that might allow them to enhance syringe access independently of the SSP; and (3) general education about common concerns (e.g., "Will SSPs increase discarded syringes?","Increase crime?","Increase drug use?," etc.); and (4) the epidemiological evidence for SSP efficacy.[56,57] It also may be useful to maintain a list of supportive pharmacies and the services they are willing to provide to IDUs, their hours and locations, and all of the necessary information for IDUs to use the services.

3.4.5 Waste Management for Syringe Disposal

As part of building community partnerships, it is useful to engage city, county or state waste management boards and their leadership, meet with them to introduce the program, and outline waste management plans. Working with waste management staff is a good way to discuss how to expand syringe disposal through hazardous waste disposal programs already in place or stand-alone syringe disposal kiosks.

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Operating Principles of SSPs

Several elements should be considered in developing local operating principles for syringe services programs (SSPs). This section first describes strategies to reduce the consequences of drug use, the philosophy underpinning SSP operating principles. Also provided in the section is a detailed description of program implementation, registration procedures, three types of syringe transaction models, safe syringe disposal practices, and the types of health and social services that can be offered on-site or through linkages with outside agencies.

4.1 Reducing Drug Use Consequences

Over time, strategies like SSPs reduce the risks and negative effects associated with substance use and addictive behaviors for the individual, the community and society as a whole. While one must take care not to promote drug use, these strategies consider the situations drug users are in by addressing the conditions of drug use. The following principles represent a general understanding of the underpinnings of such interventions:

- Drug use is complex, encompassing a spectrum of behaviors from occasional use to extreme abuse.
- All illegal drug use is harmful. Some forms of drug use are manifested differently than others in terms of the mental and physical health consequences (e.g., overdose, HIV and HCV transmission risks).
- Social inequalities, such as poverty, racism, classism, past trauma, social isolation and sex-based discrimination, influence people's ability to deal with drug use and its consequences effectively. Additionally, environmental factors, like drug availability and non-enforcement, can lead to different outcomes of drug use.
- People in recovery from drug addiction should be involved in the creation and implementation of SSP programs and policies. Services need to be provided in a manner that will help to guide people into services rather than keep them from accessing needed services. Services need to be available to everyone, regardless of gender, race/ethnicity, age, socioeconomic status or sexual orientation.
- Drug users are primarily responsible for reducing the negative outcomes of their drug use. Thus, SSPs strive to get drug users to share information about strategies that might work in their situations and support each other in using those strategies.

4.2 Program Registration

In many SSPs, the formal establishment of a relationship between IDUs and the SSP begins with intake or enrollment. It should be noted that SSPs often do not have established enrollment or program registration procedures. However, the enrollment experience can be important in gaining the participant's trust and setting the tone for future interactions. To accommodate participant needs and encourage enrollment, initial intake procedures should be kept to a minimum. However, SSP staff may need to use a longer intake process for referral to additional services, such as medical care or social services.

Collecting information may decrease participants' anonymity, which may reduce the likelihood that participants will access services. Asking participants to provide government-issued identification

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(ID) at enrollment may also deter people from using the SSP, and not everyone has a government-issued identification (ID) cards.

SSP REGISTRATION CAN SERVE THREE POTENTIAL PURPOSES:

1. The registration process can serve as a formal welcome to the SSP and provide an opportunity for educating participants in the range of services offered and assessing participants' needs. However, it is important for the program to take cues from participants in terms of how much to engage them at first, because some people may initially be reluctant to disclose information or stay at the site for any length of time.
2. In some jurisdictions, SSP participants may receive legal protection for possessing needles if they are registered in the SSP. However, SSPs without formal enrollment procedures also can provide legal protection to their participants.
3. By registering participants, the SSP can collect statistical data that staff can use to monitor the program. The purpose of monitoring is to ensure that the program is operating in conformity to its design, reaching its specific target population, and achieving anticipated implementation goals (see Section 6). Future monitoring activities can then be linked to the same participant through a unique participant code.

Table 3 presents the types of information that might be collected at intake/enrollment. This list offers a range of ideas and is not an intake template.

4.2.1 SSP Identification (ID) Cards

In areas where SSP participants receive legal protection for needle possession as a result of being formally enrolled in the SSP, ID cards can be a useful tool. Using ID cards can also facilitate transactions once participants have been enrolled in the program. Similar to other enrollment procedures, the use of ID cards should be instituted only if there is a clear benefit to the participant, such as legal protection. Using ID cards may cause concerns about the lack of anonymity for program participants. If ID cards are used, it is recommended that the program construct unique codes using non-identifiable information the participant can easily recall, such as a combination of mother's maiden name initials and their month and year of birth.

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Table 3. Types of Information Potentially Collected at Syringe Services Program Intake	
Information	**Purpose**
First name *only*	Identifies the individual as a participant, which may protect him/her from law enforcement
Initials	As an alternative to participants' names
Birth year	To describe the service population
ZIP code or area of current residence	To describe the program's reach and identify geographic areas where there are gaps
Sex or gender	To describe the service population
Sexual Orientation	To describe the service population
Race/ethnicity	To describe the service population
Preferred Language	To tailor program services to participants' needs
Injection frequency	To estimate syringe needs for needs-based distribution models (see Section 4.3.1)
Drug preferences	To evaluate program services and tailor them to participants' needs.
Medical Home	To identify access point for medical care for program planning and referrals
Access to Other Services	To identify needed medical, substance abuse, and mental health services for program planning, referrals, and quality improvement
Social Determinants of Health	To identify homelessness, unemployment, and other social factors for program planning and referrals

4.3 Syringe Transaction Models

The goal of SSPs is to provide as close to 100 percent syringe coverage as possible, which means a sterile syringe for every injection of every IDU in a jurisdiction. SSPs typically use one of three types of syringe transaction models: needs-based/negotiated distribution, strict one-for-one exchange and one-for-one plus exchange. Although there is little published research on the comparative efficacy of the three model types, subject matter experts agreed that all three types are in common usage and that each has a set of strengths and limitations. Programs will need to consider available resources and requirements of funders when selecting the type of syringe transaction model to implement. The sections below describe the different types of syringe transaction models followed by a discussion of the strengths and limitations of each.

4.3.1 Needs-Based/Negotiated Distribution

In the needs-based/negotiated syringe distribution model, the program does not set a limit on the syringes a participant can receive regardless of the number of returned syringes. Although SSPs using this model generally encourage participants to return used syringes, participants can still receive sterile syringes even if they do not. The number of syringes distributed is negotiated based on the participant's need, taking into account the number of people the participant is serving, the frequency of injection and the length of time until she/he can next access the SSP. Some SSPs place an upper limit on the number of syringes distributed under this model (e.g., 100 or 500-syringe limit), but they do not place a limit on how often a participant can access services.

4.3.2 Strict One-for-One Exchange

Strict one-for-one exchange programs provide SSP participants with the exact same number of sterile syringes that the participant brings in for disposal. For example, if the participant disposes of 14 used syringes at the SSP, then she/he receives 14 new, sterile syringes in return. With this model, participants cannot get sterile syringes if they do not bring in any used syringes for disposal.

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However, some SSPs that employ strict one-for-one exchange models issue one or more "starter kits" when participants enroll in the program to lessen the risk of syringe sharing. They might provide 10 sterile syringes the first time someone comes to the SSP even if the participant has no used syringes for disposal.

In cases where participants do not want to receive as many syringes as they returned during a single transaction, the SSP using one-for-one exchange can issue a voucher (similar to an "IOU"). For example, someone may return 300 syringes but only wants 10 syringes at that time. The SSP can give the participant a voucher for the other 290 syringes that she/he can redeem at another time. Vouchers are also useful when SSPs do not have enough supplies to complete the exchange or when there are limits on the number of syringes a participant can get during a single transaction. SSPs should consider recording the voucher on-site in case participants lose their vouchers, but recording this information would affect anonymity unless SSPs use a unique participant code.

4.3.3 One-for-One Plus Exchange

One-for-one plus exchange programs modify the basic concept of the strict one-for-one exchange programs by providing some predetermined number of extra syringes beyond one for one. For example, these programs often provide 10 extra syringes regardless of the number of disposed syringes brought in, and even if no syringes were returned for disposal they could receive 10 new syringes. Other such programs allow two-for-one exchange schemes up to a certain limit. For example, if a participant disposes of eight syringes, she/he receives 16 sterile syringes. A voucher system, described in Section 4.3.2, can also be used with one-for-one plus exchange models.

4.3.4 Strengths and Limitations of Each Syringe Transaction Model

Prior research has shown that the needs-based/negotiated distribution model is best at achieving the goal of reaching as close to 100 percent coverage as possible, followed by the one-for-one plus exchange model and then the strict one-for-one exchange model.[44] The main drawback of the strict one-for-one exchange model is that people who have no used syringes to dispose of are unable to receive any sterile syringes. People could have many legitimate reasons for not returning their used syringes. For example, their syringes may have been confiscated by law enforcement, stolen by peers or taken by family members. For reasons of public safety or fear of law enforcement action, IDUs may choose to safely dispose of syringes at the time of injection as opposed to carrying them around until the next time they access an SSP. If IDUs are not provided sterile syringes at an SSP because they did not have any used syringes to dispose of, they may use unsterile syringes from their associates, which defeat the purpose of SSPs.

Another potential drawback of a strict one-for-one exchange model may be a lack of uniformity in its implementation by staff. Staff members may relax the strict one-for-one exchange rule to further encourage safer injection, which can create a scenario in which participants favor certain staff members who appear to be willing to bend the rules. The legitimacy of the program can be called into question by participants and/or the community if there are inconsistencies in applying the rules. Thus, the one-for-one plus exchange model provides staff a built-in alternative to denying syringes without returns.

Although the needs-based/negotiated distribution model is better at increasing syringe coverage to both primary and secondary exchangers, programs may have other reasons for using a one-for-one plus exchange model. In some communities, it is more politically palatable to assure everyone that

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the program is exchanging needles as opposed to distributing them. The one-for-one plus exchange model may also be better than the needs-based/negotiated model at encouraging IDUs to access the SSP more often, which may increase opportunities for them to dispose of used syringes and the chances they will use other services, including HIV testing and drug treatment. Lastly, the needs-based/negotiated model may require spending more money on syringes, which depends on budgets and funding agencies.

4.4 Safe Syringe Disposal

All disposal venues, including SSPs, must comply with federal, state and local regulations for disposing of used syringes, which qualify as regulated medical waste (RMW). According to these regulations, health departments must work with SSPs to ensure proper disposal of used syringes. Proper disposal of used syringes is critical to protecting individual health and public safety. Safe disposal procedures help prevent accidental needlestick injuries among staff, volunteers, participants and the public. Infectious diseases can be transmitted during an accidental needlestick; therefore, the experience can be very stressful for the people involved. Furthermore, making disposal resources available to IDUs helps reduce the amount of syringes and other injection equipment found "on the street," helping to protect the SSP from public scrutiny.

SSPs must document policies and procedures governing disposal of RMW and supervise disposal to ensure that staff and volunteers are adhering to the rules. It is also important to examine statewide regulations for the proper handling and disposal of RMW. A state-by-state RMW resource locator can be found at http://www.envcap.org/statetools/rmw/rmwlocator.html

The following suggestions may help guide safe disposal procedures:

- Examine potential partnerships with waste management companies to obtain and dispose of RMW.
- Reserve funds to hire a private waste management service to collect and dispose of RMW. In many cases, these services include any necessary supplies to properly package RMW for disposal. Hiring a service also helps document proper disposal of used injection supplies.
- Do not require that returned syringes be counted by hand. Estimates can be made by observation or by weighing the returned syringes to determine the number of syringes disposed of for monitoring purposes.
- If the SPP uses a mobile unit, close sharps containers when the vehicle is moving in case the vehicle stops short or there is an accident. Similar strategies should be used when conducting street outreach.

4.4.1 Prevention of Occupational HIV Transmission among SSP Staff

As is the case for other health care workers, SSP staff can be at risk for acquiring HIV from needlestick injuries and cuts during syringe exchange and disposal. To prevent the occupational transmission of HIV, CDC offers these recommendations:[57]

SSP staff should assume that blood and other bodily fluids from SSP participants are potentially infectious, therefore requiring infection control precautions at all times including:

- routine use of barriers (e.g., gloves, goggles, closed-toe and closed-heel shoes) when anticipating contact with blood;

- immediate washing of hands and other skin surfaces after contact with blood or body fluids; and
- careful handling and disposing of sharp instruments during and after use.

Although prevention of occupational HIV transmission is the most important strategy, SSPs should have plans in place for post-exposure management of staff. CDC has issued guidelines for management of health care worker exposure to HIV and recommendations for post-exposure prophylaxis (PEP).[58] These guidelines provide considerations in determining whether health care workers should receive PEP and in choosing the type of PEP regimen. For most HIV exposures that warrant PEP, a basic four week, two-drug (multiple options) regimen is recommended. For HIV exposures that pose an increased risk of transmission (due to infection status of the source and type of exposure), a three-drug regimen may be recommended. Issues such as delayed exposure reporting, unknown source person, pregnancy in the exposed person, resistance of the source virus to antiviral agents and toxicity of PEP regimens are also discussed in the guidance. Occupational exposures should be considered urgent medical concerns.

SSPs should demonstrate continued due diligence to reduce the risk of occupational HIV transmission by:

- training all staff in infection control procedures and the importance of reporting occupational exposure; and
- promoting and monitoring the availability and use of safety devices to prevent sharps injuries, and developing a post-exposure management plan.

4.5 Health and Social Services: Provision and Linkage

IDUs participating in SSPs may need services to prevent HIV and HCV infection and to address other health and basic human needs. CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) has developed a strategy called Program Collaboration and Service Integration (PCSI) to help health departments, CBOs and other NCHHSTP-funded entities improve health outcomes, efficiency and cost-effectiveness. PCSI is a mechanism for organizing and blending interrelated health issues, activities, and prevention strategies to facilitate a comprehensive delivery of services.[58] SSPs and state and local health departments can use PCSI to structure health delivery to populations of IDUs and specifically to address the challenges associated with integrating services at an SSP location or through linkage to community service providers.

The key principles of effective PCSI include the following:[59]

Appropriateness: Integration of services must make epidemiologic and programmatic sense and should be contextually appropriate.

Effectiveness: Prevention resources cannot be wasted on ineffective or unproven interventions.

Flexibility: Organizations need the ability to rapidly change and assemble new prevention services to meet changing epidemiology, population demographics, advances in technology, or policy/political imperatives.

Accountability: Prevention partners need the ability to monitor key aspects of their prevention services and gain insight on optimizing operations.

Acceptability: PCSI must lead to improved acceptability to clients, programs, and providers through improved quantity and quality of the integrated services.

With PCSI principles as the foundation, the next sections outline strategies SSPs can undertake to increase access to services, describe the array of services that SSPs can offer and discuss how to decide whether to provide services on-site or through referral agencies.

4.5.1 Strategies to Increase Access to Services

SSPs can enhance their success by employing the following strategies:

- Establish collaborative relationships with referral agencies.
- Make referrals, when possible, to social service agencies that aim to reduce drug use and its consequences.
- Address barriers to accessing services (e.g., financial, transportation, child care, bench warrants).
- Have designated staff call ahead and escort participants to referral sites and advocate for their care.

Health departments can work with community agencies to ensure that SSP participants are able to access services. Specific strategies include the following:

- Develop protocols for referrals to relevant medical, mental health, substance abuse treatment, and social services.
- Identify points of contact within each referral agency that can facilitate SSP participant access to needed services.
- Work with SSPs to train other agencies about SSPs.
- Provide incentives or mandates for collaboration with SSPs, including referrals to SSPs by community agencies.
- Address barriers to care at community programs, including stigmatization of drug users and abstinence as a requirement for receiving services.
- Support flexible community programs that are inclusive of drug users.
- Involve state hepatitis/HIV/sexually transmitted disease (STD) coordinators.

Using a combination of motivational interviewing and financial incentives has shown promise in increasing enrollment of referred participants in drug abuse treatment.[59]

4.5.2 Specific Health and Social Services

Education and Counseling

SSPs play an important role in providing information and counseling to IDUs that allow them to reduce the consequences associated with drug use and to increase their general well-being. SSP staff can benefit from training on providing accurate information and using evidence-based approaches to counseling. Educational materials need to be accurate, up to date and matched to the population served in terms of cultural relevance, language and reading level. Specific areas to be covered can include:

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- SSP services, location and hours;
- local health centers and clinics locations and hours;
- safer injection practices and vein care;
- safer sex practices;
- identification and treatment of soft-tissue infections;
- HIV, HCV, HBV, and STD prevention and treatment associated with unsafe drug injection and sexual practices;
- drug abuse treatment options;
- overdose prevention and response; and
- accidental needlestick response.

Social Services

SSPs can help participants meet basic needs and increase engagement by providing an array of services that are appropriate for the population served and by providing appropriate referrals for services not offered on-site. Potential services can include:

- food and clothing distribution;
- hygiene supplies (e.g., feminine products, soap);
- child care;
- telephone, mail, and computer access;
- vocational assistance;
- legal aid; and
- housing.

Medical Care

IDUs have the same preventive and general medical care needs as the general population. However, they also are at higher risk for specific health problems, such as blood-borne infections and wounds. Medical services can range from screening to comprehensive care, including:

- HIV, HBV, HCV, tuberculosis (TB) and STD screening;
- linkage to and retention in care for IDUs living with HIV and/or HCV;
- primary medical care;
- pregnancy testing and prenatal care;
- vaccinations (hepatitis A/B, influenza, pneumonia);
- TB prophylaxis;
- wound care; and
- evidence-based complementary and alternative medicine (e.g., to reduce drug dependency, massage, acupuncture).

Mental Health Services

IDUs using SSP services have a high prevalence of psychiatric disorders, such as major depression and antisocial personality disorder.[60] SSP staff may benefit from training on recognizing the signs and symptoms of common psychiatric disorders so that appropriate services can be provided on-site or through a referral agency. SSP mental health services can include:

- screening and referral;
- individual and group therapy;
- psychiatric evaluation and treatment; and
- suicide prevention.

Drug Abuse Treatment
IDUs using SSP services are often characterized by a high severity of drug dependence and the abuse of multiple substances.[61] Although they report high levels of interest in drug abuse treatment, IDUs have relatively low levels of enrollment.[62, 62] Barriers to accessing drug abuse treatment may be related to lack of finances or transportation, an inadequate number of treatment slots and a lack of dual-diagnosis services.

Locating drug abuse treatment services on-site at SSPs can be an effective solution. Community drug abuse treatment programs that do not have restrictive eligibility criteria enable more SSP participants to use the services. Services available on-site or by referral can include:

- assessment, counseling and referral;
- drug counseling and support groups;
- buprenorphine treatment for opioid dependence (on-site or by referral);
- methadone treatment (payment vouchers and dedicated SSP treatment slots facilitate entry);
- medically assisted detoxification; and
- residential treatment.

Overdose Prevention
Overdose is a major cause of mortality among drug users,[63] and SSPs can address overdose prevention and response with both staff and participants. Naloxone is a drug used to counter the effects of opiate overdose. Making naloxone available to trained staff, volunteers, and participants is a recommended evidence-based strategy that reduces opioid overdose fatalities.[63] Key overdose prevention strategies include:[64]

- providing comprehensive training on overdose prevention, recognition and response for all SSP staff and volunteers, including rescue breathing and the use of naloxone;
- developing protocols for responding to overdoses on-site;
- educating program participants about overdose prevention and response; and
- making naloxone available to program participants, if resources permit.

4.5.3 Provision or Linkage

Based on multiple factors, including location, financial constraints, availability of community resources and participant preference, SSPs will need to decide to either co-locate services or provide linkages to community resources. Research and SSP experience suggest that co-location of services has advantages in both acceptability and effectiveness for SSP participants[64] because IDUs have relatively low rates of utilization of community services. Consequently, the SSP may be the participant's only or most trusted point of contact with service agencies. Moreover, providing services on-site increases utilization rates. For SSPs operating in areas with limited community resources, on-site services may be the only option.

Using community linkages to provide services also has advantages, because these collaborations can help organizations broaden their mission, develop more comprehensive strategies, ensure that participants receive high-quality services, minimize duplication of services and make the most of available resources.

Service Delivery Models

Various service delivery models can be used to make syringes available. SSPs may find that the best approach is to use a single model exclusively or to combine models to expand the program's reach. When choosing a service delivery model, SSPs will find the results from the needs assessment process helpful. Model selection should be driven by numerous factors such as available resources and budget, the organizational infrastructure, local political concerns, availability of staff and volunteers, and the local drug subculture and geographic context. Staffing needs may vary depending on service modality as well as participant volume. For solely distributing and disposing of syringes in low volume programs, adequate coverage can be achieved with as few as two people. However, a minimum of four workers would be preferable for high volume programs. Job tasks break down as:

- syringe distribution;
- syringe collection;
- tracking of basic demographics; and
- referral to services.

Staffing needs increase as more services are added to accompany syringe distribution and collection. The following sections briefly outline the inherent strengths and potential limitations of different SSP models, including fixed site, mobile/street based, secondary/peer delivery, delivery and pharmacy provision. Next, we present factors that affect the choice of syringe service modalities in rural settings. The section closes with a discussion of the benefits of blending program models to achieve the highest possible coverage.

5.1 Fixed Site

Fixed-site models include hospital/clinic-based settings, integrated syringe access services, and collaboration or satellite structures. Typically in fixed-site models, the SSP is located in a building or specific location, such as a storefront, office, or other space with street-level access. Fixed sites work best in health jurisdictions where IDUs are clustered in a somewhat centrally located area.

The strengths of fixed-site models include the following:

- It is easier for other social service agencies to refer their clients to the SSP because there is a set location with predictable hours.
- Other services can be integrated with SSP activities, including HIV, HBV, and HCV testing; STD testing; TB screening and prophylaxis; food provision; buprenorphine treatment; abscess and wound care; and overdose prevention.
- Having a permanent site makes it easier to tailor the space to the needs and preferences of the participants.
- Computer-based systems (e.g. electronically tracking inventory of syringes) can more easily be supported in a set indoor location.
- SSP services can be provided in private.
- The location provides shelter from weather and street-based activities.
- On-site storage space may be available to house materials.

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The potential limitations of fixed-site models include the following:

- A fixed-site is more costly to maintain because of higher overhead and upkeep.
- Drug users may be reluctant to go to the site because of concerns about stigma.
- It can be challenging to stay abreast of and adapt to changes in the drug scene (e.g., if the SSP's location is no longer close to where IDUs congregate).
- The community may not support the site's location.
- Participants must come to the site, which can be a barrier if IDUs are spread apart geographically and do not have transportation.

5.1.1 Hospital/Clinic-Based Settings

One fixed-site model of syringe access is locating services at a hospital or clinic-based setting. In this model, IDUs who come to hospitals or clinics can obtain syringes from health care providers and dispose of them there.[65] Distributing syringes from hospitals may be appropriate in health jurisdictions with greater restrictions on other SSP models and is often used in conjunction with other types of models.

The strengths of hospital/clinic-based settings include the following:

- Access to syringes may be greater with this type of model because doctors in hospitals can more easily write prescriptions for syringes.
- On-site procedures exist for disposing of RMW.
- It is easier to conduct overdose prevention, including providing a prescription for naloxone.
- Exchanges can take place more privately.
- It is possible to provide clients with immediate medical care for abscesses and other wounds or health issues.
- HIV and/or HBV and HCV testing exists on-site.
- Concerns about stigma are lessened because visiting hospitals and clinics is not associated specifically with drug users.

The potential limitations of hospital/clinic-based settings include the following:

- It requires IDUs to identify themselves as IDUs to their health care providers, which means they lose anonymity.
- Staff and clinicians in particular, may have to overcome preconceived notions about drug use and drug users.
- Many IDUs have had negative experiences in hospitals and clinics (i.e., poor medical treatment, stigmatization), which may lessen their interest in going there.
- Securing resources may be difficult.
- The environment may be too "clinical" and uninviting.
- Staff will likely need regular cultural sensitivity trainings.
- Pre-existing rules and regulations may make it challenging to implement certain services (e.g., Hospitals and clinics may require the confidential collection of identifying information from SSP participants. This expectation would conflict with a SSP that permits anonymous access to services by participants.)

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5.1.2 Integrated Syringe Access Services

In the integrated syringe access services model, an organization that is already serving IDUs in a fixed site adds syringe services to its existing set of services, rather than creating a separate SSP. In some cases, syringe services in these settings may be restricted to participants who are enrolled in the parent program, rather than being advertised and made available to all IDUs. Methadone maintenance treatment programs, homeless shelters, case management programs, research or clinical studies, and housing providers are all suitable settings for integrated services.

The strengths of integrated syringe access services include the following:

- This model may be easier to implement from a public relations standpoint because the community will already be accustomed to the organization and its participant base.
- Co-location of services increases IDUs' access to other services.
- The cost of this model can be relatively low if integration of syringe provision occurs within the current organizational framework.
- It easier to spread the word about services because there is an established participant base.

The potential limitations of integrated syringe access services include the following:

- Program success may be hampered if SSP services are not prioritized by the agency.
- There may be a lack of culturally appropriate materials.
- Program autonomy may be limited because of multiple funding streams.
- Staff will need cross-training.
- If the agency also serves non-IDUs, interactions between IDUs and non-IDUs may pose problems.
- The addition of syringe services may require additional engagement with relevant stakeholders (e.g., waste management for syringe disposal).

5.1.3 Collaboration or Satellite Structure

In the collaboration or satellite structure model, existing SSPs provide syringe services at partner social service agencies in fixed sites in the community (e.g., social services, shelters). It requires that the SSP provide capacity-building training for the partner agency. This approach works best in health jurisdictions where SSPs are supported and there is a need to increase access through multiple modalities. The strengths of collaboration or satellite structures include the following:

- Access to services may be enhanced through additional locations and expanded operating hours.
- The existing participant base of IDUs can help advertise the availability of syringe services with their peers.
- The parent program has experience managing public relations, which may help increase community support for syringe services.

Additional operational and human resource costs may be offset because the parent organization already has the requisite systems and expertise, an established training program and sufficient staff to implement the additional services. It may expand the program's reach by attracting new groups of IDUs.

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The potential limitations of collaboration or satellite structures include the following:

- It may be challenging to keep track of inventory if specific systems for doing so are not in place.
- The parent organization and satellite site may have different policies or procedures, which can lead to inconsistencies or discord.

5.2 Mobile/Street Based Programs

Mobile/street-based programs are conducted on foot, by bicycle or by vehicle (e.g., van, bus or recreational vehicle). This method is also referred to as outreach. Many mobile SSPs stop at specified locations and times, whereas others may simply roam unplanned. Although this model is often combined with a fixed-site program, it may also operate independently. This model is well suited to health jurisdictions where IDUs do not congregate in centralized locations or where participants have limited transportation options.

The cost for mobile sites can vary based on the style of outreach implemented and the transportation needs. For example, some mobile sites involve setting up a cart with supplies on a street corner, whereas others use recreational vehicles. Aside from the cost of a vehicle, other costs must be considered, including automobile insurance, parking, maintenance and gasoline. Training should emphasize security and safety. To ensure staff safety, it is also important to collaborate with law enforcement and other community stakeholders about the program.

The strengths of mobile/street-based sites include the following:

- The program may encounter less resistance from the local community because it will not attract congregations of IDUs.
- Mobile sites offer heightened flexibility and the advantage of being closer to a street drug market, increasing accessibility for IDUs who are unable to come to a fixed site.
- The program can adapt to changes in the drug scene or neighborhood and can relocate to places where IDUs congregate.
- The existing participant base of IDUs can help promote the time and place of services to their peers.
- The informal and easily accessible location may help put participants at ease.

The potential limitations of mobile/street-based sites include the following:

- It is less anonymous, because people can see who is using the services in the community.
- Staff need to have a valid driver's license if a motor vehicle is involved.
- Services can be interrupted if the vehicle needs to be repaired.
- It can be harder to provide additional services that require a physical location.
- The work conditions can be stressful for staff because of inclement weather or concerns about safety.
- Supplies need to be stored elsewhere and transported to the sites.
- Participants may be reluctant to come to the SSP in inclement weather.
- It can be costly to maintain because of expenses related to vehicle maintenance and insurance.
- It may be more challenging to obtain law enforcement support (thus, SSP certification) for mobile routes comprised of multiple locations.

5.3 Secondary or Peer-Delivery Models

Secondary or peer-delivery models involve SSPs providing IDUs with syringes to distribute and disposal options to their drug-using networks. Peers often get compensated for providing syringe services in a variety of ways. Often, they are paid a stipend. In other cases, they voluntarily provide the services. Ongoing capacity building is both a necessity and a perk for peers. Secondary access is typically combined with a fixed site, such that peers can come to a fixed site and obtain and dispose of syringe equipment that they then provide to other IDUs in their social networks. However, it is also possible to arrange transfer of equipment through pick-up or delivery. Secondary models require a training program that builds the capacity of IDUs to deliver syringe services to their peers. Secondary and peer-based models need to have established policies, procedures and legal protections for peers. Legal restrictions regarding the distribution of paraphernalia may limit peer-delivery options. Secondary models are best suited for health jurisdictions that are very large geographically and where IDUs tend not to be congregated in dense areas.

The strengths of secondary or peer-delivery models include the following:

- For a low cost, the program can reach many IDUs in geographically distant locations.
- Peers' knowledge of the drug market and local drug scene can extend the program's geographical reach.
- Groups of IDUs who may be less likely to visit an SSP can still get sterile syringes and dispose of used ones safely.
- Peers may feel empowered by conducting a public health service in their community.

The potential limitations of secondary or peer-delivery models include the following:

- When peers collect and transport other participants' used injection equipment, they face safety issues.
- It can be difficult for peer workers to separate out their roles as SSP providers and IDUs in the community.
- If peers are unavailable (e.g., quit using, get arrested, move away), IDUs lose their access to supplies.
- Significant costs are associated with training and supervising secondary exchangers.
- Lack of appropriate oversight could result in misinformation disseminated to IDUs.

5.4 Delivery Model

The delivery model involves the delivery of injection supplies to a prearranged site, such as a house, apartment, hotel, shooting gallery or other prearranged location. Service delivery can take place on a regular schedule or by appointment. It is a direct means of observing the more private aspects of participants' living situations, and services can be developed and tailored to meet those needs. Medical and nutritional services, overdose prevention, directly observed therapy and safer injection education, for example, can all occur in the privacy of a person's home. When syringe delivery staff members are in participants' homes, consideration needs to be given to legal concerns about reportable conditions, such as suspected child abuse. On the one hand, parenting skills can be an educational component of delivery; on the other hand, delicate and fragile relationships can be affected by legal requirements.

It may be best if site managers and landlords of the facilities are informed that unspecified social services are coming to the location. Promotion can occur by outreach workers and through the facility's management, as well as through IDU networks. Delivery is an excellent option in rural jurisdictions, where there are often large geographical areas to cover and privacy is of utmost importance. Delivery may be combined with mobile or fixed sites. Enhanced training for staff and volunteers on safety and confidentiality of participants' needs is necessary.

The strengths of delivery models include the following:

- This form of syringe access is more discreet and consequently reduces negative reactions from the neighboring community, which is rarely aware of the program activity.
- Since participants do not have to transport used injection equipment, it reduces needlestick risk and potential involvement with law enforcement.
- It can be easier to begin a delivery program than other program models due to the reduced need for a physical space.
- Information sharing about injection practices, health, and other issues can occur more privately.
- Participants' safety is enhanced if they do not need to leave their home.
- It increases access to IDUs who may be less likely or unable to attend a fixed site.
- SSP staff have more opportunities to interact with family and peer networks.

The limitations of delivery models include the following:

- It requires the SSP to have and use transportation to provide services.
- It can be challenging to sustain because of staff burnout.
- It can be potentially time consuming, depending on the geographic dispersion of participants.
- It may take time to overcome potential privacy concerns and build a foundation of trust.
- Worker and volunteer safety is a concern.
- It can be expensive to maintain and insure vehicles.

5.5 Pharmacy Distribution Model

Over-the-counter sale of syringes through pharmacies is an important model of syringe access and disposal for IDUs. Pharmacists are knowledgeable and often support community providers. However, they seldom have the time and/or experience to make essential referrals for drug-using SSP participants. Educating pharmacy staff about drug use, SSPs, and the public health benefits of providing syringes, and other related social and medical services is critical. It is also important for pharmacies to consider best disposal practices, including providing sharps containers to drug users just as they do for people with diabetes.

The strengths of pharmacy distribution models include the following:

- Pharmacies often stay open more and later hours than other models.
- Pharmacies often have more locations for IDUs to access than other SSPs.
- Services can be provided in mainstream locations, reducing concerns about stigma and privacy.
- Pharmacies would incur no additional financial cost to add syringe access, particularly if they sell syringes already.
- Participants can take advantage of other services that the pharmacy may offer, such as flu shots.

The potential limitations of pharmacy distribution models include the following:

- Pharmacists and pharmacy staff may not be culturally sensitive to the populations.
- Pharmacies may set a minimum (e.g., 10) or maximum (e.g., 100) number of syringes to distribute per transaction.
- Pharmacies may not want to provide other injection equipment, education, and social and medical service referrals.
- Pharmacies may be unable or unwilling to include syringe disposal services.
- Syringes cost money at pharmacies, which may be a hardship for impoverished IDUs.

5.5.1 Pharmacy Voucher Program

In a pharmacy voucher program, social service agencies work with pharmacies to create a voucher that IDUs can redeem for free syringes at participating pharmacies. This type of program eliminates barriers related to the cost of purchasing syringes at pharmacies. Pharmacy voucher programs are particularly helpful in jurisdictions where other SSPs have not been established and where the law permits the over-the-counter sale of syringes without a prescription. Voucher programs are also beneficial in jurisdictions where drug use occurs in remote locations and IDUs cannot travel to an SSP. SSPs may provide pharmacies with equipment and disposal services in areas where pharmacy vouchers are used. One drawback is that this model involves two steps in providing syringes to IDUs. First, SSPs must find IDUs and provide them with vouchers. Second, IDUs must go to a pharmacy to receive the syringes.

5.6 Rural Settings

Certain service delivery models are more amenable to rural settings, whereas all models are appropriate for most urban settings. As privacy can be a greater concern in rural settings, having fixed sites outside of hospital settings or a pharmacy distribution model may not be feasible. The preferred model may be a combination of delivery and secondary/peer exchange models. It can be very time intensive and expensive for staff to drive to distant locations to provide services because the geographical area may be very large. Staff burnout and budget restraints may be mitigated by combining such driving with secondary models, then each trip ends up reaching many IDUs.

5.7 Using Multiple Program Models

Incorporating multiple models may be the most effective way for programs to expand syringe coverage and reach the greatest number and diversity of IDUs within a given health jurisdiction. Combining models—for example, a fixed site with a mobile van or a mobile unit with peer-based walking delivery—helps increase the likelihood that diverse populations have access to syringes. Also, using multiple program models is more flexible and can direct resources to the most affected areas, allowing programs to respond to changes in patterns among local IDUs. Using a multiple-model approach can require significant resources and demand more effort from staff. This can make them less sustainable. However, multiple program models can be a valuable, comprehensive approach when they are well executed and have sufficient resources.

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Monitoring Syringe Services Programs

The effectiveness of SSPs has already been established through scientific evaluations (see Section 2). Therefore, the main goal of monitoring local SSPs is to assess whether a program is operating in conformity to its design, reaching its specific target population and achieving anticipated implementation goals. Health departments are strongly encouraged to require SSPs to continually conduct process monitoring and periodically conduct outcome monitoring.

6.1 Process Monitoring

The overarching goal of process monitoring is to document whether the program is being implemented as intended. The process outcomes to be monitored depend on the type of service delivery model selected and the type and number of additional services provided. In general, it is recommended that programs minimize the data collection burden associated with monitoring so they do not interfere with IDU participation or SSP operations.

Process monitoring serves a number of important and valuable functions for SSPs:

- assesses which services are being used and how often they are used;
- facilitates accounting practices;
- allows SSPs to report back to regulators, funders, and others (such as their communities) about program reach; and
- maintains or increases program support.

We recommend collecting three minimum essential data elements for every syringe transaction occurring at SSPs, without regard to the type of service delivery model:

- number of participant contacts (i.e., duplicated participant counts);
- number of syringes distributed; and
- estimated number of syringes returned for disposal (refer to Section 4.4 for safe syringe disposal strategies).

In addition to these core data elements, additional data can be used to monitor process outcomes, depending on the type of service delivery model and types of services provided. Appendix A lists additional process indicators that programs may wish to monitor, depending on the service delivery model and types of services that are provided in addition to syringe exchange.

Most programs use service logs to obtain data on the number of syringes provided per transaction and the estimated number of syringes returned. In these programs, SSP staff writes the site name and the date at the top of the log daily and record transaction data as participants access services. Then staff enters the data into a software program on a daily or weekly basis. Using a handheld electronic device programmed for data input is preferable if the program can afford it because it eliminates the need for entering data from paper forms.

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Process monitoring does not require sophisticated statistical methods. Descriptive statistics are usually sufficient to answer process monitoring questions, such as comparing actual program outputs (e.g., number of HIV tests conducted) with target outputs (e.g., projected number of HIV tests conducted).

6.2 Outcome Monitoring

Quantitative assessments should occur periodically with SSP participants for outcome monitoring. Outcome monitoring provides important information for improving program efficiency, quality and effectiveness. In general, outcome monitoring methods should aim to minimize participant burden, not disrupt normal program activities and only collect information that is critical for understanding process outcomes. Utilizing a variety of data types and sources, together with program specific outcome monitoring activities, enhances the assessment of the SSP. For example, data that provide information on HIV incidence rates, HCV incidence rates, crime statistics, incarceration rates and arrest rates may provide system-level indicators for the impact of the program on outcomes related to the overarching goals of the SSP. Quantitative assessments conducted with SSP participants should occur annually or every other year and include between 100 and 200 participants, depending on the size of the program. Choosing participants randomly is preferable but may not be feasible in all locations or for all syringe modalities. Participants may be compensated financially for providing their expertise to the SSP by participating in outcome monitoring surveys.

Outcome monitoring assessments benefit from being conducted by independent observers (e.g., a research partner). Separating personnel involved in data collection from SSP staff reduces biases that may result when participants who interact with SSP staff regularly want to give socially desirable responses. It also protects the confidentiality of participants who will continue to have a relationship with the staff after data collection. Given the personal nature of some of the data collected, it is important that the participants feel comfortable disclosing sensitive information.

Key domains for SSP outcome monitoring include:

- types of services used at the SSP;
- frequency and duration of SSP use, including estimation of numbers of syringes distributed in a given period;
- receptive and distributive syringe sharing;
- disposal practices;
- overdose risk and history;
- access and linkage to drug treatment and medical and social services (e.g., referrals and linkage to medical homes, mental health services and homes and substance abuse treatment facilities);
- participant satisfaction with program elements, such as hours, locations and staff interactions;
- client characteristics (e.g., demographics, injection drug use history, medical history, and substance abuse treatment history);
- drug use preferences (e.g., types of drugs used, including hormones or steroids) and practices (e.g., with whom and how often participants use drugs);
- estimates of number of IDUs reached through secondary exchange; and
- changes in drug use, injection, and treatment as a result of SSP participation.

An individual trained in epidemiological and statistical methods and familiar with the literature on factors associated with HIV, HCV, and overdose risk and SSPs should analyze the data. SSP staff should be involved in interpreting the results.

6.3 Program Quality Improvement

Program quality improvement relies on the systematic collection and use of process monitoring and periodic outcome monitoring to determine if and how well program objectives are being met and to reassess program goals. If goals are not being met, program quality improvement can help SSPs decide if and how to change services to better meet the needs of the target population. Based on program goals, working with a research partner can be an appropriate method for assessing program quality. Quality improvement may include perspectives from community stakeholders, SSP participants, and others with important perspectives regarding the usefulness and effectiveness of the SSP. For instance, programs can use methods such as key informant interviews and focus groups to assess participant satisfaction with program elements, such as hours, locations and staff interactions; learn how SSP participants use program services; or understand how new services might be received. Using unobtrusive approaches, programs can observe SSP transactions systematically to identify opportunities to provide more education, counseling, or other services or simply time them to determine barriers to providing other activities. Similar to participants in outcome monitoring activities, participants in program quality improvement activities may be compensated financially for providing their expert input to the SSP. Many quality improvement ideas can also be discussed through a participant or community advisory board if the SSP has one.

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Capacity Building

SSPs have been operating since the mid-1980s in the U.S. Numerous program implementation manuals and guides exist and purveyors of exchange supplies are available for both product development and advice. In addition, many health departments have experience implementing SSPs and can serve as advisors and mentors to health departments looking to begin these programs. Law enforcement officials, as well as publicly elected officials, are also resources for information and assistance with the process for gaining acceptance and approval of SSPs. Several nonprofit organizations, universities, health departments, research institutes and training centers have many years of experience providing training and technical assistance. SSP participants can also provide valuable testimony to the positive impact of SSPs on their lives, in addition to pragmatic and essential input regarding effective program strategies. In general, it is best for peers to train peers. For example, health departments may learn best from other health departments, and law enforcement may learn best from other law enforcement agencies.

7.1 Assessing and Addressing Capacity Building Needs

Before initiating or expanding SSPs, a health department may find it useful to assess its readiness with a jurisdiction (described in Section 3.2). In addition to identifying a specific or mix of SSP models that may be appropriate in a specific jurisdiction, health departments can identify areas of strength, potential deficits and promising strategies to mitigate gaps in organizational and programmatic capacity. It could be useful to discuss the results of the readiness assessment with the HPPG and other partners to facilitate the prioritization process.

Numerous tools exist for assessing readiness (see Section 7.3 for a list of resources). Readiness is typically assessed across a variety of domains including law enforcement and political climate, neighborhood receptivity, resource availability, staff availability and capabilities, infrastructure for staff training and development, leadership support, access to the target population, adequate space in which to implement program services, access to referral networks, availability of supplies, and capacity to conduct program monitoring.

It is likely that health departments and their SSPs will have different capacity building needs based on their stage of development. For example, new SSPs will be concerned with learning about the many ways they can implement services, whereas existing SSPs may be more interested in learning about strategies for program improvement or expansion. Section 7.3 includes a variety of capacity-building resources that can benefit new and existing SSPs alike.

To address identified organizational and programmatic needs, health departments may consider the following strategies to build capacity:

- Peer-to-peer delivery is a particularly effective model for capacity building. It is strongly recommended that programs build in time and resources to learn from others in the field. For example, new programs can learn effective implementation strategies from long-standing programs, such as how to work effectively and competently with the IDU community, law enforcement, pharmacists or the community at large. Existing programs, for instance, can benefit from consulting with their peers about program expansion or ways to address emergent

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barriers to implementation. Law enforcement can reach out to their peers in other cities or states. Pharmacists can speak with pharmacists in other areas that have already implemented SSPs. Peer-based capacity building may encompass site visits, conference calls, or other forms of communication.

- CDC funds non-governmental organizations to deliver free capacity-building assistance (CBA) designed to assist health department jurisdictions to implement and sustain science-based and culturally proficient HIV prevention behavioral interventions and HIV prevention strategies, including SSPs. CBA comprises information dissemination, training, technical assistance, technology transfer and facilitation of peer-to-peer mentoring and support. Health departments may request CBA to improve organizational infrastructure and program sustainability, evidence-based interventions and public health strategies, community planning, monitoring and evaluation. For more information on the CBA program, visit http://www.cdc.gov/hiv/topics/cba/cba.htm.
- If the health department does not already have an evaluator on staff, consider hiring a local consultant to assist with process and outcome monitoring. For example, a local evaluator can help programs develop a plan for and carry out a rigorous process and outcome monitoring or to brainstorm ways to use existing program data for monitoring purposes. As discussed in Section 6, establishing good monitoring practices should not be overlooked, because they serve many important purposes, some of which may be required for continued funding.

7.2 Building Capacity of SSP Staff

Building capacity of staff increases individual skill level and overall service quality and productivity. In addition to improving service delivery, training staff on the program's philosophy and mission helps ensure that participants feel welcome at the SSP and are comfortable accessing services.

SSPs often have staff or volunteers who can provide training on a regular or ad hoc basis. Other times in-house training is not available on important topics. In such cases, training and technical assistance can be obtained through other mechanisms. A number of organizations and institutions provide training and technical assistance to SSPs (see Section 7.3 for a list of capacity-building resources on a variety of topics). Additionally, staff and volunteers can attend conferences and off-site trainings that can be good opportunities to interact with other providers and gain relevant experience and insight. For training resources, visit http://www.cdc.gov/hiv/topics/cba/directory.htm.

It is recommended that all staff and volunteers complete a basic training curriculum that encompasses the core topics shown in Table 4. In addition to the core training program, health departments should prioritize ongoing staff development by offering advanced training on topics such as those shown in Table 4.

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Table 4. Basic and Advanced Training Topics for SSP Staff	
Basic Training Topics	**Advanced Training Topics**
• Standard operating procedures • Referral to medical, substance abuse treatment, mental health, other service agencies • Cultural sensitivity • Overview of neighborhood concerns • Outreach strategies • Training secondary exchangers • HIV and viral hepatitis transmission and prevention • Overdose prevention • Syringe safety/disposal • Plan for accidental needlesticks • Legal and law enforcement climate	• Polysubstance use • Conflict resolution and de-escalation • Specialized interviewing techniques (e.g., motivational interviewing) • Principles of case management • Abscess and cellulitis treatment and prevention • Domestic violence issues • Co-occurring mental health and substance use disorders

7.3 Capacity-Building Resources

This section includes links to Web-based resources to build the capacity of health departments to plan and implement SSPs. The contents of non-governmental websites do not necessarily represent the views of CDC.

Examples of SSP Policies, Guidelines and Best Practices from States, Cities and CBOs

- District of Columbia Needle Exchange Programs Policies and Procedures Manual (http://dchealth.dc.gov/doh/lib/doh/pdf/dc_nex_policy_procedures.pdf)
- The Chicago Recovery Alliance (http://www.anypositivechange.org/guideOP.pdf).
- San Francisco Department of Public Health, Syringe Access and Disposal Program Policies and Guidelines (http://sfhiv.org/documents/SPPPGVersion2.March_1_2011.pdf)
- New York State Department of Health, AIDS Institute, Syringe Exchange Programs Policies and Procedures (http://www.health.state.ny.us/diseases/aids/harm_reduction/needles_syringes/syringe_exchange/docs/policies_and_procedures.pdf)
- Ontario Needle Exchange Programs: Best Practice Recommendations (http://www.health.gov.on.ca/english/providers/pub/aids/reports/ontario_needle_exchange_programs_best_practices_report.pdf)

Evaluation Resources

- Framework for Program Evaluation in Public Health (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm)
- W.K. Kellogg Foundation Evaluation Handbook (http://www.wkkf.org/knowledge-center/resources/2010/W-K-Kellogg-Foundation-Evaluation-Handbook.aspx)
- Evaluation Guidance Handbook: Strategies for Implementing the Evaluation Guidance for CDC-Funded HIV Prevention Programs http://www.cdc.gov/hiv/topics/evaluation/health_depts/guidance/strat-handbook/pdf/guidance.pdf

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General Resources

- CDC Capacity Building Assistance Portal for HIV Prevention (http://www.cdc.gov/hiv/capacitybuilding)
- Recommended Best Practices for Effective Syringe Exchange Programs in the United States: Results of a Consensus Meeting (http://www.cdph.ca.gov/programs/Documents/US_SEP_recs_final_report.pdf)
- Department of Health and Human Services Implementation Guidance for Syringe Services Programs (http://www.cdc.gov/hiv/resources/guidelines/PDF/SSP-guidanceacc.pdf)
- North American Syringe Exchange Network (http://www.nasen.org/)

Legal Strategies

- The Project on Harm Reduction in the Health Care System (http://www.temple.edu/lawschool/phrhcs/phrhcs.htm)
- The Public Health Law Network (http://www.publichealthlawnetwork.org/)
- Syringe Access Law in the United States: A State of the Art Assessment of Law and Policy (http://www.publichealthlaw.net/Research/PDF/syringe.pdf
- State and Local Policies Regarding IDUs' Access to Sterile Syringes (http://www.cdc.gov/IDU/facts/aed_idu_pol.pdf)

Law Enforcement Strategies

- Law Enforcement and Harm Reduction Network (http://www.leahrn.org/)
- Policing for Healthy Communities (http://www.policingforhealth.org/
- Syringe Possession Information for California Law Enforcement Officers (http://www.harmreduction.org/downloads/police%20SEP%20cards.pdf)
- COPS HR: Coalition of Police Supporting Harm Reduction (http://www.harmreduction.org/downloads/COPShr.pdf)
- Do Not Cross: Policing and HIV Risk Faced by People Who Use Drugs (http://www.harmreduction.org/downloads/PoliceHIVidu.pdf)
- Needle Exchange Program: Considerations for Criminal Justice (http://www.harmreduction.org/downloads/NEPcriminaljusticeCIPP.pdf)
- Attitudes of Police Officers Towards Syringe Access, Occupational Needle-Sticks, and Drug Use: A Qualitative Study of One City Police Department in the United States (http://www.harmreduction.org/downloads/police%20attitudes.pdf)
- Law Enforcement and Harm Reduction: Advocacy and Action Manual (http://www.harmreduction.org/downloads/Police%20Harm%20Reduction%20Concerns.pdf)
- Law Enforcement and Harm Reduction (http://www.harmreduction.org/downloads/Law%20enforcement%20and%20harm%20reduction.pdf)

Overdose Prevention

- Chicago Recovery Alliance:
  - OD Intervention Card—Using Naloxone (http://www.anypositivechange.org/odcard.pdf)
  - OD Intervention Poster—Using Naloxone (http://www.anypositivechange.org/odposter.pdf)
  - Opiate OD Prevention/Intervention Training—Slideshow (http://www.anypositivechange.org/odslide.pdf)
  - Opiate OD Prevention/Intervention Training—Pre/Post Test (http://www.anypositivechange.org/naltest.pdf)
  - Injection Partner OD Checklist (http://www.anypositivechange.org/ODpartnerchecklist.pdf)

Substance Abuse Treatment and Mental Health Resources

- Substance Abuse and Mental Health Administration (http://www.samhsa.gov/)

Glossary

Acquired immune deficiency syndrome (AIDS) is the late stage of HIV infection, when a person's immune system is severely damaged and has difficulty fighting diseases and certain cancers.

Buprenorphine is used to treat opioid dependence (addiction to opioid drugs, including heroin and narcotic painkillers). Buprenorphine is in a class of medications called opioid partial agonist-antagonists. Buprenorphine alone and in combination with naloxone can prevent withdrawal symptoms when someone stops taking opioid drugs by producing similar effects to these drugs.

Capacity building refers to one or more activities that contribute to an increase in the quality, quantity and efficiency of program services and the infrastructure and organizational systems that support these program services. In the case of HIV prevention capacity building, the activities are associated with the core competencies of an organization that contribute to its ability to develop and implement an effective HIV prevention intervention and to sustain the infrastructure and resource base necessary to support and maintain the intervention.

Cooker is a spoon or bottle cap used to liquefy drugs so they can be injected.

Drug paraphernalia laws, under the Federal Drug Paraphernalia Statute, Controlled Substances Act, make it illegal to possess, sell, transport, import or export drug paraphernalia as defined. The law gives specific guidance on determining what constitutes drug paraphernalia. Many states also have enacted their own laws prohibiting drug paraphernalia.

Evaluation is a systematic method for collecting, analyzing and using information to answer questions about projects, policies and programs, particularly about their effectiveness and efficiency.

Hepatitis C virus (HCV) causes a liver disease that is the most common IDU-associated infection in the United States. HCV infection sometimes results in an acute illness but most often becomes a chronic condition that can lead to cirrhosis of the liver and liver cancer. It is transmitted by contact with the blood of an infected person, primarily through sharing contaminated needles to inject drugs.

HIV prevention community planning is a collaborative process by which health departments work in partnership with the community to implement a community planning group to develop a comprehensive HIV prevention plan that includes prioritized target populations and a set of prevention activities/interventions for each target population.

Human immunodeficiency virus (HIV) is the virus that can lead to acquired immune deficiency syndrome, or AIDS. There are two types of HIV: HIV-1 and HIV-2. In the U.S., unless otherwise noted, the term "HIV" primarily refers to HIV-1. Both types of HIV damage a person's body by destroying specific blood cells, called CD4+ T cells, which are crucial to helping the body fight diseases.

Injection drug user (IDU) is a person who injects illicit drugs, hormones, steroids, or silicone.

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Kiosks or drop boxes are places for safely disposing of used syringes. They are usually placed in publicly accessible locations. Syringes can be placed in the kiosk or drop box but cannot be retrieved, reducing reuse of contaminated syringes and risk of accidental needlesticks.

Methadone is a drug used to prevent withdrawal symptoms in patients who were addicted to opioid drugs and are enrolled in treatment programs in order to stop taking or continue not taking the drugs.

Monitoring is routine documentation of characteristics of the people served, the services provided and the resources used to provide those services.

Motivational interviewing is a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.

Naloxone is a drug used to counter the effects of opioid overdose, for example, a heroin or morphine overdose. Naloxone is used specifically to counteract life-threatening depression of the central nervous system and respiratory system.

Needs-based/negotiated distribution is a program practice that places no limits on the number of syringes an SSP participant may receive, regardless of the number of used syringes returned. While encouraged, participants do not need to return any used syringes in order to receive new, sterile syringes.

One-for-one plus exchange is a program practice that modifies one-for-one exchange by providing an SSP participant with a predetermined number of extra syringes beyond the number of sterile syringes brought in for disposal.

Program Collaboration and Service Integration (PCSI) is a mechanism of organizing and blending interrelated health issues, separate activities, and services in order to maximize public health impact through new and established linkages between programs to facilitate the delivery of services.

Regulated medical waste (RMW), also known as "biohazardous" waste or "infectious medical" waste, is the portion of the waste stream generated by health care facilities that may be contaminated by blood, body fluids, or other potentially infectious materials that may pose a significant risk of transmitting infection and endangering human health.

Secondary exchange is a type of syringe exchange program model whereby participants exchange with their peers after being supplied by the SSP.

Sharps are items with corners, edges, or projections capable of cutting or piercing the skin, such as syringes with needles.

Social networks are social structures made up of individuals (or organizations) called "nodes" that are connected by one or more specific types of interdependency, such as friendship, kinship, common interest, financial exchange, dislike, sexual relationships, or relationships of beliefs, knowledge or prestige.

Strict one-for-one exchange is a program practice whereby an SSP participant is only provided with the same number of sterile syringes as were brought in for disposal.

Subject matter experts (SME) are individuals who have expertise in the area of syringe services programs, whether from a programmatic, governmental, research or evaluation, participant, or administrator perspective.

Syringe exchange programs (SEPs) provide free sterile syringes in exchange for used syringes to reduce transmission of blood-borne pathogens among IDUs.

Syringe prescription laws require a prescription for the legal purchase or possession of a syringe by most or all buyers. Most prescription laws have been repealed or amended to allow purchase of a specified number of syringes without a prescription.

Syringe services programs (SSPs) provide a way for IDUs to safely dispose of used syringes and to obtain new, sterile syringes. SSPs also provide a range of related prevention and care services that are vital to helping IDUs reduce their risk of acquiring and transmitting blood-borne viruses, as well as maintain and improve their overall health. SSPs include syringe access, disposal, and needle exchange programs, as well as referral and linkage to HIV and viral hepatitis prevention services, drug abuse treatment and medical and mental health care.

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SYRINGE SERVICES PROGRAM PROCESS MONITORING INDICATORS

Health departments implementing syringe services programs (SSPs) may wish to incorporate the
SYRINGE SERVICES PROGRAM PROCESS MONITORING INDICATORS

Health departments implementing syringe services programs (SSPs) may wish to incorporate the following process and program monitoring indicators.

Minimum required process monitoring indicators for all SSP models:

- Number of clients/participants
- Number of syringes distributed
- Number of syringes returned/disposed of

Recommended list of process monitoring indicators for each SSP model:

- Fixed Site (e.g., hospital/clinic based settings, integrated syringe access services, collaboration or satellite structure)
  - Number of hours open per week for syringe exchange
  - Number of HIV tests provided
  - Number HIV positive
  - Number of HCV antibody tests provided
  - Number of tests positive for HCV antibodies
  - Number of referrals for HCV antibody testing
  - Number of referrals for HIV testing
  - Number of referrals for substance abuse treatment
  - Number of each type of service directly provided or referral provided
  - Client demographics: age, gender, race/ethnicity
- Mobile/Street Based
  - Number of hours open per week for syringe exchange
  - Number of HIV tests provided
  - Number HIV positive
  - Number of referrals for HIV testing
  - Number of HCV antibody tests provided
  - Number of tests positive for HCV antibodies
  - Number of referrals for HCV antibody testing
  - Number of referrals for substance abuse treatment
  - Number of each type of service directly provided or referral provided
  - Client demographics: age, gender, race/ethnicity
- Secondary or Peer Delivery
  - Number of peers distributed to
  - Number of peer distributors
- Delivery Model
- Number of delivery sites
- Number of persons served per delivery site

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- Number of referrals for HIV testing
- Number of referrals for HCV antibody testing
- Number of referrals for substance abuse treatment
- Pharmacy Distribution
  - Number of hours open per week for syringe exchange
  - Number of referrals for HIV testing and/or HIV tests provided
  - Number of referrals for HCV antibody testing and/or HCV antibody tests provided
  - Number of referrals for substance abuse treatment
  - Number of each type of service directly provided or referral provided
  - Number of vouchers redeemed (if pharmacy distribution program is combined with a voucher program)
- Multiple Programs
  - Number of hours open per week for syringe exchange
  - Number of HIV tests provided
  - Number HIV positive
  - Number of referrals for HIV testing
  - Number of HCV antibody tests provided
  - Number of tests positive for HCV antibodies
  - Number of referrals for HCV antibody testing
  - Number of referrals for substance abuse treatment
  - Number of each type of service directly provided or referrals provided
  - Client demographics: age, gender, race/ethnicity

Other process monitoring indicators:

- Number of participants
- Number of new clients
- Client demographics:
  - Age
  - Gender
  - Race/ethnicity
  - ZIP code of residence
  - Behavioral characteristics
- Number of syringes distributed
- Number of syringes collected/disposed of
- Number of syringes each participant is exchanging for
- Number of visits per client per month
- Number of hours open for syringe exchange per week
- Number of peers distributed to
- Number of peer distributors
- Number of delivery sites
- Number of persons served per delivery site
- Number of vouchers redeemed (if pharmacy distribution program is combined with a voucher program)
- Number of each type of service directly provided or referral provided
- Number of referrals made to HIV services
- Number of HIV tests provided
- Number HIV positive

- Number of HCV antibody tests provided
- Number of tests positive for HCV antibodies
- Number of referrals for HCV antibody testing
- Number of referrals for substance abuse treatment
- Number of condoms distributed
- Number of flu vaccines provided
- Number of hepatitis A vaccination doses
- Number of hepatitis B vaccination doses
- Number of negative events
- Number of community-based syringe-disposal kiosks

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NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

UCHAPS
Urban Coalition for HIV/AIDS Prevention Services

Syringe Service Program (SSP) Narrative

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

Syringe Service Program:

Currently Michigan has five existing non-department funded Syringe Service Programs (SSP) located in the following cities: Detroit, Grand Rapids, Muskegon, Ypsilanti, and Flint. The Michigan Department of Health and Human Services (MDHHS)/Population Health Administration received a CDC grant to create pilot sites through four local health departments: Central Michigan, District Health Department 10, Chippewa, and Marquette. Although there are nine established SSPs, there is still a need for enhancing current programs and expanding to additional sites throughout the state.

Michigan plans to enhance/expand services for the four pilot Syringe Service Programs and help create seven new sites. These SSPs will provide syringe access, disposal and/or exchange to injection drug users (IDUs) while also referring and linking IDUs to HIV and viral hepatitis prevention services, substance abuse treatment, and medical and mental health care. These programs have shown to increase the likelihood of persons entering treatment for substance use disorder. Funds will be used to support the following services, as appropriate: comprehensive sexual and injection risk reduction counselling; HIV, viral hepatitis, other sexually transmitted diseases (STD) and tuberculosis (TB) screening; provision of naloxone to reverse opioid overdoses; referral and linkage to HIV, viral hepatitis, other STDs and TB prevention, care and treatment services; referral and linkage to hepatitis A virus (HAV) and hepatitis B virus (HBV) vaccination; and referral to integrated and coordinated substance use disorder services, mental health services, physical health care, social services, and recovery support services.

MDHHS/Division of HIV & STD Programs has put together a Syringe Services Program Guidelines manual designed to outline the process of developing and starting a SSP. Information in this manual was developed by The National Alliance of State and Territorial AIDS Director (NASTAD) and the Urban Coalition for HIV/AIDS Prevention Services (UCHAPS) to further assist state and local health departments to plan and implement SSPs as a part of their prevention portfolios. These guidelines provide assistance to state and local health department jurisdictions that wish to support SSPs for IDUs to prevent transmission of HIV and other blood-borne viruses such as HCV and to link IDUs to vital prevention, medical and social services. For health departments currently implementing SSPs, these program implementation guidelines provide information that can be used to enhance or expand services. For health departments interested in initiating an SSP, these guidelines address key issues to be considered before implementing an SSP. This document will be shared with potential sites to guide them through the process of SSP program development and/or expansion.

MDHHS/Office of Recovery Oriented System of Care (OROSC), the SSA, plans to provide funding via a MOU with MDHHS/Population Health Administration to oversee the implementation of the SSP sites. There would be a work plan from Population Health and a budget as part of the MOU. Population Health would use SABG dollars to fund local health departments to either house an SSP on site or at a partner community organization. Michigan local health departments has the infrastructure to address this public health crisis as it relates to their communicable disease prevention efforts and mandates.

The local health departments would be required to work with Prepaid Inpatient Health Plans (PIHP) to provide SUD services including on site prevention, treatment and recovery or create a strong referral process for IDUs to receive such services at a licensed SUD provider. PIHPs are sub-entities of the state contracted to manage publicly funded behavioral health services. The local health departments would develop MOUs with PIHPs to provide SUD services and communicable disease prevention education.

In addition, Population Health Administration would contract with the Grand Rapids Red Project for technical assistance to local community SSP sites. The Red Project was one of the first syringe exchange programs in Michigan. Since 1998, they have served the city of Grand Rapids by providing people with access to the tools, information, resources, and support that they need to stay healthy. There programs consist of HIV testing, syringe access, overdose prevention, HIV case management, tobacco services, and peer groups. Using their expertise, they have provided training and technical assistance to several communities across the state.

Population Health Administration would house two employees. One Civil Service Epi Manager funded at 60% who would be responsible for coordinating the contracts, MOUs, data sharing agreements, grant work plan management, etc. One MPHI Affiliate Harm Reduction Specialist funded at 100% who would be responsible for SSP technical assistance and work plan implementation. OROSC would appoint a staff to be the key contact with oversight responsibilities to ensure expectations of the program and reporting requirements are met.

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

Syringe Service Program:

Although there are nine established SSPs throughout Michigan, there is still a need for enhancing current programs and expanding to additional sites throughout the state.

Via a request for determination of need, Michigan submitted evidence for consultation with CDC to demonstrate that our state is experiencing significant increase in viral hepatitis or HIV infections due to injection drug use. CDC concurred that Michigan is experiencing an increase in viral hepatitis or HIV infections due to injection drug use.

Michigan presented statewide data on increases in acute HCV infections and total HCV infections, and that a predominance of new cases were attributable to injection drug use.

- Michigan indicated a 200% increase in the rate of acute HCV infections between 2009 and 2015. Where risk information was ascertained on these cases, 60% reported injection drug use 2 weeks to 6 months prior to onset of symptoms.
- Michigan indicated a 2300% increase in the number of chronic HCV diagnoses per year between 2000 and 2015 in individuals aged 18-29. Where risk information was ascertained on these cases, approximately 90% reported a history of ever injecting drugs.

Epidemiological trend data in other areas (deaths from heroin and prescription opioids as well as heroin substance abuse treatment admissions) indicated increases in unsafe injection of drugs consistent with risk for a significant increase in viral hepatitis or HIV.

- Prescription opioid deaths increased 550% in Michigan between 2000 and 2014
- Heroin overdose deaths increased 480% in Michigan between 2000 and 2014
- Substance abuse treatment admissions increased over 100% in Michigan between 2000 and 2015

Michigan also provided data from a published study (Suryaprasad AG et al. Emerging Epidemic of Hepatitis C Virus Infections Among Young Nonurban Persons Who Inject Drugs in the United States, 2006–2012. Clin Infect Dis. (2014) 59 (10): 1411-1419) in which the state of Michigan participated. In this study, young persons (<30 years of age) newly diagnosed with HCV were interviewed. Among Michigan participants, 94% of interviewees reported a history of injecting drugs, 92% reported a history of using heroin, 37% reported sharing needles, 47% reported sharing cookers, 53% reported sharing cotton, and 65% reported sharing a water source for drug use and preparation.

The CDC's vulnerability study identified 11 Michigan counties in the top 5% of counties in the United States at greatest risk for rapid dissemination of HCV and/or HIV infection among persons who inject drugs. Michigan had the fifth most "vulnerable counties" among the 50 states (only behind Kentucky, Tennessee, West Virginia, and Missouri).

There was plenty of archival data for justifying geographical need for SSPs. Data that was examined per Michigan county included

- 2017 Hepatitis A Infection Rate (per 100,000 persons)
- 2016 Acute Hepatitis B Infection Rate (per 100,000 persons)
- 2016 Acute HCV Infection Rate (per 100,000 persons)
- 2016 Chronic HCV Infection Rate Age 18-29 (per 100,000 persons)
- 2011-2016 HCV Young Adult Hospitalizations (per 10,000 person years)
- Drug Poisoning Death Rate (Per 100,000 persons)
- Non-heroin Opioid Overdose Death Rate (Per 100,000 persons)
- Heroin Overdose Death Rate (Per 100,000 persons)
- NAS Rate (Per 100,000 births)

In addition, Population Health administered an Assessing Community Readiness for Implementing a Syringe Services Program survey to local health department's Health Officers and Medical Directors regarding readiness for SSPs in their communities. Questions varied from perception of how necessary it is to have an SSP operating in their jurisdiction to level of support or opposition they think the general public/community, persons who inject drugs, or local law enforcement would have if a SSP were implemented in their jurisdiction. They were also asked the likelihood of establishing a SSP in their jurisdiction in 2019.

The above data was put together in a chart format to easily identify health department jurisdictions that were in most need of a SSP. Some local health departments were chosen for expansion or new sites based on if they had at least one CDC highly vulnerable county. And the others that were chosen, have

higher than average rates of various metrics that represent, or might indicate, a high risk of transmission of infectious diseases among persons who inject drugs.

Based on review of the data, the proposed SSP locations include:

Expansion of the following health department's SSP

- Central Michigan
- District HD 10
- Chippewa
- Marquette

New sites with the following health departments

- Macomb
- St Clair
- District HD 2
- District HD 4
- Northwest MI HD (Petoskey)
- Grand Traverse (Traverse City)
- Luce-Mackinac-Alger-Schoolcraft HD

Budget Narrative:

OROSC would develop an MOU with Population Health Administration in the amount of $800,000 for staff positions and SSP support implementation.

$100,000	One Civil Service Epi Manager funded at 60% - with salary, fringe, travel, etc. This person would be responsible for coordinating the contracts, MOUs, data sharing agreements, etc.
$100,000	One MPHI Affiliate Harm Reduction Specialist funded at 100% - with salary, fringe, travel, etc. This person would be responsible for SSP technical assistance.

Total for staff = $200,000

$200,000	Current SSP pilot site enhancement expansion 4 x $50,000 each Central Michigan Health Department, District Health Department 10, Chippewa Health Department, Marquette Health Department
$350,000	New SSP sites to be created 7 x $50,000 = $350,000 Macomb County Health Department, St. Clair County Health Department, District Health Department 2, District Health Department 4, Northwest MI Health Department (Petoskey), Grand Traverse Health Department (Traverse City), Luce-Mackinac-Alger-Schoolcraft Health Department

Total for sites = $550,000

$50,000	Technical assistance for SSP sites by Red Project Subcontract with Red Project to provide training, consultation and TA

Total for Red Project = $50,000

$800,000	TOTAL BUDGET

Michigan SSP Expansion Timeline

Activity	Timeline	Responsible Party
Develop a new SSP project in EGrAMS to provide funding to local health departments	Oct 2018	MDHHS
Hire staff to assist with implementation of the project	Oct 2018	MDHHS
Develop contract with a local agency to provide consultation and TA to MDHHS and new SSPs	Oct 2018	MDHHS CBO
Determine LHD staff to assign to SSP activities and act as points of contact	Oct 2018	LHDs
Schedule meetings with law enforcement, local substance abuse treatment providers, community mental health agencies, health care providers, persons who inject drugs, and the public to discuss benefits, costs, ordinances, logistics, and possible locations for an SSP	Oct-Dec 2018	LHDs
Work to develop contractual workplans, MOUs, and data sharing agreements between local and State agencies	Oct-Dec 2018	MDHHS LHDs
Develop advertising materials	Nov 2018	LHDs
Develop standard progress reporting forms and timelines	Nov-Dec 2018	MDHHS LHDs
Participate in harm reduction training	Nov 2018 and ongoing	MDHHS CBO LHDs
Develop contracts and relationships for biological waste disposal, sharps disposal, SUD treatment referral, provision of naloxone, HIV and HCV testing, and HAV and HBV vaccine	Dec 2018	LHDs
Conduct focus groups to determine location(s) of SSP(s)	Dec 2018 - Jan 2019	LHDs
Develop intake form and ID cards for SSP client registration	Jan 2019	LHDs
Prepare worksite for SSP operations (e.g. educational materials, supplies, etc.)	Feb 2019	LHDs
Sign and finalize workplans, MOUs, data sharing agreements	Feb 2019	MDHHS LHDs
Develop relationships with agencies that may refer clients to the SSP (EDs, pharmacies, SUD providers, PCPs)	Mar 2019	LHDs
Begin SSP operations	Mar 2019	LHDs

Begin reporting progress metrics to MDHHS	Mar 2019	LHDs MDHHS
Maintain database of SSP progress for reporting and evaluation	Mar 2019	MDHHS
Standing meetings with LHD SSP and healthcare and community stakeholders	Monthly / Quarterly	LHDs
Standing meetings between LHDs and MDHHS	Monthly / Quarterly	MDHHS LHDs CBO
Ongoing and routine TA and support to LHD SSPs	Ongoing	MDHHS CBO

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A

Syringe Services Program SSP Agency Name	Main Address of SSP	Dollar Amount of SABG funds used for SSP	SUD Treatment Provider	Number Of Locations (include mobile if any)	Narcan Provided
Macomb County Health Department	43525 Elizabeth Road, Mt. Clemens, MI -48043	$50,000	No	1	No
St. Clair County Health Department	3415 28th Street, Port Huron, MI -48060	$50,000	No	1	Yes
Chippewa County Health Department	508 Ashmun Street, Suite 120, Sault Ste. Marie, MI -49783	$50,000	No	3	Yes
Marquette County Health Department	184 US 41 East, Negaunee, MI -49866	$50,000	No	1	Yes
Grand Traverse County Health Department	2600 LaFranier, Suite A, Traverse City, MI -49686	$50,000	No	1	No
Central Michigan District Health Department	2012 E. Preston Avenue, Mt. Pleasant, MI -48858	$50,000	No	1	No
District Health Department #2	630 Progress Street, West Branch, MI -48661	$50,000	No	1	No
District Health Department #4	100 Woods Circle, Suite 200, Alpena, MI -49707	$50,000	No	1	No
District Health Department #10	521 Cobbs Street, Cadillac, MI -49601	$50,000	No	1	No
Northwest Michigan Health Department	220 W. Garfield Street, Charlevoix, MI -49720	$50,000	No	1	No
LMAS District Health Department	14150 Hamilton Lake Road, Newberry, MI -49868	$50,000	No	1	No

Footnotes:

Macomb County Health Department - Clients are referred out for treatment and Narcan. One location is to be funded.
St. Clair County Health Department - Clients are referred out for treatment. One location is to be funded.
Chippewa County Health Department - Clients are referred out for treatment and they plan to provide Narcan.
Marquette County Health Department - Clients are referred out for treatment.
Grand Traverse County Health Department - Clients are referred out for treatment and Narcan. One location is to be funded.
Central Michigan District Health Department - Clients are referred out for treatment and Narcan.
District Health Department #2 - Clients are referred out for treatment and Narcan.
District Health Department #4 - Clients are referred out for treatment and Narcan. One location is to be funded.
District Health Department #10 - Clients are referred out for treatment and Narcan. One location is to be funded.
Northwest Michigan Health Department - Clients are referred out for treatment and Narcan. One location is to be funded.
LMAS District Health Department - Clients are referred out for treatment and Narcan. One location is to be funded.

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table B

Syringe Service Program Name	# of Unique Individuals Served		*[Please enter total number of individuals served]*				
			HIV Testing	Treatment for Substance Use Conditions	Treatment for Physical Health	STD Testing	Hep C
	0	ONSITE Testing	0	0	0	0	0
		Referral to testing	0	0	0	0	0

Footnotes:

Environmental Factors and Plan

24. 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:

http://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

Footnotes:

Behavioral Health Advisory Council

State of Michigan

August 18, 2017

Nick Lyon, Director
Michigan Department of Health and Human Services
333 South Grand Avenue
P.O. Box 30195
Lansing, MI 48909

Dear Mr. Lyon:

The state's Behavioral Health Advisory Council (BHAC) met today, August 18, 2017, to review and discuss Michigan's Fiscal Year 2018-2019 State Behavioral Health Assessment and Plan for the Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant.

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

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

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

Sincerely,

Mark Reinstein

Mark Reinstein, Chair
Behavioral Health Advisory Council
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