Michigan
UNIFORM APPLICATION
FY 2020/2021 Block Grant Application
SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT
OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/16/2019 12:38.01 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

**Plan Year**

- Start Year: 2020
- End Year: 2021

**State SAPT DUNS Number**

- Number: 113704139
- Expiration Date: 9/30/2020

**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**: Larry
- **Last Name**: Scott
- **Agency Name**: Michigan Department of Health and Human Services
- **Mailing Address**: Behavioral Health & Developmental Disabilities Administration, Office of Recovery Oriented Systems of Care, 320 S. Walnut, 5th Floor
  - **City**: Lansing
  - **Zip Code**: 48913
- **Telephone**: (517) 335-0174
- **Fax**: (517) 241-2969
- **Email Address**: ScottL11@michigan.gov

**State CMHS DUNS Number**

- Number: 113704139
- Expiration Date: 9/30/2020

**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**: Jeffery
- **Last Name**: Wieferich
- **Agency Name**: Michigan Department of Health and Human Services
III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ☐ Yes ☐ No

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

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

From
To

V. Date Submitted
Submission Date
Revision Date

VI. Contact Person Responsible for Application Submission

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

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

Footnotes:
August 20, 2019

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

Dear Secretary Azar:

As the federal and state governments are working together to implement federal mental health and substance abuse block grants, this letter designates Robert Gordon, Director of the 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. Gordon 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,

[Signature]

Gretchen Whitmer
Governor of Michigan

c: Odessa F. Crocker, Supervisory Grants Management Specialist
Robert Gordon, Director
Dr. George Mellos, Senior Executive Psychiatrist Director, Deputy Director
Karen Cashen, Grants Manager
August 20, 2019

Ms. Odessa F. Crocker  
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 federal and state governments are working together to implement federal mental health and substance abuse block grants, this letter documents my designation of Jeff Wieferich, Director of the Bureau of Community Based Services, as administrator of the Community Mental Health Services Block Grant. I also designate Larry Scott, Director of the Office of Recovery Oriented Systems of Care, as administrator of the Substance Abuse Prevention and Treatment Block Grant.

Additionally, Mr. Wieferich and Mr. Scott are designated the authority to submit 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,

[Signature]

Robert Gordon

RG:mr

c: Dr. George E. Mellos  
Jeff Wieferich  
Larry Scott  
Karen Cashen
### State Information

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

**Fiscal Year 2020**

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

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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).

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.


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

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions...


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

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

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

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a “covered transaction” and verify each lower tier participant of a “covered transaction” under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:

   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

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

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,”
generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the
Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section
1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying
undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING
$100,000 in total costs.

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

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain
provisions for children’s services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

**HHS Assurances of Compliance (HHS 690)**


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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

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

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

State: __________________________________________________

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

Signature of CEO or Designee: __________________________________________________

Title: Director, Office of Recovery Oriented Systems of Care

Date Signed: mm/dd/yyyy

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

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

Footnotes:
# State Information

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**Fiscal Year 2020**

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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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11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions
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15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

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LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

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

2. Certification Regarding Drug-Free Workplace Requirements

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

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"
generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

State: ____________________________

Michigan

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

Larry Scott

Signature of CEO or Designee 1: ____________________________

Date Signed: 7/23/19

Title: Director, Office of Recovery Oriented Systems of Care

Date Signed: ________________

mm/dd/yyyy

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

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

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

HHS Assurances of Compliance (HHS 690)


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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

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

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

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

### Fiscal Year 2020

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  
Title 42, Chapter 6A, Subchapter XVII of the United States Code

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   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
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b. Establishing an ongoing drug-free awareness program to inform employees about--

   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

   c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

   d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--

      1. Abide by the terms of the statement; and
      2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

   e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

   f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?

      1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
      2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

   g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,”
generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure of Lobbying Activities,” in accordance with its instructions. (If needed, Standard Form-LLL, “Disclosure of Lobbying Activities,” its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801-3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children’s services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

**HHS Assurances of Compliance (HHS 690)**


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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

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

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

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

Signature of CEO or Designee:  

Title:  Director, Bureau of Community-Based Services  

Date Signed:  

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

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

Footnotes:
State Information

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

Fiscal Year 2020

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
Title 42, Chapter 6A, Subchapter XVII of the United States Code

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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

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

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

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §504), which prohibits discrimination on the basis of handicap; (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) §§5523 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.


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 11993; (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).


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

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

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

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

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

2. Certification Regarding Drug-Free Workplace Requirements

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

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

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5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

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

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

Name of Chief Executive Officer (CEO) or Designee: Jeff Wieferich

Signature of CEO or Designee:

Title: Director, Bureau of Community Based Services

Date Signed: 07/23/2019

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

OM8 No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
## State Information

### Disclosure of Lobbying Activities

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

**Standard Form LLL (click here)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Robert Gordon</th>
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<tbody>
<tr>
<td>Title</td>
<td>Director</td>
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<tr>
<td>Organization</td>
<td>Michigan Department of Health and Human Services</td>
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**Signature:**  
**Date:**

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

**Footnotes:**
State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name
Robert Gordon

Title
Director

Organization
Department of Health and Human Services

Signature: [Signature]

Date: 8/16/19

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

Footnotes:
Planning Steps

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

Narrative Question:
Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD 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 SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and 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.
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 then-Governor Snyder enacted PA 107 of 2017, which instructed 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 instructed 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 has been in the process of developing and implementing the aforementioned pilots, however due to the extensive work and details involved implementation has been delayed until at least FY21.

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 August 6, 2019, 632,254 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 several mechanisms in place to provide leadership in the coordination of mental health services within the broader system. The PIHP contracts currently describe the PIHPs’ responsibilities and deliverables. These contracts place a heavy emphasis on customer service, uniform data collection and encounter data reporting, fiscal management, quality assessment, and utilization.

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

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

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

Based on July 1, 2018 United States Census Bureau information (the most recent data available), Michigan’s population is 9,995,915, a 1.1% increase from the April 2010 estimates. Race/ethnic origins are White- 79.3%; Black of African American- 14.1%; American Indian and Alaska Native-0.7%; Asian- 3.4%; two or more races (unspecified) - 2.5%; Hispanic or Latino- 5.2%. Population characteristics from 2013-2017 include 581,527 Veterans and 6.6% foreign born persons. Females comprise a slight majority (50.8%) of Michigan’s population, compared to males (49.2%). Although there continues to be a lack of adequate data on specific demographic subsets of Michigan’s population in relation to alcohol, tobacco and other drugs, depression and trauma, processes have continued to improve the collection of this information via an oversampling on the Michigan Behavior Risk Factor Survey (BRFS).

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

Public Act (PA) 653 was passed by Michigan’s 93rd Legislature in 2006 and became effective in January 2007. PA 653 focuses on five racial, ethnic and tribal population groups in Michigan: African American, Hispanic/Latino, American Indian/Alaska Native, Asian American/ Pacific Islander, and Arab and Chaldean American. In accordance with this law, MDHHS has the responsibility to develop and implement a departmental structure to address racial and ethnic minority health disparities in Michigan. A report on efforts across the department is prepared for the legislature each year. In 2015, population health, health equity, and social determinants of health requirements began to be integrated into Medicaid Managed Care Request for Proposal (RFP). (Bureau of Medicaid Care Management and Quality Assurance/Managed Care Plan). MDHHS also worked with community partners to increase the adoption of CLAS standards among all Michigan organizations.
In 2018, MDHHS released its Diversity, Equity and Inclusion (DEI) Plan. This plan outlines key actions the department should take toward achieving diversity, equity and inclusion throughout the organization. Given the diverse structures, functions and work environments of the various areas within the department, the DEI committee took a broad, high-level approach and created a plan that allows local offices, state hospitals and other organizational areas within MDHHS to be successful at achieving diversity, equity and inclusion in their unique setting. The DEI Plan provides a framework that is applicable to all of the administrations, bureaus and divisions within the department and is adaptable to their individual needs. The guiding framework is built around five key areas or indicators of success: (1) Leadership; (2) Culture and Climate; (3) Recruitment, Hiring and Retention; (4) Training and Professional Development; and (5) Service Delivery. Plans for 2019 include administering a structured, department-wide assessment in order to gather data to further inform the work of Action Teams, including where to focus their efforts. This assessment data will also provide a baseline from which to measure progress and impact of DEI Plan initiatives. BHDDA actively participates in the DEI committee.

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

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

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

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

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

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


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

These block grant-supported projects target the service practice areas below. As many of these practices are only partially implemented and/or are encountering sustainability challenges, they continue to represent ongoing needs for the coming Fiscal Year 2020-21 grant cycle:

**Assertive Community Treatment**

The 76 community-based Michigan Assertive Community Treatment (ACT) teams engage and work with adults who experience the most severe and troubling symptoms of serious mental illness. Firmly embedded in the public mental health system and a Medicaid covered service, ACT uses proactive engagement to provide continuous, rapid, flexible, twenty-four hour a day, seven days a week, three hundred and sixty-five days a year treatment. Although there is a well-established 20-year history of ACT, assuring the necessary skills and information in workforce development and support of this very high intensity evidence-based practice remains a priority. An ACT-specific training is required annually by Medicaid, and the Quality Management Site Review Team emphasizes adherence to Medicaid. A quality improvement tool, the Michigan Field Guide to ACT was created, adopted and is used to support ACT teamwork addressing consumer relations, satisfaction and outcomes.

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

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

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

Since the last update to the Federal Mental Health Block Grant application, ACT has been revised in the Medicaid Provider Manual. Each carefully considered change addresses challenges. In some areas, psychiatric care is not available, and telepsychiatry is now included; Physician Assistants and Clinical Nurse Specialists may assist in providing psychiatric care in a manner similar to the previously approved Nurse Practitioners role. Additionally, up to one FTE paraprofessional staff may count in the 1:10 ratio. Only ACT Teams are in the unique position to assess changing consumer needs 24/7, adjust treatment and/or provide onsite pre-admission inpatient screens. Routine for many teams, pre-admission inpatient screening requirements were new for others.

Because early treatment is critical to engagement and long-term recovery, in FY20, two pilot sites will each treat up to five people experiencing First Episode Psychosis (FEP) using Navigate on existing ACT teams. The pilot ACT teams will receive Navigate training, supportive consultation and information that compares, contrasts and sensitizes ACT staff to differences in FEP and most traditional ACT consumers.

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

Standard agency enrollment requirements for ACT, such as a history of multiple hospitalizations, LOCUS score, or ACT waiting list, can be waived to participate in the pilot, bypassing waiting lists and less intensive services to immediately access ACT treatment. CMH programs primarily provide treatment through Medicaid and not private insurance, thus eliminating access to coordinated intensive team delivered care consistent with the ACT (and RAISE/Navigate) model. In agencies that accept private insurance, ACT is not a covered service. Block grant funds will support ACT for FEP who are not covered by Medicaid assuring a path to intensive timely treatment.

**Family Psychoeducation**

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

Representation on the 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. An FPE Sustainability document has been updated, and a toolkit created. Quarterly Steering Committee meetings focus on FPE staff’s current needs and challenges. In effort to maintain high fidelity, technical assistance/fidelity reviews are offered to PIHPs annually. There are 17 active supervisors/trainers spread regionally to provide regular supervision throughout the State.

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

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

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

- **MIFAST:**
  Integrated Dual Disorder Treatment (IDDT) readiness assessment, onsite fidelity reviews, and follow-up technical assistance including training, coaching and consulting.
  Dual Disorder Capability in Mental Health Treatment (DDCMHT) onsite reviews and follow-up technical assistance including training, coaching and consulting.

- **Practice Improvement Steering Committee (PISC):**
  The PISC has goals and objectives for the continuance of implementation sustainability and improvement of the standards of practice for integrated treatment. Quarterly meetings of this Committee include a standing agenda for Co-occurring Competency in both Mental Health and Substance Use Disorder Treatment as well as Integrated Treatment for Co-occurring Disorders (formerly Integrated Dual Disorder Treatment) which is specialized care for Co-occurring disorders at the ACT level. The project leader reports on the prior quarter activities as well as implementation plans and activities for the next quarter. Evaluation of the program and improvements targeting performance trends are discussed.

The 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 2020-2021 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.

An annual 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. This event includes various classes specific to clinical supports and services. Participants are able to attend classes on screening, assessment, facilitation skills for developing and individualized plan of service from the person-centered planning process, interventions specific to co-morbid effects of both disorders on functioning, matching treatment approaches to level of readiness and evaluating and adjusting treatment goals, supports and services.

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

Motivational Interviewing

Motivational Interviewing (MI) is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalence resulting from conflicting beliefs about change is the
primary obstacle to behavioral change. Motivational Interviewing is an evocative, assistive and collaborative facilitation strategy that helps to resolve ambivalence by finding and strengthening intra-personal motivation for the overcoming of ambivalence and promoting changes in behavior. MI represents a philosophy as well as a set of skills for effectively engaging and assisting Michigan’s behavioral health system’s service recipients facing one or more areas of difficult behavior change. Behaviors over a wide range, including participation and follow-through with supports and services, improving effectiveness of medications and treatments, behaviors for remaining in safe and affordable housing, benefiting from achieving and sustaining employment, relationships and increasing the ability to manage recovery activities independently are all examples of the beneficence of Motivational Interviewing practice.

Goals for 2020-2021 and beyond regarding MI include:

- Review and improve 20 MI Training Modules on www.improvingmipractices.org
- 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, coaching, 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, and result in significant and severe harm to those afflicted.

- With approximately 40 DBT teams delivering services across Michigan’s public behavioral health system, most PIHP regions feature one or more DBT team providing this evidence-based treatment to service recipients with Borderline Personality Disorder.
- Ongoing core and refresher training continues to be provided annually to Michigan’s public behavioral health workforce, along with evaluation of the effectiveness of the current training approach, using outcomes from training surveys as well as information on the continuing development of the model to make improvements that are cost-effective and help strengthen and sustain program and practitioner skills.
- Increase use of the practice knowledge exam, which has been developed to better gauge the level of core knowledge and skills of DBT practitioners, as well as to inform future training and support for performance quality. The DBT practice knowledge exam is available via the www.improvingmipractices.org website. Test results are immediately available to MDHHS for aggregation and analysis for the purposes of supporting high-quality service delivery, and to help inform needed training moving forward.
- Statewide efforts to improve and expand the quality and availability of DBT services is being guided by a DBT Subcommittee, led by experienced practitioners from within
Michigan’s behavioral health service network, and includes DBT team leaders, which advances the products of its work to the PISC.

- The sub-committee formed into an arm of the MIFAST for DBT. The team trained on the Global Informational Index (GOI) as an on-site evaluation tool and used it in nine site visits to assist teams in identifying the degree to which they have achieved implementation and identify areas for further development. A DBT specific tool developed in 2015 for use along with the GOI for site assistance has resulted in 20 reviews and follow-up consultation and training for areas identified by the site visit activity as requiring further development. In 2020 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 24 Individual Placement and Support (IPS) sites actively providing services and striving to achieve or maintain at least fair fidelity. These IPS sites represent 12 of the 46 Community Mental Health Services Programs (CMHSPs) in Michigan and provide these services in 21 of the 83 counties in Michigan. One former agency financially failed and so that IPS ended. Four new IPS sites have emerged in the last 18 months all achieving a FAIR baseline fidelity review in the spring and summer of 2019. The Upper Peninsula as well as other rural areas struggle with efforts to build and/or follow the IPS model and are challenged to determine enough potential candidates to merit a full-time staff. Funding and budgeting for IPS employment staff is also challenging given its clear focus on INDIVIDUAL Competitive Integrated employment versus historical models. Outreach has continued through technical assistance for counties considering the IPS model.

The State lead continues to meet with the Michigan core review team on a quarterly basis. Training events are intentional by invitation to supervisors, sites and organizations committed to following or showing sincere interest in launching a site prepared to follow the IPS model.

In the 2nd quarter of Fiscal Year 2019, 1690 individuals with serious mental illness were supported through the Michigan IPS initiative. The cumulative average wage per hour was $11.00 and cumulative average hours worked per week was 27.65 hours. All jobs were reported as competitive, integrated employment. Although significant progress has been made in recent years, efforts continue to increase reporting employment data, set goals, and promote stronger partnering with vocational rehab for shared successes. Key focus areas to increase quality employment outcomes for FY 2020 and beyond include:

**Core Review Team:**
The core review team has consistently maintained eight active members. The State lead anticipates one or two of these individuals may leave the team due to retirement and work changes. Two new individuals are beginning a very intentional year of more of orientation, which is expected to meet the review needs for the immediate future.

**Funding Challenges:**
There continues to be significant variance in the rates and/or staffing costs associated with these 24 IPS providers. Six 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 worked with its current IPS sites to increase the contract payment amount to better cover actual program costs. This has brought valued stability to most of the now nine sites.

It continues to be clear that in order to grow the IPS model in Michigan, a strategy must be developed to not only develop new IPS sites but to provide the framework to support that growth through timely reviews, training events, and even consideration/implementation of incentives to gain heightened provider commitment. A Michigan IPS Summit will be held in late July 2019 with national presenters, facilitation of interactive sessions with vocational rehabilitation partners, and many of the core fidelity review team. We are also strategically working to include peers to advance and improve our work.

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

Michigan DB101 - Disability Benefits 101 at [http://www.mi.db101.org](http://www.mi.db101.org) has grown with six videos available to address basic SSI/Medicaid and SSDI/Medicare concerns related to employment. By focusing on webinar trainings on the use of this site, it saved IPS professionals time working individuals, and provided almost immediate information on changes to disability benefits when planning employment or changing jobs.

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

**Documentation and Data Tracking:**
Michigan has implemented a requirement that each CMHSP will report quarterly the number of individuals employed (focus on individual, competitive, integrated employment), average hours and average wage. Michigan is also collecting an additional 24 data points ranging from 90, 180, & 365 job retention, vocational rehabilitation eligibility, Medicaid/Medicare, number of employment specialists, and other data points. Collecting such quarterly data is allowing the State to more effectively create policy, procedures and contracts to advance IPS. CMHSPs or providers now clearly recognize the need to attain State approval to present themselves as a recognized IPS site.

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) guided the
development of an updated Memorandum of Understanding (MOU) at the state level in November of 2017. We continue to grow as partners with State-level agency changes, many new staff, and other employment initiatives such as Employment First. Michigan remains committed to the IPS initiative and seeks strategies for effective growth that honors high quality fidelity and increased employment outcomes for Michigan citizens with serious mental illness.

**Older Adults**

Older adults are eligible for the same service array as younger adults within the public behavioral health system. In FY 2017 over 11,728 older adults (65 and over) received public behavioral health services, which is approximately 5% of the total number of adults served. Approximately 4,028 of these individuals had an Intellectual/Developmental Disability, 6,530 had a mental illness, and 1,170 had both.

The Older Adult Wellbeing Workgroup is an MDHHS planning and networking monthly meeting with department specialists and stakeholders focusing on older adult behavioral health issues in serious mental illness and substance use disorder. There is a particular emphasis on prevention through the Office of Recovery Oriented Systems of Care.

MDHHS continues to partner with Lansing Community College in the Mental Health and Aging Project (MHAP), to provide a variety of seminars and workshops related to both mental illness and dementia. An annual Mental Health and Aging Conference and regional seminars focus on the mental health needs of elders. Other partnerships include collaborative work with the Michigan Assisted Living Association (MALA), providing materials, curriculum, and training on dementia care to staff of facilities whose residents include over half persons with dementia. MDHHS is supporting MALA’s two-day Dementia Trailblazer Conference which includes national and international speakers as well as workshops by persons living with dementia.

The work of the Michigan Dementia Coalition, a grassroots collaboration of representatives of universities, community agencies, and state government units continues. MDHHS is reviewing their newly developed 2019-2022 Roadmap for Creating a Dementia Capable Michigan. In 2019, the Older Adult Wellbeing Workgroup was formed with MDHHS and stakeholders to network, inform colleagues and discuss resources.

**Clubhouse**

Currently there are 44 Clubhouses that serve over 4,500 consumers in the state. 39 of these Clubhouses are fully accredited with Clubhouse International. The balance of the clubhouses will be fully accredited by the end of FY21.

There are clear differences in outcomes between Clubhouse International (CI)-Accredited clubhouses and non-CI-Accredited clubhouses, particularly in transitional employment (TE). Based on the latest Michigan Clubhouse Survey (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 FY19 MDHHS sponsored 20 different Michigan Clubhouses to participate in 2-3 emersion training through-out the United States. The initiative provided funding for Clubhouse colleagues (members and staff) to attend comprehensive trainings at any of the 6 accredited training bases in North America. Comprehensive trainings come in the form of 3-week or 2-week courses. All trainings are for 1 staff and 1 member for the full duration, and one administrator for the final week. The trainings follow a uniquely experiential program where colleagues are immersed in the practices of some of the strongest Clubhouses in the world. Training content includes Employment Development, Education Support, Meaningful Work-Ordered Day & Relationships Opportunities, Physical Wellness and more. Many Michigan Clubhouses need assistance to attain model fidelity, and comprehensive trainings like these are a catalyst for strong, positive changes. High fidelity Clubhouses provide a better experience, significantly improve mental health, and are very cost-effective. MDHHS will continue to sponsor 20 Clubhouses annual to attend emersion training.

**Clubhouse Mentoring:** FY20 will be the third year of the Clubhouse Mentoring program. Eight (8) accredited Clubhouses volunteered to mentor newly accredited Clubhouses, or those who are in the beginning stages of the accreditation application process. Each Mentor Clubhouse maintains consistent communication and provides mentoring with several Clubhouses across the state, based on proximity. A total of 30 Clubhouses are currently being mentored. MDHHS will continue to support this effort in FY20 and beyond.

**Data Collection:** Michigan is in the process of finding ways to improve data collection capabilities for Clubhouses. Better data will shed light on program effectiveness and will identify gaps for improvement. Beginning in FY20, Michigan is also rolling out a data pilot program with three to five identified sites. The pilot program will allow data from all Clubhouses in the state to be centrally collected. This could illuminate trends in member employment, education, wellness, service costs, mental health outcomes, housing/homelessness prevention, and much more. In order to do this, better software is needed that is tailored to a Clubhouse’s unique needs and offers the privacy protection that is necessary. The deeper value of integrating data into a
Clubhouse is that members get to work hands-on in the collection and analysis of the information, thereby teaching them more skills that can be utilized in other real-world applications such as employment. New user feedback would be shared as needed during the pilot year.

**Jail Diversion**

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 were 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 mental illness and developmental disability interests; mental health, DD advocate; school administration; juvenile courts; and children’s medical psychiatric.

The Mental Health Diversion Council 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 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 statewide. 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 were 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 transportation to and from treatment appointments, access to peer supports (all of this is considered on the whole as a “warm handoff”).
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 interact 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 the Sequential Intercept Model 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). The Mental Health Diversion Council is working to utilize the Sequential Intercept Model as the common language that the state uses in describing jail diversion efforts and recognizing gaps therein.

Data and Evaluation:
The Mental Health Diversion Council has partnered with Wayne State University (WSU) to supply comprehensive data and evaluation reports for each pilot individually and as a whole. What this means is that the WSU 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.
Stepping Up Technical Assistance:
The Center for Behavioral Health and Justice (CBHJ) through Wayne State University is providing technical assistance to those communities around the state that are seeking to bolster their jail diversion efforts through the national Stepping Up initiative. This initiative utilizes a community’s County Commission as it’s focal point and the CBHJ assists county’s by shepherding them through a series of questions that get them to a point of working with stakeholders more effectively and helps them gather data to seek the best path of diversion programming.

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

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

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

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

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

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

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

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

1. Conduct cross-training initiatives to assure the publicly funded behavioral health care system is appropriately trained on Veteran and Military culture; and provide training on effective behavioral health care screening and referral for Veteran and Military groups as requested
2. Engage in inter-and-intra agency collaboration in order to leverage resources and partnerships
3. Identify, train and embed Veteran Navigators/Liaisons into the publicly funded behavioral health care system throughout the State of Michigan
4. Provide the publicly funded behavioral health care system with resources to evidence-based programs in order to strengthen Military families
5. Develop processes and systems to gather and utilize data to gain a clearer perspective on Veteran and Military families in Michigan, their needs and gaps in services
6. Leverage additional resources for long-term sustainability of this plan
The core of this BHDDA plan has been designed around a 5-pronged coordinated approach among key stakeholders and their partners to meet the comprehensive needs of Veterans and Military family members across the state: (1) MDHHS, including BHDDA and provider network of PIHPs, CMHSPs, and SUD treatment and prevention providers, as well as Adult/Family Services local offices and the Director’s office Veteran Liaison; (2) Veteran’s Affairs and Michigan Veterans Affairs Agency, in conjunction with Veterans Community Action Teams (VCAT), Michigan Veteran Trust Fund, and VCAT Regional Coordinators; (3) Michigan Army National Guard; (4) Other significant community assets including 211, Give an Hour, Partners in Care, Military Support Programs and Network-Buddy-to-Buddy and service groups such as the Veterans of Foreign Wars and American Legion; and (5) Cross-Training on military culture for the behavioral health care field and training on behavioral health issues for Military units.

Beginning in FY17 combined MHBG and SABG began funding a PIHP Regional Veteran Navigator in all ten PIHP regions. During the first year of implementation, performance indicators on number of individuals reached were exceeded by 1200%. Since then, 70% of Veterans, Military Members and their families connected to the Veteran Navigator program report being better equipped to reach out for help. These efforts will continue in FY20 and 21.

Other efforts being initiated or continuing in FY20 and 21 through the use of both mental health and SUD block grant funds include:

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

**Recovery-Oriented Care / Recovery Support Services**

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

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

This fiscal year a partnership with the Michigan Community Health Worker Alliance (MICHWA) provided the opportunity to train both CPSS and Certified Peer Recovery Coaches (CPRC). Forty-two individuals have achieved certification requirements. The Community Health Worker (CHW) training has increased the skills of the workforce in assisting individuals served by the public behavioral health system to self-manage their physical health conditions. Currently Michigan is one of three states invited by SAMHSA over the past 3 years.

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

Expansion with a former BRSS TACS grant to train individuals in prisons across the state as a peer support specialist and/or peer recovery coach has resulted in 94 individuals receiving certification. Michigan Department of Corrections has sustained and expanded the project. Additional continuing education training is provided to assist with re-entry into communities as returning citizens and to provide job opportunities as peers.

**Consumer/Peer-Run Services and Advocacy**

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

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

**Integrated Physical & Behavioral Health**

MDHHS continues to fund efforts to better integrate mental health and substance use disorder treatment services with physical health services. This occurs in a variety of settings including Federally Qualified Health Centers (FQHCs), in primary care clinics, CMHSPs and other health care settings.
Each fiscal year, an increasing number of projects have requested and received funding for integrated health efforts. For FY 19, twenty projects are receiving funding for integrated health. Activities funded include technology enhancements to the electronic health record and data analytics for population health, dedicated integrated health team staff such as nurse practitioners, peers as health coaches, health navigators/care coordinators, and a “Food As Medicine” project which partners a CMHSP with the local community college culinary project to provide nutrition and healthy eating education outreach to direct care workers and dietician services for consumers. A number of Michigan’s Federally Recognized Native American Tribes have also requested and received funding for integrated health efforts to secure, enhance dedicated psychiatric services and clinical staff, assist with transportation, and enhance health and wellness activities such as traditional healing. It is anticipated that communities will continue to seek funding for new strategies or to enhance existing integrated health strategies.

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

**Trauma-specific and Trauma-informed Services**

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

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

Trauma specific Evidence Based Practices have been included in this project and include Trauma Focused Cognitive Behavioral Therapy, Trauma Recovery and Empowerment (TREM), and MTREM), Seeking Safety, and Prolonged Exposure Therapy.
An arm of the MIFAST has been developed to provide an ascertainment of the degree to which agencies have achieved implementation of Trauma Informed Care. A standardized tool for measuring the degree to which agencies provide trauma informed and trauma specific supports and series is used and a cadre of staff who are experts in Trauma-Informed Care provide on-site reviews, training, consultation, and coaching. FY20 will be the fourth year of the Trauma MIFAST implementation program with a goal of completing 6 reviews and adding a trauma summit event with the intention of continuing as an annual event.

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. State agencies in Michigan are organized in such a way that each agency may provide multiple services. As of April 10, 2015, an executive order went into effect that merged the Michigan Department of Human Services and the Michigan Department of Community Health into one department, the Michigan Department of Health and Human Services (MDHHS). MDHHS is responsible for public health and behavioral health services, medical and dental services, Medicaid and Children’s Special Health Care Services (Title V), employment and other disability related and state assistance programs. The Family Division of County Circuit Courts is responsible for juvenile court services. The state level policy direction to the local public mental health and substance use disorder service delivery system is provided by the Behavioral Health and Developmental Disabilities Administration which includes the Mental Health Services to Children and Families Division, which was moved out of the Children’s Service Agency and back into Behavioral Health in FY19. 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.

PIHP/CMHSP providers are required to have the capacity to treat co-occurring disorders as well. Some PIHP/CMHSPs have specifically focused on the treatment of co-occurring disorders (COD) in youth and these include Oakland and Central Michigan. Oakland County PIHP has held training in Motivational Interviewing in order to increase engagement of families in treatment, as well as addressing the mental health and substance use issues of adolescents and family members. CMH for Central Michigan also includes a specific COD focus on children/adolescents to assist with meeting goals around reducing their substance use. Several other PIHPs use Multi-Systemic Therapy (MST) as a strategy for addressing co-occurring disorders. In FY18, MDHHS sponsored a Motivational Interviewing training for CMHSP staff who serve children and families using MHBG funding. Additionally, Michigan received a State Youth Treatment-Planning (SYT-P) grant in Fiscal Year 2015 to develop and expand the infrastructure for adolescent and transitional age youth treatment and recovery support services. Through the 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.

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 FY20-21. 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. This RFP was offered again in FY18 and additional sites were added. These projects are ongoing. However, many barriers remain in the development of a statewide comprehensive SOC and access to mental health
services for children who need them. Human service agencies recognize that they need to continue to explore ways to reduce the duplication of services and maximize the use of funds.

Historically in Michigan and currently, efforts have been made to move children into communities from more restrictive out-of-home placement, while still providing beneficial and helpful treatment interventions. This movement has continued and will continue to be supported with mental health block grant funding. The development and implementation of intensive community-based services has been crucial to moving children into the least restrictive environment without compromising treatment effectiveness. Mental Health Block Grant dollars were offered to the CMHSPs in FY18-19 for start-up of Intensive Crisis Stabilization Services (Mobile Crisis) and Crisis Residential for children/youth. These services are essential pieces of the continuum of service for children with SED and providers continue to work on establishing and supporting these services in sufficient capacity. A major part of Michigan’s transformation plan has been the incorporation of family-driven and youth-guided practice, which has led to increased consumer choice and treatment interventions that are designed as the child and family desires. 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. Additionally, the MDHHS child welfare residential transformation process with consultation from children’s mental health staff continues. MDHHS continues to consult with the Building Bridges initiative to determine how this approach may enhance residential treatment for the youth to whom it may be beneficial. MDHHS is continuing to pilot Treatment Foster Care – Oregon in two urban communities and is in the process of onboarding an additional site. 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 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.) 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. To date the team has served over 140 children.

Michigan has also successfully utilized the 10% set-aside for First Episode Psychosis services for young adults. There are four pilot sites in Michigan, with one or two more to be added in FY20, 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 FY20-21 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 recently been awarded several collaborative federal grants in which MDHHS is a partner including the SAMHSA Healthy Transitions grant and the HRSA Child Collaborative Care-Connect grant.

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 to 7 the Preschool Early Childhood Functional Assessment (PECFAS) (Hodges, 1994a)⁴ are used to assess treatment effectiveness for all children served in the public mental health system. With regard to MDHHS monitoring the effectiveness of public mental health services to children and youth with SED, MDHHS contracts with Michigan State University (MSU) to procure the services of Dr. John Carlson and student assistants required to produce the Level of Functioning (LOF) Project, at an amount not to exceed $35,621 annually, which evaluates the functional assessment data collected on every child with SED served by the public mental health system. MSU LOF Project staff works collaboratively with Multi-Health Systems (MHS), the purveyor of the CAFAS and PECFAS tools, to obtain information entered into the FAS Outcomes system by direct service providers who serve children with SED in the Michigan public mental health system. This information is analyzed and used to generate reports that demonstrate the amount of improvement in functioning of children with SED served that has occurred under several pre-determined conditions. Special attention is given in analysis to the variables associated with positive outcomes as measured by both initial (from previous fiscal years) and most recent/exit CAFAS and PECFAS ratings. For those receiving evidence-based practices (EBPs), scores prior to receiving those services will be used to reflect the potential improvements resulting from the EBP. Reports are shared with CMHSPs/PIHPs annually to utilize in children’s mental health services quality improvement activities. MDHHS continues to utilize block grant funds to support 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.

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.

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 FY20-21. 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 FY20-21.

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 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 has 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. Some of the very important goals of this project were 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.

MDHHS is also very interested in making sure that the community-based services and supports that are available in the public mental health system to serve children with SED are resulting in positive outcomes for these children and families. In addition to the LOF Project mentioned above, MDHHS will continue to contract with Michigan State University to procure the services of Dr. John Carlson and student assistants required to evaluate particular approaches and services, at amounts not to exceed those listed next to each project annually, to ensure that public mental health services funded by all sources are producing optimal results.

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

- **Children’s Trauma Initiative Evaluation $101,959:** MSU and MDHHS Children’s Trauma Initiative staff work collaboratively with CMHSP direct service providers involved in the Michigan public mental health system’s Children’s Trauma Initiative to determine the effectiveness of the services being provided to children who have experienced trauma. Outcome and fidelity information is collected via the Research Electronic Data Capture (REDCap) system and analyzed. Information is analyzed on a regular basis and consultation provided to allow project staff to generate/create brief reports to be shared with the field across the year. An end of the fiscal year report for each of the three subprojects (TF-CBT, Screening, Caregiver Education) is generated as well.

- **Parent Support Partner Evaluation $88,822:** MSU, MDHHS, ACMH and direct Parent Support Partner (PSP) service provider agencies work together to collect and analyze information being submitted via REDCap about the provision of the PSP service to parent participants who are receiving PSP services in the public mental health system. Providers can access the online system for real-time data review and additional analysis through the availability of report features to monitor service provision and outcomes. Through a peer-parent relationship, parents/caregivers feel increased hope and confidence and are empowered to find and use their voices so, in partnership with providers, they can inform services and supports for their child/youth—thus leading to better outcomes.

- **Wraparound Evaluation $141,588:** MSU, MDHHS and direct Wraparound service providers work together to determine and demonstrate the effectiveness of Wraparound services being provided to children with SED in the public mental health system across the state of Michigan. The purpose of this analysis is to examine the effectiveness and fidelity/acceptability of services currently being delivered under the leadership of Wraparound facilitators. Information regarding outcomes gathered from Wraparound facilitator ratings on the Family Status Reports (FSR) is submitted via REDCap and analyzed regularly and full feedback reports are completed semi-annually. Analysis involves looking at
outcome variables over time for improvement and the relationship between outcome data and fidelity data to determine if certain Wraparound practices and services are leading to improved outcomes.

- **Children with Serious Emotional Disturbance (SED) and Neuro-developmental Disorders (NDD) Strategies Evaluation $50,021**: MSU SED/NDD Strategies staff work collaboratively with MDHHS and CMHSP/PIHP participants that are serving children with SED/NDD in the public mental health system using specified techniques to determine if these techniques improve outcomes for this population and to inform treatment for children with SED/NDD in the entire system. Outcome and fidelity variables are collected from CMHSP/PIHP direct service providers via REDCap. An annual report for each of the treatment initiatives (e.g., screening and assessment, Families moving Forward, SED/NDD Strategies) is provided annually to be shared with MDHHS, the sites and the entire public mental health system.

- **Infant and Early Childhood Mental Health Consultation (IECMHC) Evaluation $70,000**: MSU IECMHC staff work collaboratively with MDHHS and CMHSP/PIHP IECMHC participants that are serving children with SED to determine the effectiveness of the intervention. Evaluation includes assessment of program impact on (1) child care provider caregiving practices, (2) the impact of these practice changes on young children’s social and emotional development, (3) the impact of these practice changes on program/child expulsion rates, (4) caregiver reflective capacity; (5) carrying out the IECMHC model as intended (fidelity), and (6) perceptions of program acceptability. Reports of outcomes and trends are provided on an annual basis.

All these evaluation projects are for the betterment of the public mental health system for children and the good of the people of Michigan.

**SUBSTANCE USE PREVENTION**

Michigan Department of Health and Human Services (MDHHS) is responsible for health policy and management of the state's publicly funded health service systems. The Michigan Public Health Code, Public Act 368 of 1978 (as amended), Sections 6201 and 6203, establishes the state's single state authority (SSA) and its duties. The Office of Recovery Oriented Systems of Care (OROSC) functions as the SSA within MDHHS. Responsibilities include the administration of federal and state funding for substance abuse prevention, treatment, recovery, and gambling 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 Strategic Plan FY2019 – FY2023, Priority 1: Combating the Opioid Crisis through the Expansion of Prevention, Treatment, and Recovery Support Systems and Priority 3: Advancing Prevention, Treatment, and Recovery Support Services for Substance Use, OROSCs approach to prevention aligns with the following objectives: 1.3: Improve access to, utilization of, and engagement and retention in prevention, treatment, and recovery support services; 1.4: Target the availability and distribution of overdose-reversing drugs; 3.1: Increase public awareness and subsequent behavior change regarding the risks of substance use with a focus on alcohol, marijuana, and stimulants; 3.2 Expand community engagement around substance use prevention, treatment, and recovery; 3.3 Reduce youth substance use initiation through strengthening protective factors and reducing risk factors; and, 3.4 Support the identification and adoption of evidence-based practices, programs, and policies that prevent substance use, increase provision of substance use disorder treatment, and enable individuals to achieve long-term recovery. The overall purpose of OROSC’s prevention efforts is to utilize both community and individual level interventions to address the prevention priorities - reducing underage drinking and marijuana use among persons aged 12-20, prescription drug misuse and abuse and heroin use among persons aged 12-25, and youth tobacco use - by building upon and enhancing the current community substance abuse prevention infrastructure and capacity at the PIHP regional level by strengthening collaboration and partnerships with a focus on primary care providers, local intermediate school districts and school health centers and the communities they serve. In addition, there is an emphasis on prevention with older adults ages 55+.

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); 5) Strategic Prevention Framework Partnerships for Success II (PFS II); and, 6) Partnership for Success 2015-2020 Grant and recently the State Targeted Response to the Opioid Crisis Grant and State Opioid Response 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 / SOR 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
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 school 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.
- OROSC has developed a new partnership with the MDHHS’ Mental Health Services to Children and Families to fund Social / Emotional Consultants to intervene with childcare providers and families to improve the social, emotional and behavioral health of young children.

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 2013 Michigan 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 and MiYRBS.

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

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

**INDIVIDUALS 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 inject drugs (PWIDs): 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. In addition, harm reduction efforts include funding for Syringe Service Programs (SSPs) through local health departments. SSPs collaborate with PIHPs’ access centers to provide treatment support.

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 a SUD also have a mental health concern. There are several residential programs in the state that offer services to the adolescent population, as well as numerous outpatient treatment centers. Children and youth who are at risk for mental, emotional and behavioral disorders, including but not limited to addiction, conduct disorder and depression: This population is not served through the SUD treatment system, but can access prevention and mental health services.
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 childcare are offered both to mothers and fathers who are primary caregivers. Michigan law ensures parents at risk of losing their children to the child welfare system are a priority population in Michigan and are able to access SUD treatment services immediately.

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

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

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

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

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

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

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

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.
- A needs assessment regarding older adults age 55+ determined an increase in alcohol and opioid use disorders among this population. Interventions will be explored to address the older adult population.
Planning Steps

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

Narrative Question:
This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. 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.

A data-driven process must support the state's priorities and goals. 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, 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 disorder prevention, 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.

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, 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.

Footnotes:

ADULTS WITH SERIOUS MENTAL ILLNESS (SMI)

Michigan’s estimated population was around 9,995,915 persons as reported by the July 1, 2018 United States Census Bureau. Of that number 78.3% were over the age of 18, constituting an estimate of 7,826,680 adults. Per the 2016-2017 data set (most recent available) provided by the National Survey on Drug Use and Health (NSDUH), 4.56% (349,000) of Michigan’s adult population are estimated to have serious mental illness, and there were 231,306 persons served through the Michigan mental health services system in 2017. Penetration rate per 1000 was 23.22, slightly lower than national rate of 22.69. Nearly 72% of these persons served met the federal definition of having a serious mental illness, slightly above the US average of 70%. According to this same data set, 27% of adults served were individuals with a co-occurring MH/SA disorder, which is equal to the national rate of 27%.

These figures suggest a significant gap between the prevalence of serious mental illness estimated in Michigan’s population and the penetration of public sector mental health services. It is unlikely this difference of 117,694 individuals can be fully accounted for by being served in the private-sector, or via other systems. Improvement in identifying, engaging, and serving adults who may be in need of public sector mental health services in Michigan continues to be needed. This gap between prevalence and service penetration continues to support the global need for greater availability of and access to care for Michigan’s adult serious mental health population. These are needs that block grant funding resources can assist in meeting.

Characteristics of adults served in Michigan based on the 2018 SAMHSA Uniform Reporting System show the largest age group is aged 25-44 (32.9%), with a 31.4 per 1000 population penetration rate. Across the nation, this is also the largest age group receiving services (31.7%), with a slightly lower penetration rate of 28.7 per 1000. The next largest age group receiving services in Michigan are aged 45-64 (28.9%) with a 24.5 penetration rate, compared to national data showing 25.4% served with a 23.5 per 1000 penetration rate.

Other age demographics and percentage of Michigan adults served were age 18-20 (4.6%) with a penetration rate of 26.5; 21-24 (6.4%) with a penetration rate of 25.9; 65-74 (3.9%) with a penetration rate of 9.2; and age 75 and over (1.2%) with a penetration rate of 3.9. Michigan demographic percentages of adults served are higher in each age group with the exception of age 75 and over (US 1.5%).

Compared to the US, Michigan has a lower percentage of women receiving services than men at 45.4%; national percentage of 51.4%. Men receiving services in Michigan comprises 49.9%, compared to US at 48.1%. This could be indicative of the lower penetration rates in Michigan for women as compared to men. In Michigan, the penetration rate for women is 20.8, compared to the Midwest at 26.7 and the US at 24.0. The penetration rate for men in Michigan is 23.5, compared to the Midwest at 25.4 and the US at 23.1.

In terms of race, individuals who are white comprise 51.9% of persons served in Michigan as compared to the US at 59.9%, with the corresponding penetration rates of 15.2 in Michigan compared to 18.7 in the US. The next largest racial group receiving services, which is a change
from the previous application, is Multi-Racial at 18.6% in Michigan compared to 2.8% in the US. Michigan has a higher penetration rate of 177.3 per 1000, compared to both the Midwest at 52.8 and the US at 26.5. Black/African American population accounted for 17.7% of individuals receiving services in Michigan, compared to 18.4% in the US. American Indian/Alaskan Native population accounted for 0.5% of individuals receiving services in Michigan, compared to 1.3% in the US. In Michigan, 4.7% of individuals receiving services identified Hispanic/Latino ethnicity, compared to 14.9% in the US, with penetration rates being higher in Michigan (21.5) versus the Midwest (13.4) and the US (18.9). Ethnicity was not available for 14.8% of individuals receiving services in Michigan, compared to 9% in the US.

As previously noted, nearly 72% of adults served in Michigan met the federal definition of having a serious mental illness. In Michigan, more women (50.6%) than men (49.4%) met this definition, which is similar to national figures of 52.2% women and 47.7% men. A variance in Michigan as compared to the US revealed a smaller proportion of young adults ages 18 to 20 in Michigan (2.7%) suffered serious mental illness than in the nation overall (4.4%), however penetration rate for this age group in Michigan was 8.4 per 1000 population, compared to 19.0 rate for the nation.

According to 2016-17 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 (24.05%) to the national average (23.93%). Findings of any mental illness for Michigan adults aged 26 and older were slightly less (17.39%) when compared to the national average (17.69%).

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 2017 age-adjusted suicide rate was 13.6 per 100,000 individuals, 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 1,405 suicides for all ages in 2017, 79.2% (1,113) of the decedents were male and 20.8% (292) were female. In 2017, intentional self-harm or suicide was the tenth leading cause of death in Michigan, which is comparable with the nation.

Data supplied by SAMHSA’s Uniform Reporting System – 2018 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:

<table>
<thead>
<tr>
<th>Evidence-Based Practice</th>
<th>Michigan Rate</th>
<th>US Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Psychoeducation</td>
<td>0.2%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Integrated Dual Diagnosis Treatment</td>
<td>1.3%</td>
<td>11.6%</td>
</tr>
</tbody>
</table>

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 on 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 https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Michigan-2018.pdf, Michigan is above the national average in terms of the evidence-based practices of Assertive Community Treatment (Michigan rate: 4.0%; national rate: 2.1%) and Supported Employment (Michigan rate: 3.8%; national rate 2.0%).

**CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE**

According to 2016 US Census figures, Michigan has an estimated population of 9,928,300, with approximately 2,194,154 of those residents being children ages 0-17. Prevalence data supplied by the Substance Abuse and Mental Health Services Administration’s (SAMHSA) 2013 National Outcome Measures Prevalence Report suggests 6-12% of the 1,184,104 children from ages 9 to 17 in Michigan could be identified as having a serious emotional disturbance (SED). That means anywhere from 71,046 to 142,092 children ages 9 to 17 might have been eligible for services in the public mental health system in 2013 alone. However, data compiled by MDHHS for FY17 indicates 43,314 children (ages 0 through 17) with SED were served in the public mental health system in Michigan. Improvement in identifying and engaging children who may be in need of mental health services in Michigan is needed.

In May 2019, 13,492 children were residing in out-of-home foster placements per MDHHS. According to the Michigan Department of Education (MDE) the statewide high school drop-out rate in 2018 was 8.7%, 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 4.2% in May 2019 which was much better than previous years but remained 0.6% above the national average of 3.6% for that same time. According to the Michigan League for Public Policy’s 2019 Kids Count Data Book, (https://mlpp.org/kids-count/national/national-2019-data-book/) Michigan ranked 30th out of 50 states for economic well-being. In 2017, 20% of children in the state lived in a family with income below the poverty line. This is two percentage points above the national average for this same time period. Data reported in the MDHHS’ Green Book Report of Key Statistics, May 2019 edition, indicates that 936,611 of Michigan’s children were eligible for Medicaid in that month. In addition, Medicaid births in Michigan are now approximately 43% of all births in the state. According to the Child Trends Data Bank (http://www.childtrends.org/?indicators=children-in-poverty,) poverty is related to increased risks of negative health outcomes for young children and adolescents. When compared with all children, poor children are more likely to have poor health and chronic health conditions. As adolescents, poor youth are more likely to suffer from mental health problems, such as personality disorders and depression. Moreover, in comparison to all adolescents, those raised in poverty engage in higher rates of risky health-related behaviors, including smoking and early initiation of sexual activity. Poverty in childhood and adolescence is also associated with a higher risk for poorer cognitive and academic outcomes, lower school attendance, lower reading and math test scores, increased distractibility, and higher rates of grade failure and early high school dropout. Poor children are also more likely than other children to have externalizing and other behavior problems, or emotional problems, and are more likely to engage in delinquent behaviors during adolescence. Poverty continues to be a major issue for children in Michigan.

Although the economy in Michigan has rebounded, the economic downturn in Michigan resulted in fewer resources for all child-serving systems during that time and the funding and support for such resources has not bounced back. This is unfortunate, but helped to create an environment where the former MDCH and MDHS (now MDHHS) were open to collaborating and matching funds which resulted in the SEDW pilot 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 will expand statewide in FY20 and continue to demonstrate fiscal saving and better outcomes for children and families.

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 2020-2022 will be to: 1) expand the scope of the SEOW to include treatment and recovery (not just prevention) and to include mental health disorder prevention and treatment, as well as mental health promotion; 2) continue to gather new data as it becomes available, particularly around prescription and over-the-counter drug abuse; 3) analyze data being gathered, and serve as a resource for both the state and local Community Epidemiology Workgroups (CEWs); 4) continue work on maintaining a web-based central data repository for Michigan that can be easily accessed and updated; and 5) evaluate and prioritize continued data gaps, and develop plans for filling these gaps.

The SEOW is chaired by the Prevention and Outreach Coordinator of Community Mental Health Authority of Clinton, Eaton, Ingham Counties (CMHA-CEI). Membership on the SEOW includes representatives of 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 June 18, 2018, the following are SEOW members:
<table>
<thead>
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<th><strong>Member Name</strong></th>
<th><strong>Organization</strong></th>
<th><strong>Workgroup Affiliation</strong></th>
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<tr>
<td>Elizabeth Agius</td>
<td>Wayne State University</td>
<td>Member</td>
</tr>
<tr>
<td>Lisa Gee-Cram</td>
<td>Michigan State Police</td>
<td>Member</td>
</tr>
<tr>
<td>Lisa Coleman</td>
<td>Region10 Prepaid Inpatient Health Plan</td>
<td>Member</td>
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<tr>
<td>Joseph Coyle</td>
<td>MDHHS/Division of Communicable Disease</td>
<td>Member</td>
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<tr>
<td>Jane Goerge</td>
<td>Community Mental Health Partnership of Southeast Michigan</td>
<td>Member</td>
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<tr>
<td>Brian Hartl</td>
<td>Kent County Health Department</td>
<td>Member</td>
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<tr>
<td>Denise Herbert</td>
<td>network180</td>
<td>Member</td>
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<tr>
<td>Patrick Hindman</td>
<td>MDHHS/ Lifecourse Epidemiology &amp; Genomics Division</td>
<td>Member</td>
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<tr>
<td>Joel Hoepfner</td>
<td>Community Mental Health Authority of Clinton, Eaton, Ingham Counties</td>
<td>Member/Chairperson</td>
</tr>
<tr>
<td>Scott Josephs</td>
<td>Michigan State Police</td>
<td>Member</td>
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<tr>
<td>Jeanne Kapenga</td>
<td>Physician</td>
<td>Member</td>
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<tr>
<td>Tom Largo</td>
<td>MDHHS/Injury Prevention</td>
<td>Member</td>
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<tr>
<td>Brittany Leek</td>
<td>MDHHS/OROSC (Prevention)</td>
<td>Member</td>
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<td>Mary Ludtke</td>
<td>MDHHS, Mental Health</td>
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<td>Rob Lyerla</td>
<td>Western Michigan University</td>
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<td>Lindsey Naeyaert</td>
<td>Michigan Primary Care Association</td>
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<td>Su Min Oh</td>
<td>MDHHS/OROSC</td>
<td>Member/SEOW Epidemiologist/Staff Liaison</td>
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<tr>
<td>Dawn Radzioch</td>
<td>Macomb County CMH Services</td>
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<td>Bill Ridella</td>
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<tr>
<td>Sarah Rockhill</td>
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<td>Brooke Rodriguez</td>
<td>Wayne State University</td>
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<td>Christy Sanborn</td>
<td>MSP/Office of Highway Safety Planning</td>
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<td>Larry Scott</td>
<td>MDHHS/OROSC</td>
<td>Member/PFS 20152020 Project Director</td>
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<tr>
<td>Angela Smith-Butterwick</td>
<td>MDHHS/OROSC (Prevention and Treatment)</td>
<td>Member</td>
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<td>Gery Shelafoe</td>
<td>NorthCare Network</td>
<td>Member</td>
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<td>Danielle Stolicker</td>
<td>Region 10 Prepaid Inpatient Health Plan</td>
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<tr>
<td>Brenda Stoneburner</td>
<td>MDHHS, Mental Health</td>
<td>Member</td>
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<tr>
<td>Gabrielle Stroh Steiner</td>
<td>MDHHS/Bureau of Epidemiology and Population Health</td>
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<tr>
<td>Stephanie VanDerKooi</td>
<td>Lakeshore Regional Partners</td>
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<tr>
<td>Richard Isaacson</td>
<td>Drug Enforcement Administration</td>
<td>Consultant</td>
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<tr>
<td>Jeff Wieferich</td>
<td>MDHHS/Quality Management and Planning</td>
<td>Consultant</td>
</tr>
<tr>
<td>Bret Bielawski</td>
<td>Physician</td>
<td>Consultant</td>
</tr>
<tr>
<td>Eva Petoskey</td>
<td>Anishnaabek Healing Circle Access to Recovery Inter-Tribal Council of Michigan</td>
<td>Consultant</td>
</tr>
</tbody>
</table>

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 FY2018, there were 20,313 treatment admissions where the route of use was identified as injecting. This number includes primary, secondary and tertiary drugs of choice. Of that number, 8,560 were women, and 447 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 109 TB cases reported in 2018, an average of 1.1 cases per 100,000 people which is well below the national average. Michigan has experienced a decline in TB cases from 2015 through 2018. MDHHS estimates that there were 1,720 HIV cases attributed to individuals who inject drugs in 2017. Individuals who inject drugs comprised 11% 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 diseases.
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. OROSC has increased LGBTQ data sources by partnering with YRBS for gender identity data. There is a need and desire to improve data collection, as well as identify and implement evidence-based programs and practices to address this target population.

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. Historically only a small number of providers utilized recovery supports (approximately 4%) due to the majority of families not having access to services after formal treatment ends. There is currently an expansion of recovery support systems and collaborations. More providers are interested in and investing in recovery supports. From FY2015 to FY2016, there was a $10.6 million drop in payment for all SUD services for those age 16-21. In FY2015 51% ($2,462,563) of all funds spent were on residential services for this population compared to 44% ($2,700,946) in FY2016. Actual amount spent went up nearly $250,000 from FY2015 to FY2016 but more efforts were put into non-residential services. This supports the efforts made to integrate treatment and recovery support services.

5. **Adult-Use Marijuana**

   On November 6, 2018, Michigan voters approved Proposal 1, creating the Michigan Regulation and Taxation of Marihuana Act (MRTMA). This legislation allows personal possession and
use of marijuana by persons 21 years of age or older as well as cultivation and sale of marijuana and industrial hemp by and to persons 21 years of age or older. Nationally, perceived risk of marijuana use among students in 8th, 10th, and 12th grades decreased since the mid-2000s. Fewer teens now believe using marijuana is harmful, but no significant increase in overall use. Coinciding with national results, marijuana use in the last 30 days among high school students has been leveled, from 19.3% in 2015 to 23.7% in 2017 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 2016 to 2017, overdose deaths involving heroin rose from 732 to 786 (rates from 7.6 to 8.2 per 100,000), while overdose deaths involving prescription opiate declined from 697 to 647 (rates from 7.2 to 6.6 per 100,000). Recent NSDUH surveys (2016-2017) reported that 0.3% (n=26,000) of Michigan residents, 12 or older, reported heroin use in the past year. Drawing upon the 2016-2017 NSDUH surveys, the estimated prevalence of illicit drug dependence or abuse in the past year for Michigan was 3.0% among persons aged 12 or older.
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](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 on-line through a subscription log in. In December 2016, Michigan expanded the TEDS web-based platform to implement SAMHSA’s new Behavioral Health (BH) TEDS. This system has stabilized in the 3 years since that inception. Michigan took this step, in part, 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, developed in-house working with the Michigan Department of Management and Budget. It is 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 or requested at this time.
### Table 1 Priority Areas and Annual Performance Indicators

<table>
<thead>
<tr>
<th>Priority #</th>
<th>Priority Area</th>
<th>Priority Type</th>
<th>Population(s)</th>
<th>Goal of the priority area</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>System of Care for Children/Youth with Serious Emotional Disturbance (SED) and Their Families</td>
<td>MHS</td>
<td>SED</td>
<td>Treatment outcomes for children/youth with SED and their families improve statewide.</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Annual Performance Indicators to measure goal success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator #: 1</td>
</tr>
<tr>
<td>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 FY20 and in FY21 from a baseline average obtained in FY16.</td>
</tr>
<tr>
<td>Baseline Measurement: 55%</td>
</tr>
<tr>
<td>First-year target/outcome measurement: 55% or more</td>
</tr>
<tr>
<td>Second-year target/outcome measurement: 55% or more</td>
</tr>
<tr>
<td>Data Source: John Carlson, PhD and the Michigan Level of Functioning Project.</td>
</tr>
<tr>
<td>Description of Data: Statewide aggregate CAFAS data.</td>
</tr>
<tr>
<td>Data issues/caveats that affect outcome measures: None.</td>
</tr>
</tbody>
</table>

| Indicator #: 2                                       |
| Indicator: The number of children/youth with SED served in the public mental health system that receive wraparound services will surpass 2000 in FY20 and again in FY21. |
| Baseline Measurement: 2,000 |
| First-year target/outcome measurement: 2,200 |
Second-year target/outcome measurement: 2,225
Data Source:
MDHHS Division of Quality Management and Planning State encounter data.

Description of Data:
Total number of children/youth served in wraparound per fiscal year.

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 FY20 and again in FY21 from a baseline of number served in FY18.

Baseline Measurement: 760
First-year target/outcome measurement: 775
Second-year target/outcome measurement: 780

Data Source:
MDHHS Division of Quality Management and Planning state Fingertip Report.

Description of Data:
Total number of children/youth served in PMTO per fiscal year.

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 FY20 and again in FY21 from a baseline of number served in FY18.

Baseline Measurement: 1,000
First-year target/outcome measurement: 1,050
Second-year target/outcome measurement: 1,100

Data Source:
MDHHS Division of Quality Management and Planning state encounter data.

Description of Data:
Total number of children/youth served in TFCBT per fiscal year.

Data issues/caveats that affect outcome measures:
None.

Indicator #:
5
Indicator:
The number of Parent Support Partners (PSPs) trained to work in the public mental health system will increase in FY20 and again in FY21 from a baseline of number trained in FY18.

Baseline Measurement: 216
First-year target/outcome measurement: 220
Second-year target/outcome measurement: 225

Data Source:

Description of Data:
Cumulative total number of PSPs trained.

Data issues/caveats that affect outcome measures:
None.

Indicator #: 6
Indicator: The number of Youth Peer Support Specialists (YPSSs) trained to work in the public mental health system will increase in FY20 and again in FY21 from a baseline of number trained in FY18.
Baseline Measurement: 43
First-year target/outcome measurement: 45
Second-year target/outcome measurement: 48

Data Source:
Michigan Youth Peer Support Training Project.

Description of Data:
Cumulative total of YPSSs trained.

Data issues/caveats that affect outcome measures:
None.

Priority #: 2
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 determined in FY18, number of youth screened in FY20 and FY21 will surpass FY18 baseline.

Baseline Measurement: 752
First-year target/outcome measurement: 760
Second-year target/outcome measurement: 770

Data Source:
Mental Health Juvenile Justice Screening Projects.

Description of Data:
Total number of youth screened per fiscal year.

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 FY20 and again in FY21 from FY18 baseline.
Baseline Measurement: 2,762
First-year target/outcome measurement: 2,770
Second-year target/outcome measurement: 2,775

Data Source:
MC3 Project.

Description of Data:
Total number of children served by integrated physical and mental health projects per fiscal year.

Data issues/caveats that affect outcome measures:
None.

Indicator #:
3
Indicator: The number of youth receiving co-occurring services will increase in FY20 and again in FY21 from FY18 baseline.
Baseline Measurement: 987
First-year target/outcome measurement: 1,000
Second-year target/outcome measurement: 1,050

Data Source:
MDHHS Division of Quality Management and Planning Encounter data.

Description of Data:
Total number of youth receiving co-occurring services per fiscal year.

Data issues/caveats that affect outcome measures:
None.

Indicator #:
4
The number of young adults receiving NAVIGATE first episode psychosis services through the 10% set-aside pilots will increase in FY20 and again in FY21 from the baseline obtained in FY18.

**Baseline Measurement:** 205  
**First-year target/outcome measurement:** 210  
**Second-year target/outcome measurement:** 215

**Data Source:** 10% Set-aside Project Coordinator.  
**Description of Data:** Total number of young adults who received NAVIGATE first episode psychosis services through the 10% set-aside pilots per fiscal year.  
**Data issues/caveats that affect outcome measures:** None.

**Priority #:** 3  
**Priority Area:** Psychosocial Rehabilitation - Clubhouses  
**Priority Type:** MHS  
**Population(s):** SMI  
**Goal of the priority area:** Psychosocial Rehabilitation / Clubhouse accreditation progress  
**Objective:** Utilize the final accreditation report from five Clubhouses who have gone through the accreditation process and received an accreditation status of a three-year conditional outcome on their most recent accreditation to demonstrate progress from one accreditation review period to the following accreditation review.  
**Strategies to attain the objective:** Review and track the final accreditation reports with the assistance of Clubhouse International. who will provide all data point reports.

### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>Indicator</th>
<th>Baseline Measurement</th>
<th>First-year target/outcome measurement</th>
<th>Second-year target/outcome measurement</th>
<th>Data Source</th>
<th>Description of Data</th>
<th>Data issues/caveats that affect outcome measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Track five Clubhouses over the course of the next re-accreditation review with an expectation for three of the five Clubhouses to demonstrate an upgraded accreditation status on their scheduled re-accreditation visit.</td>
<td>This is a new indicator with no baseline yet established.</td>
<td>At least one Clubhouse will demonstrate an improved accreditation report.</td>
<td>At least two Clubhouses will demonstrate an improved accreditation report.</td>
<td>Clubhouse International</td>
<td>Final full reports with recommendations from the accrediting body.</td>
<td>None.</td>
</tr>
</tbody>
</table>

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Priority #: 4
Priority Area: Individual Placement & Support (IPS)
Priority Type: MHS
Population(s): SMI

Goal of the priority area:
Measure IPS Competitive Employment Outcomes

Objective:
Increase to 26 recognized IPS Sites in Michigan and increase the percentage of individuals working continuously for 90 days

Strategies to attain the objective:
1. Share the annual Statewide IPS Report highlighting the 41% employment rate with all 46 Community Mental Health Services Programs.
2. Share news about IPS during partner organizational meetings.
3. Increase focus on 90 days of continuous employment.
4. Post/share the 90 day employment percentage across all IPS sites

### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>Indicator</th>
<th>Baseline Measurement</th>
<th>First-year target/outcome measurement</th>
<th>Second-year target/outcome measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Increase the employment rate of individuals in the IPS model</td>
<td>41% as of FY19, 2nd Quarter (Jan-Mar)</td>
<td>43%</td>
<td>44%</td>
</tr>
</tbody>
</table>

Data Source:
Michigan Behavioral Health and Developmental Disabilities Administration IPS Quarterly Data Report

Description of Data:
23 IPS Sites reported the number of individuals working during the quarter. This was divided by the total Statewide caseload during the 2nd quarter of FY 2019 (the denominator).

Data issues/caveats that affect outcome measures:
It is an aggregate average. It is susceptible to the economy.

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>Indicator</th>
<th>Baseline Measurement</th>
<th>First-year target/outcome measurement</th>
<th>Second-year target/outcome measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Increase the percentage of individuals working continuously for 90 days</td>
<td>8% as of FY19, 2nd Quarter (Jan-Mar)</td>
<td>9%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Data Source:
Michigan Behavioral Health and Developmental Disabilities Administration IPS Quarterly Data Report

Description of Data:
23 IPS Sites reported the number of individuals working during the quarter. This was divided by the total Statewide caseload during the 2nd quarter of FY 2019 (the denominator).

Data issues/caveats that affect outcome measures:
Aggregate average, susceptible to the economy.
Priority #: 5
Priority Area: Evidence-Based Practice Implementation
Priority Type: MHS
Population(s): SMI

Goal of the priority area:
Increase the impact of the Michigan Fidelity Assistance Support Team (MIFAST) implementation process on agency performance measures for Assertive Community Treatment / Integrated Dual Disorder Treatment (ACT/IDDT)

Objective:
Determine the degree to which the MIFAST review process is effective for improving selected performance measures and for improving overall General Organizational Index (GOI) performance across agencies

Strategies to attain the objective:
1. Evaluation of aggregated scoring data from ACT/IDDT reviews for FY19
2. Identify the average score for GOI 8-Supervision and all 12 anchors of the GOI across all reviews conducted in FY19 as baselines
3. Evaluate aggregated scoring data from FY20 for GOI 8-Supervision and for all 12 anchors of the GOI for agencies reviewed in FY19
4. Determine the degree of change resulting from having been reviewed in FY19 as demonstrated by a second review in FY20
5. Determine the impact of a 3rd review of the same agencies using aggregated data in FY21

Annual Performance Indicators to measure goal success

| Indicator #: | 1 |
| Indicator: | Increase score of GOI 8 by 1 full scoring point after 3rd review |
| Baseline Measurement: | 3.1 for Supervision (average across all reviews in 2019) |
| First-year target/outcome measurement: | 3.6 for Supervision |
| Second-year target/outcome measurement: | 4.1 for Supervision |

Data Source:
Aggregated scoring data from MIFAST reviews

Description of Data:
Aggregated scoring data across all reviews conducted in FY19, FY20, and FY21 for teams who have 3 reviews

Data issues/caveats that affect outcome measures:
The number of teams who have annual reviews may change by the end of the measurement due to staff, program, or funding changes.

| Indicator #: | 2 |
| Indicator: | Increase average score of the 12 GOI anchors by 1 full scoring point after 3rd review |
| Baseline Measurement: | 3.84 |
| First-year target/outcome measurement: | 4.3 |
| Second-year target/outcome measurement: | 4.84 |

Data Source:
Aggregated scoring data from MIFAST reviews

Description of Data:
Aggregated scoring data across all reviews conducted in FY19, FY20, and FY21 for teams who have 3 reviews

Data issues/caveats that affect outcome measures:
The number of teams who have annual reviews may change by the end of the measurement due to staff, program, or funding changes.
### Priority # 6
**Priority Area:** Veteran Navigator Increased Revenue/Cost Savings  
**Priority Type:** MHS  
**Population(s):** SMI

**Goal of the priority area:**
Demonstrate cost savings of 30% of Veteran Navigator budget

**Objective:**
In connecting previously unidentified Veterans with Veterans Benefit Agency (VBA), they will see an increase in their potential Service Connection and, ultimately, an increase in their household income.

**Strategies to attain the objective:**
Connecting all eligible Veterans with their local Veteran Service Officer (VSO) for a new claim or an appeal for a denied claim or an increase in disability claim.

### Annual Performance Indicators to measure goal success

| Indicator #: | 1 |
| Indicator: | Revenue Increase/Cost Savings |
| Baseline Measurement: | 53 Veterans in 9 months with increases from 0–100% Service Connection - Based on FY19 Budget of $873,000 |
| First-year target/outcome measurement: | Federal Revenue based on VBA benefit increases of $262,000 |
| Second-year target/outcome measurement: | Federal Revenue based on VBA benefit increases of $436,500 |

**Data Source:**
Veteran Navigator base information of number of Veterans that they have personally connected with that have seen a significant increase in Service Connection that was not previously being tracked in specifics

**Description of Data:**
Service Connection increase through VBA administered by VSOs

**Data issues/caveats that affect outcome measures:**
Not receiving current disability rating, Veteran non-disclosure, lack of VSO connection, data sharing

### Priority # 7
**Priority Area:** Veteran Navigator - Connecting Veterans to Community Supports Outside the VHA  
**Priority Type:** MHS  
**Population(s):** SMI

**Goal of the priority area:**
Increase the level of connection of Veterans/Non-VA Eligible Veterans to community mental health resources such as CMH and other community assets when the VA is either not an option or Veteran does not currently wish to engage with the VA despite a VA benefit.

**Objective:**
Increase by 10% the number of Veterans/Military Record Veterans that are being connected to community mental health resources first year and 20% second year

**Strategies to attain the objective:**
Veteran Navigators at all Prepaid Inpatient Health Plans and some Community Mental Health Services Programs will connect Veterans to community...
Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Connect Eligible and Non-Eligible Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and Operation New Dawn (OND) Veterans to community mental health resources
Baseline Measurement: Based on FY18 data collected, MDHHS served approximately 300 OIF/OEF/OND Veterans
First-year target/outcome measurement: 30 new OIF/OEF/OND Veterans to be connected to CMH/Community Mental Health Resources
Second-year target/outcome measurement: 60 new OIF/OEF/OND Veterans to be connected to CMH/Community Mental Health Resources

Data Source:
https://www.thenationalcouncil.org/topics/veterans/

Description of Data:
Veteran Mental Health data describing percentages particularly among OIF/OEF/OND Veterans and the lack of MH treatment for over 50% of them

Data issues/caveats that affect outcome measures:
Identification of OIF/OEF/OND Veterans and the willingness of Veterans to connect with resources

Priority #: 8
Priority Area: Workforce Development
Priority Type: MHS
Population(s): SMI
Goal of the priority area:
To support recovery the efforts of people receiving treatment services for serious mental illness and co-occurring disorders through workforce development in the Michigan public behavioral health system through improvingmipractices.org (IMP).

Objective:
Develop and offer learner centered courses and resources that support recovery efforts on improvingmipractices.org

Strategies to attain the objective:
Offer Michigan specific interactive asynchronous and blended learning opportunities

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of improvingmipractices.org users engaged in courses
Baseline Measurement: 1,920
First-year target/outcome measurement: 2,100
Second-year target/outcome measurement: 2,280

Data Source:
Google Analytics

Description of Data:
Website Summary 'IMP Analytics Report'
**Data issues/caveats that affect outcome measures:**
Variations and timing for training needs, agencies and staff decision to engage on IMP, ability to create and offer needed training

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Cumulative monthly number of unique users on improvingMIpractices.org</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>17,400</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>18,000</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>24,000</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Google Analytics</td>
</tr>
<tr>
<td>Description of Data:</td>
<td>Website Summary ‘IMP Analytics Report’</td>
</tr>
<tr>
<td>Data issues/caveats that affect outcome measures:</td>
<td>Variations and timing for training needs, agencies and staff decision to engage on IMP, ability to create and offer needed training</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Time to Treatment</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>FY18 Baseline = 13.8% of individuals waiting over 10 days to enter treatment</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>FY19 Target = 13.1% of individuals</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>FY20 Target = 12.4% of individuals</td>
</tr>
<tr>
<td>Data Source:</td>
<td>TEDS treatment admission record will be used to track the elapsed number of days between date of service request and actual services.</td>
</tr>
<tr>
<td>Description of Data:</td>
<td>Days of waiting are derived by subtracting the date of first request from the date of admission in the TEDS admission records.</td>
</tr>
<tr>
<td>Data issues/caveats that affect outcome measures:</td>
<td>Variations and timing for training needs, agencies and staff decision to engage on IMP, ability to create and offer needed training</td>
</tr>
</tbody>
</table>
Inconsistent reporting of the date of first contact in relationship to the admission date across the provider network

<table>
<thead>
<tr>
<th>Priority #:</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Area:</td>
<td>Increased Access to Treatment</td>
</tr>
<tr>
<td>Priority Type:</td>
<td>SAT</td>
</tr>
<tr>
<td>Population(s):</td>
<td>PWWDC</td>
</tr>
</tbody>
</table>

**Goal of the priority area:**

Access to treatment will be increased for parents with dependent children

**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

<table>
<thead>
<tr>
<th>Indicator #:</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Parents with Dependent Children Access/Retention in Residential Care</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>FY18 Baseline = 44.5% of parents with dependent children who continue 14 days in residential treatment</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>FY19 Target = 42.3% of parents with dependent children</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>FY20 Target = 40.2% of parents with dependent children</td>
</tr>
</tbody>
</table>

**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:**

Inconsistent reporting of the date of discharge that does not mirror the last date of a billable service

---

Priority #: 11

Priority Area: Increase the use of integrated MH and SUD 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: FY18 Baseline = 13.3% of expenditures |
|First-year target/outcome measurement: FY19 Target = 14.4% |
|Second-year target/outcome measurement: FY20 Target = 15.8% |

Data Source:
Section 904 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: Promote Health Births
Priority Type: SAT
Population(s): PWWDC

Goal of the priority area:
Promotion of Healthy births

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 care 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: 161 drug free births in FY 2018 |
|First-year target/outcome measurement: 170 drug free births in FY 2020 |
|Second-year target/outcome measurement: 175 drug free births in FY 2021 |

Data Source:
FY20 Target = 15.8%
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 continues to work diligently to ensure numbers are reported accurately and continues to encourage case management and recovery supports for pregnant women as they exit formal treatment. MDHHS has begun piloting NAS projects in each PIHP region to help connect women with an opioid use disorder with all the services she and the baby need for a successful deliver and postpartum period, and this allows for better tracking of healthy pregnancies as well.

Total birth rates in Michigan have decreased recently. This decrease in birth rates influences and impacts the number of drug free births, as well. This was taken into account as we decreased our target to reflect the decreasing birth rates overall in Michigan.

Priority #: 13
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) to prevention services.
6. Encourage the use of Communities that Care, Community Trials, or other appropriate coalition models in order to address underage drinking in communities.
7. Encourage the use of Strengthening Families, Prime for Life or other appropriate prevention education curriculums to address underage drinking risk and protective factors.
8. Coordinate a statewide underage drinking prevention coalition

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Alcohol use in past month among individuals aged 12 to 20
Baseline Measurement: 22.5% - 2016/2017 NSDUH
First-year target/outcome measurement: 21.5%
Second-year target/outcome measurement: 21.0%
Data Source: National Survey on Drug Use and Health (NSDUH)

Description of Data:
Indicator #: 2
Indicator: Binge alcohol use in past month among individuals aged 12 to 20
Baseline Measurement: 14.2% - 2016/2017 NSDUH
First-year target/outcome measurement: 13.5%
Second-year target/outcome measurement: 13.0%
Data Source:
National Survey on Drug Use and Health (NSDUH)
Description of Data:
NSDUH is an annual survey of the U.S. civilian, noninstitutionalized population ages 12 years or older

Priority #: 14
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. Conduct Synar and non-Synar compliance checks to discourage sells to minors during annual Synar required inspection period and non-Synar regionally scheduled phases throughout the year.
2. Use of research-based practices and classroom curriculum to reduce the initiation of tobacco use among children, adolescents and young adults.
3. Provide vertical driver’s license education (promote “Read the Red” and MI Secretary of State awareness website) as part of tobacco vendor education sessions.
4. Encourage tobacco retailers through positive community recognition via mass media, trade magazine feature articles and E-blast acknowledgments.
5. Encourage tobacco retailers to engage staff in merchant retailer education via OROSC’s ImprovingMIpractices.org free online certificated training.
6. Provide birthdate and legal awareness (YTA) signage to all merchants on the state’s tobacco Master Retail List.
7. Encourage participation in environmental efforts, such as “Kick Butts” annual smoking cessation day. Alliance with existing “Do Your Part” campaign using fact sheets, PowerPoint and video resources by developing an attention getting website for educators, merchants, parents along with research resources for youth.
8. Update the Strategic Tobacco Plan and increase multi-system collaboration to implement strategies identified during the planning process.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Effect 10% tobacco retailers sell rate to minors
Baseline Measurement: 10.7% retailer violation rate – SFY2018
First-year target/outcome measurement: 10.3% FY 2020
Second-year target/outcome measurement: 10.0% FY 2021

Data Source:
Annual Synar Survey

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

Data issues/caveats that affect outcome measures:
None

Priority #: 15
Priority Area: Health Disparities
Priority Type: SAP
Population(s): Other (LGBTQ)

Goal of the priority area:
Health disparities among LGBT youth and adults will be decreased.

Objective:
Decrease health disparities among LGBT youth and adults as related to behavioral health issues.

Strategies to attain the objective:
1. Review and share data from existing sources to gain additional knowledge 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. Disseminate LGBT materials and information to the statewide prevention provider network.
4. Evaluate effective evidence-based prevention programs and practices for this target population in anticipation of future pilot projects.
5. Identify training and TA needs to help prevention providers and coalitions address this population.

Annual Performance Indicators to measure goal success

Indicator #:
1
Indicator: Tobacco use in past month among LGBT individuals aged 18 and older
Baseline Measurement: 41.4% use in last month
First-year target/outcome measurement: 40.0%
Second-year target/outcome measurement: 39.0%

Data Source:
Michigan Behavioral Risk Factor Surveillance System (BRFSS)

Description of Data:
BRFSS is an annual national health-related telephone survey.

Data issues/caveats that affect outcome measures:
None

Indicator #:
2
Indicator: Binge alcohol use in past month among LGBT persons aged 18 or older
<table>
<thead>
<tr>
<th>Indicator #</th>
<th>Indicator</th>
<th>Baseline Measurement</th>
<th>First-year target/outcome measurement</th>
<th>Second-year target/outcome measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Tobacco use in past month among LGBT high school students</td>
<td>27.0%</td>
<td>26.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td>4</td>
<td>Binge alcohol use in past month among LGBT high school students</td>
<td>15.4%</td>
<td>14.5%</td>
<td>13.5%</td>
</tr>
</tbody>
</table>

Data Source:
- Michigan Behavioral Risk Factor Surveillance Systems (BRFSS)
- Michigan Youth Risk Behavior Surveillance System (YRBSS)

Description of Data:
- BRFSS is an annual national health-related telephone survey
- The national survey, conducted every two years by CDC, provides data representative of 9th through 12th grade students in public and private schools in the United States.

Data issues/caveats that affect outcome measures:
- None
- Data are available in every two years.
Population(s): Other ( Adolescents w/SA and/or MH, Students in College)

Goal of the priority area:

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

Objective:

Increase perceived risk of marijuana and decrease marijuana use.

Strategies to attain the objective:

1. Develop a comprehensive strategic plan to prevent youth marijuana use.
2. Increase multi-system collaboration to implement strategies identified in the strategic plan.
3. Use fact sheets and infographics as a prevention tool to increase awareness of impact of marijuana use.
4. Implement statewide media campaign focusing on 12-20 year old.

---

**Annual Performance Indicators to measure goal success**

<table>
<thead>
<tr>
<th>Indicator #:</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Perceived great risk of smoking marijuana once a month among 12 to 17 years old</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>23.5%</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>24.0%</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>24.5%</td>
</tr>
<tr>
<td>Data Source:</td>
<td>NSDUH</td>
</tr>
</tbody>
</table>

**Description of Data:**

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

**Data issues/caveats that affect outcome measures:**

None

---

<table>
<thead>
<tr>
<th>Indicator #:</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Marijuana use in past month among 12 to 17 years old</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>7.7%</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>7.0%</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>6.5%</td>
</tr>
<tr>
<td>Data Source:</td>
<td>NSDUH</td>
</tr>
</tbody>
</table>

**Description of Data:**

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

**Data issues/caveats that affect outcome measures:**

None

---

<table>
<thead>
<tr>
<th>Indicator #:</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Marijuana use in past month among 18 to 25 years old</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>24.2%</td>
</tr>
</tbody>
</table>

---
First-year target/outcome measurement: 23.5%
Second-year target/outcome measurement: 23.0%

Data Source:
NSDUH

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

Data issues/caveats that affect outcome measures:
None

Priority #: 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. 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.
6. Develop strategic plan around older adults (55+) and heroin and other opioid issues / problem behaviors as well as relationship to alcohol.

Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>Indicator</th>
<th>Baseline Measurement</th>
<th>First-year target/outcome measurement</th>
<th>Second-year target/outcome measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pain reliever misuse in past year among individuals aged 12 and older</td>
<td>4.4%</td>
<td>4.0%</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

Data Source:
NSDUH

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

Data issues/caveats that affect outcome measures:
None
First-year target/outcome measurement: 0.2%
Second-year target/outcome measurement: 0.2%

Data Source:
NSDUH

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

Data issues/caveats that affect outcome measures:
None

Priority #: 18
Priority Area: Infant and Early Childhood Mental Health Consultation (IECMHC)
Priority Type: SAP
Population(s): PP

Goal of the priority area:
Social / Emotional Consultants to intervene with childcare providers and families to improve the social, emotional and behavioral health of young children.

Objective:
Consultants will complete at least 90% of fidelity to the model for cases that are accepted and active.

Strategies to attain the objective:
1. Consultants will track and input data into the electronic IECMHC data base system to maintain fidelity to the model and continually improve practices.
2. Consultants will provide specialized training to childcare staff and/or families as appropriate.
3. Consultants will provide programmatic consultation within the care setting to improve the overall social and emotional quality of care services and promote skills across a universal level.
4. Consultants will follow the standard, yet flexible approach to programmatic consultation per state level identified model steps.
5. Consultant will provide prevention based targeted or child/family centered consultation within the care setting and through home visits to address the issues which challenge a child’s ability to succeed in a child care setting (e.g. child is at risk for expulsion).
6. Consultants will follow the standard, yet flexible approach to child/family consultation per state level identified model steps.

Annual Performance Indicators to measure goal success

Indicator #:
1

Indicator:
Number of cases met 90% fidelity to the model

Baseline Measurement:
50 cases

First-year target/outcome measurement:
75 cases

Second-year target/outcome measurement:
90 cases

Data Source:
IECMHC data base and fidelity checklist

Description of Data:
CMH Supervisors and SEC will use the Fidelity Checklist, at least monthly, to identify and assess completion and/or barriers to completion of all required components, to ensure fidelity to the model.

Data issues/caveats that affect outcome measures:
None
## Planning Tables

### Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021.

ONLY include funds expended by the executive branch agency administering the SABG

<table>
<thead>
<tr>
<th>Activity (See instructions for using Row 1.)</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention* and Treatment</td>
<td>$84,069,169</td>
<td></td>
<td>$126,000,000</td>
<td>$31,913,052</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children*</td>
<td></td>
<td>$1,124,488</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td>$82,944,681</td>
<td>$126,000,000</td>
<td>$31,913,052</td>
<td>$16,804,495</td>
<td></td>
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<tr>
<td>2. Primary Prevention</td>
<td>$0</td>
<td></td>
<td>$0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td>$22,418,444</td>
<td></td>
<td>$3,030,006</td>
<td>$2,685,200</td>
<td></td>
<td></td>
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<tr>
<td>b. Mental Health Primary Prevention</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td>$0</td>
<td></td>
<td>$0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td>$0</td>
<td></td>
<td>$0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. State Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Other 24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)</td>
<td>$5,604,611</td>
<td></td>
<td>$0</td>
<td></td>
<td>$2,000,000</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>10. Total</td>
<td>$112,092,224</td>
<td>$0</td>
<td>$126,000,000</td>
<td>$34,943,058</td>
<td>$47,427,220</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Prevention other than primary prevention

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

## Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

**Planning Period Start Date:** 7/1/2019  
**Planning Period End Date:** 6/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Mental Health Primary Prevention*</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**</td>
<td>$4,038,197</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. State Hospital</td>
<td></td>
<td>$45,464,800</td>
<td>$0</td>
<td>$494,290,400</td>
<td>$25,603,400</td>
<td>$24,513,800</td>
<td></td>
</tr>
<tr>
<td>7. Other 24 Hour Care</td>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td></td>
<td>$0</td>
<td>$4,900</td>
<td>$0</td>
<td>$387,700</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)***</td>
<td>$2,019,098</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>10. Total</td>
<td>$0</td>
<td>$6,057,295</td>
<td>$45,469,700</td>
<td>$0</td>
<td>$494,678,100</td>
<td>$25,603,400</td>
<td>$24,513,800</td>
</tr>
</tbody>
</table>

* 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 3B should include Early Serious Mental Illness programs funded through MHBG set aside
*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.
Footnotes:
6. State Hospital, Column G. Other = State Restricted funding
### Planning Tables

**Table 3 SABG Persons in need/receipt of SUD treatment**

<table>
<thead>
<tr>
<th>Aggregate Number Estimated In Need</th>
<th>Aggregate Number In Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pregnant Women</td>
<td>22699</td>
</tr>
<tr>
<td>2. Women with Dependent Children</td>
<td>1224</td>
</tr>
<tr>
<td>3. Individuals with a co-occurring M/SUD</td>
<td>10970</td>
</tr>
<tr>
<td>4. Persons who inject drugs</td>
<td>34655</td>
</tr>
<tr>
<td>5. Persons experiencing homelessness</td>
<td>20313</td>
</tr>
</tbody>
</table>

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

8,351 count are an average daily count for all persons homeless in Michigan. All other estimates use census data and NSDUH prevalence estimates to derive an estimate of need. The treatment counts are obtained via Michigan internal TEDS data collection system.

Footnotes:
## Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019    Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>FFY 2020 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment*</td>
<td>$42,034,584</td>
</tr>
<tr>
<td>2. Primary Substance Abuse Prevention</td>
<td>$11,209,222</td>
</tr>
<tr>
<td>3. Early Intervention Services for HIV**</td>
<td>$0</td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td>$0</td>
</tr>
<tr>
<td>5. Administration (SSA Level Only)</td>
<td>$2,802,306</td>
</tr>
<tr>
<td>6. Total</td>
<td>$56,046,112</td>
</tr>
</tbody>
</table>

* Prevention other than Primary Prevention  

** 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:
## Table 5a SABG Primary Prevention Planned Expenditures

**Planning Period Start Date:** 10/1/2019  
**Planning Period End Date:** 9/30/2021

<table>
<thead>
<tr>
<th>Strategy</th>
<th>IOM Target</th>
<th>FFY 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Universal</td>
<td>$426,559</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td>$6,682</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$65</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$433,306</strong></td>
<td></td>
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</table>

1. Information Dissemination

<table>
<thead>
<tr>
<th></th>
<th>Universal</th>
<th>$1,323,420</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Selective</td>
<td>$669,336</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$294,540</td>
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<td></td>
<td>Unspecified</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$2,287,296</strong></td>
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</tr>
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</table>

2. Education

<table>
<thead>
<tr>
<th></th>
<th>Universal</th>
<th>$288,106</th>
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<tbody>
<tr>
<td></td>
<td>Selective</td>
<td>$169,833</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$646</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$458,585</strong></td>
<td></td>
</tr>
</tbody>
</table>

3. Alternatives

<table>
<thead>
<tr>
<th></th>
<th>Universal</th>
<th>$89,117</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Selective</td>
<td>$385,159</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$142,783</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$617,059</strong></td>
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</tr>
</tbody>
</table>

4. Problem Identification and Referral

<table>
<thead>
<tr>
<th></th>
<th>Universal</th>
<th>$1,371,783</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Selective</td>
<td>$385,159</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$142,783</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,371,783</strong></td>
<td></td>
</tr>
<tr>
<td>5. Community-Based Process</td>
<td>Selective</td>
<td>$9,732</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$565</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$1,382,080</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Environmental</th>
<th>Universal</th>
<th>$272,361</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Selective</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$272,361</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Section 1926 Tobacco</th>
<th>Universal</th>
<th>$578,148</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Selective</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$578,148</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Other</th>
<th>Universal</th>
<th>$5,137,281</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Selective</td>
<td>$27,709</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$15,397</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$5,180,387</strong></td>
</tr>
</tbody>
</table>

| Total Prevention Expenditures | **$11,209,222** |
| Total SABG Award*             | **$56,046,112** |

**Planned Primary Prevention Percentage**

20.00%

---

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

0930-0169 Approved: 07/17/2017 Expires: 07/30/2020

**Footnotes:**
### Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019  Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2020 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Direct</td>
<td>$7,776,314</td>
</tr>
<tr>
<td>Universal Indirect</td>
<td>$1,710,461</td>
</tr>
<tr>
<td>Selective</td>
<td>$1,268,451</td>
</tr>
<tr>
<td>Indicated</td>
<td>$453,996</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td><strong>$11,209,222</strong></td>
</tr>
<tr>
<td><strong>Total SABG Award</strong></td>
<td><strong>$56,046,112</strong></td>
</tr>
<tr>
<td><strong>Planned Primary Prevention Percentage</strong></td>
<td><strong>20.00 %</strong></td>
</tr>
</tbody>
</table>

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

Footnotes:
**Table 5c SABG Planned Primary Prevention Targeted Priorities**

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

**Planning Period Start Date:** 10/1/2019  
**Planning Period End Date:** 9/30/2021

<table>
<thead>
<tr>
<th>Targeted Substances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
</tr>
<tr>
<td>Tobacco</td>
</tr>
<tr>
<td>Marijuana</td>
</tr>
<tr>
<td>Prescription Drugs</td>
</tr>
<tr>
<td>Cocaine</td>
</tr>
<tr>
<td>Heroin</td>
</tr>
<tr>
<td>Inhalants</td>
</tr>
<tr>
<td>Methamphetamine</td>
</tr>
<tr>
<td>Synthetic Drugs (i.e. Bath salts, Spice, K2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Targeted Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students in College</td>
</tr>
<tr>
<td>Military Families</td>
</tr>
<tr>
<td>LGBTQ</td>
</tr>
<tr>
<td>American Indians/Alaska Natives</td>
</tr>
<tr>
<td>African American</td>
</tr>
<tr>
<td>Hispanic</td>
</tr>
<tr>
<td>Homeless</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islanders</td>
</tr>
<tr>
<td>Asian</td>
</tr>
<tr>
<td>Rural</td>
</tr>
<tr>
<td>Underserved Racial and Ethnic Minorities</td>
</tr>
</tbody>
</table>

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## Planning Tables

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

Planning Period Start Date: 10/1/2019    Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. SABG Treatment</th>
<th>B. SABG Prevention</th>
<th>C. SABG Combined*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td></td>
<td></td>
<td>$32,000</td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td>$300,000</td>
<td>$100,000</td>
<td></td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td>$300,000</td>
<td>$100,000</td>
<td></td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td>$100,000</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>7. Training and Education</td>
<td>$500,000</td>
<td>$170,000</td>
<td>$300,000</td>
</tr>
<tr>
<td><strong>8. Total</strong></td>
<td><strong>$1,200,000</strong></td>
<td><strong>$402,000</strong></td>
<td><strong>$300,000</strong></td>
</tr>
</tbody>
</table>

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

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## Planning Tables

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

MHBG Planning Period Start Date: 10/01/2019  
MHBG Planning Period End Date: 09/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2020 Block Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>$350,000</td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td>$20,049,160</td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td>$5,180,398</td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td>$24,000</td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td>$3,443,844</td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td>$2,674,232</td>
</tr>
<tr>
<td>7. Training and Education</td>
<td>$8,329,372</td>
</tr>
<tr>
<td><strong>8. Total</strong></td>
<td><strong>$40,051,006</strong></td>
</tr>
</tbody>
</table>

0930-0169 Approved: 07/17/2017 Expires: 07/30/2020

**Footnotes:**
Environmental Factors and Plan

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

**Narrative Question**

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

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

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

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

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

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

One key population of concern is persons who are dually eligible for Medicare and Medicaid. 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. 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. Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider. SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with
partners to mitigate regional and local variations in services that detrimentally affect access to care and integration. SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment. Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states’ Medicaid authority in ensuring parity within Medicaid programs. SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA’s National Behavioral Health Quality Framework includes core measures that may be used by providers and payers. 40

SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs. 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.

26 http://www.samhsa.gov/health-disparities/strategic-initiatives
1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community-based mental and substance use disorders settings.

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

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

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

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

- Comprehensive care management;
- Care coordination,
beneficiaries with an MCT service.

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

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

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

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

Background
On October 1, 2018, MDHHS implemented the OHH to help mitigate Michigan’s opioid epidemic in Michigan’s Prepaid Inpatient Health Plan (PIHP) Region 2, which is comprised of the 21 northernmost counties in Michigan’s lower peninsula. This region was chosen due to its high per capita prevalence of Medicaid beneficiaries with an opioid use disorder (OUD), poor health outcomes and behaviors, a dearth of providers, and significant geographical/socioeconomic barriers. The OHH is predicated on the Vermont “Hub and Spoke” Health Home model. MDHHS consulted with and brought in Vermont officials for provider orientation events. The OHH provides intensive care management and coordination to Medicaid beneficiaries with OUD to attend to the spectrum of one’s needs. Per state plan requirements, providers deliver on-site primary, behavioral, and recovery-centered care services (including Medication Assisted Treatment [MAT]) through an interdisciplinary care team, including peer recovery coaches and community health workers.

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

Enrollment
As of March 2019, the OHH has 209 enrolled beneficiaries (note: marketing efforts by the PIHP, the Michigan Primary Care Association, and MDHHS Communications are in progress and several new providers have recently been designated and signed contracts with the PIHP).

Notable Links
- Michigan’s OHH Website: https://www.michigan.gov/mdhhs/0,5885,7-339-71547,4860_87523---,00.html

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

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

The MCT program is currently offered through FQHCs and Tribal Health Centers (THC). Today, 10 FQHCs provide MCT services in 21 counties throughout the upper and lower peninsula. Providers receive a monthly case rate directly from MDHHS for enrolled beneficiaries with an MCT service.
Enrollment
As of March 2019, the MCT has over 3,400 beneficiaries enrolled into the program.

Notable Links
- MI Care Team Sites: https://www.michigan.gov/documents/mdhhs/MI_Care_Team_Health_Homes_Sites_527378_7.pdf

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

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

Given the growing prevalence of individuals with mental illness and its associated fundamental outcomes like the alarming growth in suicide rates, BHDDA is in the process of revamping and expanding the BHH. In fact, BHDDA recently submitted a concept paper to the Michigan Health Endowment fund to secure grant funding to help recalibrate the diagnostic focus and operations of the program to better serve and expand access to integrated services for Medicaid beneficiaries with SMI/SED. BHDDA anticipates a more specified diagnostic focus per identification of high-cost, high-use SMI/SED diagnostic codes will lead to program expansion. Contingent upon funding, the immediate plan is to expand the BHH to all counties in PIHP Region 2, with the goal of serving 1,500-3,000 beneficiaries within two years.

Enrollment
As of March 2019, Michigan's BHH serves roughly 100 people annually through two CMHSPs. At its peak, the BHH served nearly 800 beneficiaries. Revamping the BHH will lead to substantial increases in enrollment.

Notable Link

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

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

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

MDHHS worked with local CMHSP and FQHC organizations and the Community Mental Health Association of Michigan and the
Michigan Primary Care Association to select state partnerships that synchronized need and readiness per the terms of the PIPBHC application. As a result, the following providers were selected as partners:
- Cherry Health FQHC (secondary partner with Barry County CMHSP)
- Saginaw County CMHSP (secondary partner with Great Lakes Bay Health Center FQHC)
- Shiawassee County CMHSP (secondary partner with Great Lakes Bay Health Center FQHC)

SIM
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, BHDAA has provided and fostered training in Medication Assisted Treatment and Evidence-Based Practices (like SBIRT) in settings outside the typical PIHP/CMHSP structure. Michigan’s Federally Qualified Health Centers are one benefactor of such trainings and these providers have augmented their ability to provide Medication Assisted Treatment services as a result, which is critical to help mitigate the opioid crisis. While there are many other integration projects underway, other initiatives designed to integrate systems of care include utilizing community health workers, peer support specialists, and peer recovery coaches to ensure optimal care transitions and coordination. These workers also help bridge the gap between different care disciplines. Finally, Michigan Public Act 107 of 2017 instructs MDHHS to pursue up to 3 financial integration pilots whereby Medicaid Health Plans would receive first-dollar Medicaid monies and be expected to coordinate all physical and behavioral health care for their beneficiaries.

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

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?

6. Do the M/SUD providers screen and refer for:
   a) Prevention and wellness education
   b) Health risks such as
      ii) heart disease
      iii) hypertension
      iv) high cholesterol
      v) diabetes
   c) Recovery supports

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?

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

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

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

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

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

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

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

\(^{42}\) http://www.minorityhealth.hhs.gov/npha/files/Plans/HHS/HHS_Plan_complete.pdf

\(^{43}\) http://www.healthypeople.gov/2020/default.aspx

\(^{44}\) https://www.minorityhealth.hhs.gov/npha/files/Plans/NSS/NSS_07_Section3.pdf

\(^{45}\) http://www.ThinkCulturalHealth.hhs.gov

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Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?
   a) Race
   b) Ethnicity
   c) Gender
   d) Sexual orientation
   e) Gender identity
   f) Age

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?

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care?

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

Health Care Value = Quality ÷ Cost, \( V = \frac{Q}{C} \)

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

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

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

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

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

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

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)55 was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.
SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers’ decisions regarding M/SUD services.


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


53 [Link]

54 [Link]

55 [Link]

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.

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

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

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Footnotes:


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


53 [Link]

54 [Link]

55 [Link]
Environmental Factors and Plan

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

Required MHBG

Narrative Question

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

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

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

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

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

Please respond to the following items:

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

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

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

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

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

   Michigan is fortunate to have an extensive array of state plan behavioral health services that can provide individualized treatment...
to those eligible for services, who may or may not be appropriate for an ESMI approach. There are many opportunities for integrated mental and physical health treatment available for both adults and youth and many of these projects are also MHBG funded. For those experiencing a first episode of psychosis, block grant funded Navigate projects are available in some communities.

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

5. Does the state collect data specifically related to ESMI?  
   - Yes  
   - No

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

7. Please provide an updated description of the state’s chosen EBPs for the 10 percent set-aside for ESMI.  
   Michigan is implementing the Navigate approach from the RAISE model (http://navigateconsultants.org/). This has not changed since the launch of the project.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state’s ESMI programs including psychosis?  
   The following activities will continue to occur in FY20 and 21. All of these activities are dependent upon the continuing availability of funds.

   In FY20, we hope to identify 1 to 2 new Navigate Teams.

   New implementation team(s) will reach capacity (30 individuals) in FY20.

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

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

   Teams will promote the sustainability of FEP treatment programs

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

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

   Outcomes on treatment for first episode psychosis will be available.

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

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

9. Please explain the state’s provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.  
   Teams report required data quarterly to the project coordinator. Quarterly and annual reports are provided to MDHHS by the project coordinator. Data collected thus far includes demographic data, Clinical Global Impression (CGI) and the Service Utilization Review Form (SURF) data and COMPASS data. Project coordinator and teams will continue to work with a university researcher to analyze data and get a web-based data collection portal up and running for the teams to enter outcome data and generate reports.

10. Please list the diagnostic categories identified for your state’s ESMI programs.  
    Navigate diagnostic category is psychosis - first episode.

    Please indicate areas of technical assistance needed related to this section.  
    Sustainability and planning when funding is variable.

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Footnotes:
Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

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

1. Does your state have policies related to person centered planning?  
   Yes [ ]  No [ ]

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

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

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

   The Michigan Mental Health Code also requires use of PCP for development of an Individual Plan of Services:

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

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

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

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

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

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

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

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

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

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

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. Program Integrity - Required

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

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

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

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

Please respond to the following items:

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

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

3. Does the state have any activities related to this section that you would like to highlight?
   - No
   
   Please indicate areas of technical assistance needed related to this section
   
   No technical assistance is needed at this time.

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Footnotes:
Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

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

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

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

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

56 https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282020%29.pdf

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 eleven consultation sessions with federally recognized Tribes during 2018.

2. What specific concerns were raised during the consultation session(s) noted above?
   Specific concerns raised included: MISACWIS access, Medicaid work requirements, telemedicine, assorted funding concerns (including Medicaid Administration, grant funding, and behavioral health funding), coverage for traditional medicine, prescription reimbursement rates, federal and state language conflicts, non-emergency medical transportation and Indian Outreach Workers.

3. Does the state have any activities related to this section that you would like to highlight?
   The Michigan Department of Health and Human Services (MDHHS) currently has three tribal liaisons charged with maintaining regular, open communication with Michigan’s 12 tribes and one Urban Indian Health Center. Two representatives from Michigan tribes currently serve on the Behavioral Health Advisory Council, which is Michigan’s planning council. A tribal liaison from the Legislative Affairs and Constituent Services division attends the Michigan Tribal Health Directors Association Meetings to share and receive information that provides the department information on how to assist the Tribes in their efforts at administering population health and social service programs. Additionally, the department hosts quarterly conference calls to discuss any current issues of concern to the tribes, held in between the Tribal Health Directors Association meetings to further open communication between the tribes and MDHHS. Behavioral Health and Developmental Disabilities Administration (BHDDA) staff attend the Michigan Inter-Tribal Council’s Behavioral Health Communications Network meetings for the purpose of sharing administrative and programmatic information relevant to tribal implementation of substance use and mental health disorder programs. BHDDA staff also receive value added information from tribal members of the network in issues impacting their ability to serve their constituents. A tribal liaison from the Children’s Services Administration conducts quarterly Tribal/State Partnership meetings with tribal children’s and human services directors.
In addition to the formal consultation noted in response #1 above, MDHHS BHDDA staff members meet with members of the Tribal Behavioral Health Communication Network on a quarterly basis to identify and address areas of interest with regard to public behavioral health service delivery. Some focus has been on ensuring that available payment processes are working properly for I/T/U providers that work with Medicaid eligible Tribal Members.

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

No technical assistance is needed at this time.

Footnotes:
Environmental Factors and Plan

8. Primary Prevention - Required SABG

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

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

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

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)?
   - [ ] Yes  [ ] No
2. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)?
   - [ ] Yes  [ ] No
   a) [ ] Data on consequences of substance-using behaviors
   b) [ ] Substance-using behaviors
   c) [ ] Intervention variables (including risk and protective factors)
   d) [ ] Other (please list)
3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
   - [ ] Children (under age 12)
   - [ ] Youth (ages 12-17)
   - [ ] Young adults/college age (ages 18-26)
   - [ ] Adults (ages 27-54)
   - [ ] Older adults (age 55 and above)
   - [ ] Cultural/ethnic minorities
   - [ ] Sexual/gender minorities
   - [ ] Rural communities
   - [ ] Others (please list)
4. Does your state use data from the following sources in its Primary prevention needs assessment? (check all that apply)
Archival indicators (Please list)

Consumption data
Outcome data
Consequence data

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

5. Does your state use needs assessment data to make decisions about the allocation SABG primary prevention funds?

- Yes
- No

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

If no, (please explain) how SABG funds are allocated:
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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

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

### 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 (currently the Community Mental Health Association of Michigan). Training needs and technical assistance is determined by an advisory committee of the training agency and via surveys of the field.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? [ ] Yes [ ] No
   
   *If yes, please describe mechanism used*
   
   The Community Readiness Survey Model (Tri-Ethnic) has been used to assess community readiness.
Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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

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

**Planning**

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?  
   - Yes  
   - No
   
   If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan.
   
   The strategic plan is attached.

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

3. Does your state’s prevention strategic plan include the following components? (check all that apply):
   - a) [ ] Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
   - b) [ ] Timelines
   - c) [ ] Roles and responsibilities
   - d) [ ] Process indicators
   - e) [ ] Outcome indicators
   - f) [ ] Cultural competence component
   - g) [ ] Sustainability component
   - h) [ ] Other (please list):
   - i) [ ] Not applicable/no prevention strategic plan

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

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

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

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

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;

2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

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

**Implementation**

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

   a)  [ ] SSA staff directly implements primary prevention programs and strategies.

   b)  [ ] The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).

   c)  [ ] The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.

   d)  [ ] The SSA funds regional entities that provide training and technical assistance.

   e)  [ ] The SSA funds regional entities to provide prevention services.

   f)  [ ] The SSA funds county, city, or tribal governments to provide prevention services.

   g)  [ ] The SSA funds community coalitions to provide prevention services.

   h)  [ ] The SSA funds individual programs that are not part of a larger community effort.

   i)  [ ] The SSA directly funds other state agency prevention programs.

   j)  [ ] Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

   a)  Information Dissemination:

      Distribution of materials at events such as health fairs, community round tables. Speaking engagements (direct) – Presentation about SUD. Speaking engagements (indirect) – Radio or TV interview, print media.

   b)  Education:

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

   c)  Alternatives:

      Supervision and guiding ATOD free recreational events. Supervision and guiding community events. Supervision and guiding youth/adult leadership events.

   d)  Problem Identification and Referral:

      Student assistance programs, case finding, provision or referral. Conducting DUI/DWI/MIP classes. Prevention assessment and referral.

   e)  Community-Based Processes:

      Implementing needs assessment tools. Community coalition building and facilitating including collaboratives, task forces.
and community planning teams. Coalition technical assistance.

f) Environmental:


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?

If yes, please describe

Substance Use Block Grant spending for primary prevention is monitored via contract and consultation staff. Financial reports are submitted on a monthly basis to contract and consultation staff for review and approval.
Narrative Question

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

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

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

**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 for substance abuse prevention is attached.

2. Does your state’s prevention evaluation plan include the following components? (check all that apply):
   a) Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
   b) Includes evaluation information from sub-recipients
   c) Includes SAMHSA National Outcome Measurement (NOMs) requirements
   d) Establishes a process for providing timely evaluation information to stakeholders
   e) Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
   f) Other (please list)
   g) Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:
   a) Numbers served
   b) Implementation fidelity
   c) Participant satisfaction
   d) Number of evidence based programs/practices/policies implemented
   e) Attendance
   f) Demographic information
   g) Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:
   a) 30-day use of alcohol, tobacco, prescription drugs, etc
   b) Heavy use
   c) Binge use
   d) Perception of harm

Printed: 8/16/2019 12:38 PM - Michigan - OMB No. 0930-0168  Approved: 04/19/2019  Expires: 04/30/2022
c)  Disapproval of use

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

e)  Other (please describe):
Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Admin.

Office of Recovery Oriented Systems of Care
Strategic Plan FY 2018 – FY 2020

The Office of Recovery Oriented Systems of Care (OROSC) aligns services and priorities consistent with the February 2015 Executive Order and Reinventing Michigan’s Healthcare System Blueprint for Health Innovation. OROSC implements a recovery-oriented system of care in which specialty behavioral health services are delivered within a full continuum of care. In addition, we have identified strategic priorities that target the prevention and treatment of substance use, trauma, and mental health disorders across the lifespan of individuals and families in Michigan. OROSC will continue the process of building a healthier Michigan serving as a leader in recovery-oriented services and health innovation.

Mission

The Michigan Department of Health and Human Services (MDHHS) provides opportunities, services and program that promote a healthy, safe, and stable environment for residents to be self-sufficient. (Source: MDHHS)

Vision

Develop and encourage measurable health, safely and self-sufficiency outcomes that reduce and prevent risks, promote equity, foster healthy habits, and transform the health and human services system to improve the lives of Michigan families. (Source: MDHHS)

Purpose

By promoting wellness, strengthening communities, and facilitating recovery for the people of Michigan, Behavioral Health and Developmental Disabilities Administration (BHDDA) serves citizens by diminishing the impact and incidence of addiction, emotional disturbance, mental illness, and developmental disability. (Source: BHDDA)

Guiding Principles

Promote and strengthen OROSC’s delivery of specialty behavioral health services including behavioral health promotion, prevention, treatment, and recovery efforts across the lifespan of individuals and families.

- Further enhance an interagency collaborative approach aimed to improve behavioral health through services that include prevention, treatment, and recovery
- Promote behavioral health wellness and recovery for individuals across the lifespan with
dignity and respect

- Develop innovative practices to improve behavioral health outcomes that result in the reduction of the misuse of alcohol and other drugs
- Promote an interagency collaborative approach to Gambling Disorder prevention and treatment using evidence-based practices and recovery support services to increase abstinence and improve overall health and wellness
- Increase access to all behavioral health services for persons residing in communities with significant health disparities
- Increase access to integrated health care for persons receiving recovery services
- Support safe and healthy behavioral health services to Michiganders across the lifespan in a culturally and developmentally competent manner
- Promote the use of a Strategic Planning Framework to address behavioral health needs and reduce preventable substance use and mental health disorders across all service systems (e.g. primary care settings, criminal justice, and child welfare)
- Implement evidence-based, promising, and best practices that support a recovery-oriented system of care
- Promote emotional health and reduces the impact of mental health and substance use disorders
- Implement a trauma informed system of care that includes evidence-based and promising practice
- Collect, analyze, and report on behavioral health trends and emerging issues

Strategic Priorities

Children: Improve Outcomes for Children (youth and families)

Goal 1: Reduce underage drinking

Performance Indicator: Reduce past 30-day use of alcohol among youth by FY 19 - Target: 14% (Source: Youth Risk Behavior Survey [YRBS])

Objective 1.1: Conduct Epidemiological (EPI) profile to track prevalence, mortality, and trend data
Objective 1.2: Increase visibility of anti-use campaign (Do Your Part)
Objective 1.3: Convene Michigan Higher Education Network (MIHEN)
Objective 1.4: Convene State Epidemiological Outcomes Workgroup (SEOW) to address data
Objective 1.5: Impaired Driving Action Team participation
Objective 1.6: Convene Recovery Oriented Systems of Care, Transformation Steering Committee (ROSC/TSC) Prevention Workgroup
Objective 1.7: Establish prevention programming and partnership with adolescent health centers
Objective 1.8: Establish and increase peer recovery community for adolescents
Objective 1.9: Promote utilization of the Michigan Model statewide
Objective 1.10: Secure training and technical assistance
Objective 1.11: Encourage the use of evidence-based programs, practices and strategies shown to impact underage drinking

Goal 2: Reduce Youth Access to Tobacco and Illegal Sales to Minors

Performance Indicator: Effect a 10.79 percent tobacco sales rate to minors by FY 19 (Source: SYNAR Survey Results)
Objective 2.1: Conduct an EPI Profile
Objective 2.2: Provide training and technical assistance (TA) to Designated Youth Tobacco Use Representative (DYTUR) on SYNAR regulations and policy
Objective 2.3: Convene Youth Access to Tobacco Workgroup (YATTW)
Objective 2.4: Continue collaboration w/tobacco section
Objective 2.5: Continue collaboration w/attorney general
Objective 2.6: Continue implementation of the Federal Drug Administration (FDA) retailer inspection program in the state
Objective 2.7: Continue implementation of the SYNAR retailer inspection program in the state
Objective 2.8: Track and report on legislation regarding youth access to tobacco
Objective 2.9: Develop and submit the annual SYNAR report to Substance Abuse and Mental Health Administration (SAMHSA)
Objective 2.10: Update Do Your Part campaign
Objective 2.11: Improving MI Practices campaign for retailer education

Goal 3: Reduce Substance Exposed Births
Performance Indicator: Increase number of drug-free births by FY 19 - Target: 200
Objective 3.1: Review analysis of Women’s Specialty Services report
Objective 3.2: Review data related to impact of substance use provided by Population Health and Children’s Protective Services
Objective 3.3: Increase access to treatment for pregnant women
Objective 3.4: Decrease the stigma for pregnant women who seek treatment
Objective 3.5: Outreach to other agencies that serve children and families to improve education
Objective 3.6: Align policies regarding substance exposed births across the state
Objective 3.7: Reduce the impact of substance use in families by enhancing and improving access to treatment
Objective 3.8: Establish and increase community support to families with children recovery
Objective 3.9: Secure federal grants to reduce the impact of substance abuse in families

Goal 4: Increase youth awareness of Gambling Disorder
Performance Indicator: Reduce past 30-day gambling activity among youth (Source: Michigan Profile for Healthy Youth [MiPHY])
Objective 4.1: Use existing infrastructure to expand Gambling Disorder prevention efforts to youth and adolescents
Objective 4.2: Provide training opportunities and technical assistance for effective prevention service development and implementation
Objective 4.3: Revise media campaign to target youth and adolescents
Objective 4.4: Promote parent utilization of Gambling Disorder help-line
Objective 4.5: Continue participation with ROSC/TSC workgroup

Goal 5: Reduce the effects of parental substance use on youth
Performance Indicator: Increase the number of students and children receiving indicated services
Objective 5.1: Improve screening of youth whose parents are served in pregnant and parenting women’s programs
Objective 5.2: Provide training and technical assistance to pregnant and parenting women’s
programs, regarding Adverse Childhood Experiences (ACEs) and resiliency factors that can be enhanced by the treatment provider

**Objective 5.3:** Review pregnant and parenting women’s programing referral process to ensure that children are receiving the services indicated by screening

**Adults and Family Support:** Promote and Protect Health, Wellness, and Safety (across the lifespan within communities)

**Goal 1:** Build community assets to address behavioral health needs

**Performance Indicator:** Increase number of consumer-run drop-in centers in the state

**Performance Indicator:** Increase number of naloxone kits distributed by start of FY20 (Source: Reported by Prepaid Inpatient Health Plans [PIHPs])

**Performance Indicator:** Increase number of environmental and community-based prevention strategies by FY20 (Source: Michigan Prevention Data System)

**Objective 1.1:** Create and develop drop-in recovery support pilots to provide resources and movement of peers back to the community

**Objective 1.2:** Promote consumer-run drop-in center locations in the community

**Objective 1.3:** Conduct and implement the Anti-Stigma Educational Day, which promotes anti-stigma initiatives in the community

**Objective 1.4:** Involvement of community interactions, outings, and connectedness by the implementation of the Federal Block Grant, Health and Wellness Grant to consumer-run drop-in centers

**Objective 1.5:** Implement training of trauma informed care in Community Mental Health Service Providers (CMHSPs) and their communities with adults

**Objective 1.6:** Promote community-wide overdose education and training on use of naloxone

**Objective 1.7:** Promote purchase and distribution of naloxone statewide

**Objective 1.8:** Track distribution of naloxone kits

**Objective 1.9:** Promote utilization of Naloxone Standing Order

**Objective 1.10:** Creation and distribution of statewide language regarding definition of and Frequently Asked Questions (FAQs) regarding behavioral health needs

**Objective 1.11:** Encourage multi-system collaboration to implement prevention and mental health promotion strategies

**Objective 1.12:** Continue to build and enhance community prevention infrastructure and capacity
Goal 2: Reduce prescription and over-the-counter drug misuse and abuse

**Performance Indicator:** Reduce non-medical use of prescription drugs, including opiates

**Performance Indicator:** Increase the number of prescription drug collection sites

Objective 2.1: Collaborate with community programs, organizations, health centers and law enforcement to be area specific when planning permanent collection sites or take-back day events

Objective 2.2: Encourage multi-system collaboration at state and community levels, including leadership development to oversee surveillance, intervention, education, and enforcement

Objective 2.3: Broaden the use of brief screenings in behavioral and primary care settings

Objective 2.4: Promote increased access to and use of prescription drug monitoring program

Objective 2.5: Provide training and technical assistance for communities to address emerging issue of unprecedented increases in opioid use among adults age 55 and older

Goal 3: Reduce misuse and abuse of alcohol, opioid medications, and illicit drugs.

**Performance Indicator:** Decrease in overdose deaths due to any opioid, heroin, synthetic or non-synthetic non-heroin opioids - rate and number (Source: Michigan Death Certificates); Decrease in hospitalizations due to opioid overdose (Source: Michigan Inpatient Database)

**Performance Indicator:** Decrease in past 30-day use of alcohol among young adults (18 to 25 years) and older adults (age 55+) by FY20

Objective 3.1: Promote the utilization of best practice guidelines for opioid prescribing

Objective 3.2: Promote alternative pain management strategies to patients and medical providers

Objective 3.3: Increase visibility of the stopoverdose website

Objective 3.4: Increase utilization of the state prescription drug monitoring program (PDMP) to reduce overprescribing of prescription opioids

Objective 3.5: Develop and promote campaign to increase awareness of opioid misuse and abuse

Objective 3.6: Support the development of culturally competent messaging for tribal communities on opioid misuse and abuse

Objective 3.7: Implement evidence-based primary prevention practices to reduce opioid misuse and abuse

Objective 3.8: Outreach to other agencies that implement educational initiatives

Objective 3.9: Implement evidence-based alcohol misuse/abuse prevention strategies specific to young adults and older adults

Objective 3.10: Engage all segments of the community in establishing a recovery-oriented system of care and increase the use of brief intervention

Objective 3.11: Provide technical assistance and resources to the Higher Education Network, to address problem drinking and other drug use among college students
**Goal 4:** Reduce barriers to accessing treatment for opioid use disorders

**Performance Indicator:** Increase the number of individuals accessing treatment, by county, by FY20
(Source: Encounter Database and Behavioral Health Treatment Episode Data Set [BH TEDS])

**Performance Indicator:** Expansion and collaboration with community partners

**Objective 4.1:** Review BH TEDS and other data sources for identification of gaps in treatment

**Objective 4.2:** Expand use of peers in healthcare settings, to increase early referral to treatment

**Objective 4.3:** Increase TA to treatment providers for persons with opioid use disorder

**Objective 4.4:** Increase transportation resources for persons seeking treatment for opioid use disorder

**Objective 4.5:** Promote expansion of treatment options for incarcerated populations

**Objective 4.6:** Increase coverage of uninsured and underinsured persons seeking various treatment and recovery support options for opioid use disorder

**Objective 4.7:** Identify and share community resources to support recovery

**Objective 4.8:** Train program employees in evidence-based programs, such as Motivational Interviewing and Trauma Focused Cognitive Behavioral Therapy

**Objective 4.9:** Disseminate information and training to the field for a statewide assessment

**Objective 4.10:** Increase collaboration between programs, including sharing of assessments

**Objective 4.11:** Provide health disparity reports, regarding gaps in services to Michiganders, to continue creation of services to underserved areas

**Objective 4.12:** Creation of financial map of the state, to evaluate current trends and influence future financial priorities

**Goal 5:** Increase longevity and quality of life, by reducing health disparities and improving self-management

**Performance Indicator:** Increase in treatment usage; decrease in injuries and deaths related to substance use disorders

**Performance Indicator:** Increase medication assisted treatment services to specialty populations, such as expectant mothers and adolescents

**Performance Indicator:** Reduce past 30-day gambling activity (Source: Behavioral Risk Factors Surveillance System [BRFSS])

**Objective 5.1:** Develop statewide activities during Gambling Disorder Awareness Month

**Objective 5.2:** Support and participate in workgroups tasked with further developing Gambling Disorder prevention services

**Objective 5.3:** Promote utilization of peer-led recovery support services within populations receiving treatment for opioid use disorder

**Objective 5.4:** Yearly disparity reports, regarding gaps in services to Michiganders, to continue creation of services to underserved areas

**Objective 5.5:** Delay initiation of first use of drugs or alcohol

**Objective 5.6:** Increase exposure of behavioral health resources
Health Services: Transform the Healthcare System

**Goal 1:** Continue the implementation of a recovery-oriented system of care across the lifespan

**Performance Indicator:** Provide increased services to adolescent and transitional aged youth

**Performance Indicator:** Increase services to adults and older adults (Source: BH TEDS)

Objective 1.1: Increase prevention services to youth and adolescents

Objective 1.2: Increase recovery and outpatient services for adolescents and transitional aged youth

Objective 1.3: Develop community-based recovery opportunities (e.g. support groups, youth peer mentors) for youth and families

Objective 1.4: Collaborate with primary care and the behavioral health field to identify gaps in resources for adults/older adults

Objective 1.5: Offer trainings and technical assistance around the Self-Healing Communities model and how a community’s Adverse Childhood Experience score influences all aspects of health

**Goal 2:** Expand integrated behavioral health and primary care services for persons at risk for and with substance use and mental health disorders

**Performance Indicator:** Number of consumer-run drop-in center members participating in health activities (per location and statewide)

**Performance Indicator:** Increase number of resources for co-occurring (MH and SUD) disorders

Objective 2.1: Implement the Health and Wellness Federal Block Grant to 37 consumer-run drop-in centers

Objective 2.2: Promote health care to peers at drop-in centers, support groups, workshops, and conferences

Objective 2.3: Identify, recognize, and acknowledge drop-in centers and peers who are achieving their new health goals

Objective 2.4: Provide training opportunities to programs regarding co-occurring behavioral health and physical disorders

Objective 2.5: Increase number of health homes that include mental health and substance use disorder services onsite

Objective 2.6: Increase the capacity for a community specific prevention referral system, to engage Michigan residents in prevention services

**Goal 3:** Promote opportunities for individuals with mental health disorders to self-direct their services and supports

**Performance Indicator:** Increase number of persons involved in Self-Directed Care (SDC) as a part of the Robert Wood Johnson (RWJ) study – Target: 150 by FY20

Objective 3.1: Develop and provide a curriculum for 2-day trainings to Certified Peer Support Specialists (CPSS) on Person-Centered Planning (PCP)

Objective 3.2: Develop and provide Train the Trainer class on PCP curriculum

Objective 3.3: Select CPSS trainers and provide ongoing mentoring

Objective 3.4: Continue to provide technical assistance for SDC to Bay Arenac Behavioral Health (BABH) and other CMHSPs
Objective 3.5: Develop up to two additional CMHSPs to expand the SDC project
Objective 3.6: Work with Human Services Research Institute (HSRI) for data collection and interpretation
Objective 3.7: Update Institutional Review Board (IRB), as needed, and reapply annually
Objective 3.8: Develop and implement a curriculum of the role of CPSS and independent support brokers and disseminate to the field

Goal 4: Promote and strengthen the role of consumer-run programs
Performance Indicators: Number of activities, contacts of the technical assistance center of Justice in Mental Health Organization (JIMHO) contracted with the State of Michigan
Objective 4.1: Support, oversee, provide technical assistance to the 50 consumer-run drop-in centers
Objective 4.2: Implement statewide two self-help support conferences
Objective 4.3: Provide technical assistance to the drop-in center for the Health & Wellness Grant
Objective 4.4: Promote the creation of new consumer-run initiatives

Goal 5: Treat addiction as a chronic disease
Performance Indicator: Increase client retention in recovery-based services
Objective 5.1: Creation of continuum of care for individuals that begins with prevention and follows through to recovery
Objective 5.2: Increase education to partners and communities to reduce stigma
Objective 5.3: Increase provider use of Medication Assisted Treatment (MAT)
Objective 5.4: Increase client use of MAT services

Goal 6: Improve behavioral health outcomes while leveraging efficiencies in cost and societal consequence
Performance Indicators: Decreased cost of behavioral health
Objective 6.1: Increase length of time in recovery
Objective 6.2: Collect data from access centers and programs for admitted individuals, through BH TEDS, Global Assessment of Individual Needs (GAIN), M-90, and transfer of GAIN assessment between programs
Objective 6.3: Gather data from outreach/follow-up services
Objective 6.4: Explore connection between completion of follow-up services and length of recovery (include MAT data)

Workforce: Strengthen Workforce and Economic Development
Goal 1: Provide statewide training in best-practice behavioral health services including prevention, treatment, and recovery technology
Performance Indicator: Creation of a workforce development plan
Performance Indicator: Increase number of certified individuals providing services to individuals in treatment for mental health and substance use disorders
Performance Indicator: Increase number of clinicians trained in best-practice psychosocial techniques (Source: reported by PIHPs and State Training Coordinators [CMHAM])
Objective 1.1: Promote utilization of best-practice psychosocial techniques for clinicians treating individuals with opioid use disorder

Objective 1.2: Creation and dissemination of a workforce development ladder for prevention specialists

Objective 1.3: Creation and dissemination of a workforce development ladder for treatment specialists

Objective 1.4: Creation and dissemination of a workforce development ladder for recovery specialists

Objective 1.5: Provide education opportunities that target the components of certification

Objective 1.6: Work with credentialing body to develop a mechanism to effectively assist those with development plans, to ensure they successfully complete the requirements and pass exams

Objective 1.7: Ensure that learning opportunities are available to the field related to evidence-based and promising practices and emerging issues impacting the field

Goal 2: Increase the number of individuals certified as peer support specialist and recovery coaches

Performance Indicator: Increase number of individuals certified in each workforce area – Target: 80 CPSS and 550 Certified Peer Recovery Coach (CPRC) for FY 18-19

Performance Indicator: Increase number of training opportunities offered/available to CPSS and CPRC

Objective 2.1: Compile, interview and approve each CPRC who meet the requirements submitted for grand parenting

Objective 2.2: Develop and train CPRC trainers to implement the new curriculum

Objective 2.3: Organize, plan, and implement statewide and regional CPRC trainings

Objective 2.4: Develop CPRC examination and scoring process

Objective 2.5: Organize, plan, and implement statewide and regional CPSS trainings

Objective 2.6: Provide ongoing oversight, technical assistance and mentoring with trainers

Goal 3: Provide training and continuing education to strengthen skills of CPSS and CPRC

Performance Indicator: Increase number of CPSS/CPRC trainings offered – Target: 70 for FY 18-19

Objective 3.1: Secure training sites and develop a calendar of training dates to send out to stakeholders

Objective 3.2: Develop and provide classes based on promising, best, and evidence-based practices

Objective 3.3: Review evaluations and participate in networking during trainings to add new and additional trainings recommended by the workforce

Objective 3.4: Request information from peer liaisons on training topics beneficial to peers in their agencies

Objective 3.5: Track and review data for CPRC and CPSS after each training

Goal 4: Expand employment opportunities for Certified Peer Recovery Coaches and Certified Peer Support Specialists in primary and integrated care settings

Performance Indicator: Number of peers trained and certified in the areas of Wellness Recovery Action Planning (WRAP), Whole Health Action Management (WHAM), tobacco recovery and as
certified Community Health Workers (CHW) - Target: 10% of the workforce FY 18-20
Objective 4.1: Organize, plan, and implement 2-day and 5-day WRAP trainings
Objective 4.2: Organize, plan, and implement WHAM trainings
Objective 4.3: Organize, plan, and implement tobacco recovery/smoking cessation trainings
Objective 4.4: Develop and strengthen partnerships with the Michigan Community Health Worker Alliance (MICHWA) to meet entrance requirements for peers to become CHWs
Objective 4.5: Provide CHW certification training
Objective 4.6: Assist and participate in recruiting CPSS and CPRC by providing draft questions for interviewing and using the Microsoft Access database to refer individuals for employment opportunities in gambling

Goal 5: Increase the capacity of prevention efforts to address Gambling Disorder

Performance Indicator: Increase number of Gambling Disorder trained individuals in each workforce area
Objective 5.1: Disseminate Request for Information (RFI) to all PIHPs to assess interest and capacity
Objective 5.2: Equip each PIHP with a Gambling Disorder Prevention Coordinator
Objective 5.3: Organize and implement North American Training Institute (NATI) Gambling Disorder training
Objective 5.4: Educate the prevention workforce about comorbidities, overlapping risk, and protective factors between SUD, MH, and Gambling Disorder
Objective 5.5: Host annual Gambling Disorder Symposium
Objective 5.6: Convene Gambling Disorder TSC workgroup
Objective 5.7: Use existing infrastructure to expand Gambling Disorder prevention efforts
Objective 5.8: Provide training opportunities and technical assistance for effective prevention service development and implementation
Objective 5.9: Enhance Gambling Disorder prevention efforts to underserved populations

Office of Recovery Oriented System of Care Website Development:

Goal 1: Information Dissemination

Performance Indicator: Increase visits on OROSC website
Objective 1.1: Promote OROSC website and ease of access to program information
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.
I. Introduction

The purpose of the “Guidance Document: Selecting, Planning, and Implementing Evidence-Based Interventions for the Prevention of Substance Use Disorders” is to increase uniformity in the knowledge, understanding, and implementation of evidence-based substance abuse prevention programs, services, and activities in the state of Michigan.

This document is a compilation of the latest information and research from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP), who provided guidance for the document entitled, Identifying and Selecting Evidence-Based Interventions,” including additional supporting resources, and input from a panel of prevention professionals in the state of Michigan. The goals of this guide are to:

A. Strengthen local ability to identify and select evidence-based interventions.
B. Provide capacity building tools and resources.
C. Foster the development of sound community prevention systems and strategies as part of comprehensive community planning to establish prevention prepared communities.

The Evidence-Based Workgroup hopes that this document will result in an increased ability for local prevention planners to critically assess prevention interventions based on the strength of evidence that an intervention is effective, to implement evidence-based interventions with a balance between fidelity and necessary local adaptations, and to demonstrate the relationship between evidence and achieving outcomes.

The Bureau of Substance Abuse and Addiction Services (BSAAS) offers a special thank you to the workgroup members who took the time to research and provide the information for this document. Leadership was provided by the chair, Kori White-Bissot, who gathered input and content from the Evidence-Based Workgroup membership in compiling this document.

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II. Evidence-Based Practices – Overview and Background

**Definition:** A prevention service (program, policy, or practice) that has been proven to positively change the problem being targeted.

In general, there needs to be evidence that the intervention has been effective at achieving outcomes through some form of evaluation. This is done by collecting evidence through an evaluation process when a specific intervention is implemented in a community. The evaluation process monitors outcomes to determine whether the intervention positively impacted the target problem and/or contributing condition. The type of evidence collected during an evaluation process will vary for different types of interventions.

The remainder of this guide will assist in thinking critically about these issues, while identifying interventions appropriate for individual communities.

**A. Program:** Usually thought of as an intervention that is:

1. Guided by curricula or manuals.
2. Implemented in defined settings or organized contexts.
3. Focused primarily on individuals, families, or defined settings.

**Examples:** *Strengthening Families Program, Botvin’s Life Skills, and Project ALERT.*

**Evidence:** Evidence is usually collected by tracking participants for a period of time after receiving the intervention and comparing them to a group of similar individuals who did not receive the intervention. The evaluation then determines whether the individuals who received the intervention report having lesser rates of substance abuse than those who did not receive the intervention.

**B. Policy:** Efforts to influence the courses of action, regulatory measures, laws, and/or funding priorities concerning a given topic. A variety of tactics and tools are used to influence policy, including advocating their positions publicly, attempting to educate supporters and opponents, and mobilizing allies on a particular issue.

**Example:** Smoke-free laws and regulations.

**Evidence:** Usually evidence that a policy was effective is collected by looking at communities that have implemented the policy and the impact that was documented when they did so. In some cases, evidence is collected by looking at communities that have historically had the policy and then removed it. The negative outcomes of this change may be appropriate to use in order to document the positive benefits of the policy.

**C. Environmental Strategy/Practices:** Activities working to establish or change written and unwritten community-focused standards, codes, and attitudes, in order to change behavior in the community. This is done by changing the shared environment through three interrelated factors: norms, availability, and regulations. By changing the shared environment of a community, the desired behavior change is supported by everyone in the community (Arthur, M. D. & Blitz, C., 2000).
Example: Consistent enforcement of *Youth Tobacco Act*.

Evidence: Evidence for an environmental strategy is usually assessed by looking at communities that have implemented the strategy and the impact it has on the local condition (e.g., easy access to tobacco) targeted by the strategy.

It is often difficult to determine how one environmental strategy contributes to the longer-term goal of changing the problem being targeted (e.g., tobacco use). Since it is challenging to document how strategies impact the larger problem being targeted:

1. Environmental strategies must be incorporated into a comprehensive plan addressing multiple contributing conditions that have been shown to positively impact the problem being targeted.

2. Each strategy that makes up the comprehensive plan needs to have been documented to positively impact the contributing condition that each targets, often demonstrated in a logic model. (See Attachment 2.)

**Strength of Evidence:** The strength of evidence will fall along a continuum from weak to strong. Where an intervention falls on this continuum is determined by the scientific rigor of the evaluation process that was employed to document the intervention’s positive impact on the problem and/or contributing condition. It is not determined by how large an impact the intervention has demonstrated on the problem being targeted.

One should not to confuse ‘strength of evidence’ with the magnitude of an intervention’s impact on the targeted problem. There may be evidence-based interventions that have documented small levels of impact on the problem they target. However, they may be rated as having ‘very strong’ evidence because they used a rigorous evaluation process to document their small impact and have submitted their research for review to experts in the field. In turn, there may be untested interventions that have a large impact on the problem targeted. However, until the outcomes are tested and documented using rigorous evaluation standards, the intervention will not be categorized as ‘evidence-based.’

**Additional Considerations:** When selecting an intervention it is important to assess more than just whether an intervention has been effective. In order for the intervention to be effective in the community, one must also consider a practical and conceptual fit and the framework for the plan must be logical and data-driven throughout. This is especially important for prevention practices that are more effective when they are completed as a component of a comprehensive prevention plan and are unlikely to be included on a federal registry of effective prevention programs due to the nature of the activities.

In summary, when selecting prevention services, consider interventions that have both conceptual and practical fit for the community, that have the strongest level of evidence, and that are effective at addressing the targeted problem and local contributing conditions. For more information, refer to Section IV (B).
III. Evidence-Based Categories

For more in-depth information about the following three categories, please refer to Identifying and Selecting Evidence-Based Intervention, (Health and Human Services [HHS], 2009).

Because evidence-based categories fall along a continuum, it can be challenging to determine which evidence-based category an intervention falls within. Interventions will often straddle categories as they work to move up the continuum to a stronger level of evidence category. Local prevention planners should do their best to review the evidence available and determine which category most closely represents the strength of evidence for an intervention.

A. Federal Registries

1. National Registry of Effective Prevention Programs (NREPP): A program that was previously listed on the SAMHSA model program list or currently listed on NREPP with positive outcomes demonstrated. SAMHSA no longer publishes a list of “model” programs. NREPP now posts the results found for each program that they have reviewed, including programs that were found not to be effective. Therefore, being listed on NREPP does not alone provide evidence of effectiveness. It is imperative that agencies critically review the outcomes detailed and the strength of the evaluation described in the NREPP review. For more information about using the NREPP registry, refer to Section IV D.

2. Other Federal Agency: The program/model is listed by another federal agency as an effective prevention program/model. Federal lists or registries are limited in scope since they are geared to interventions most amenable to assessment using traditional research designs and methodologies for evaluation. For more information, refer to Section IV C.

The following should be considered when assessing programs on other federal registries:

- Does the intervention have evidence that it positively impacts the local contributing conditions being targeted? If the intervention is promoting broad outcomes (e.g., reduction in alcohol and tobacco use), it will be necessary to identify the contributing conditions that the intervention targeted in order to reach those broad outcomes. If unable to identify the targeted contributing conditions, it will be challenging to determine whether the intervention is an appropriate fit for the community.

- Is the intervention culturally appropriate for the community and target audience? Has it been tested with a target audience similar to the one selected? If not, is it possible to modify the program to meet the needs of the target audience while maintaining the minimum fidelity standards to achieve the desired outcomes? For more information, see Section V (A).

- What research standards are required to be included on the registry? The level of evidence required varies greatly between federal registries. Review the standards to
ensure confidence that the outcomes are well documented and were documented using rigorous research standards.

B. Peer Review Journal

This category refers to interventions whose research findings have been published in a peer-reviewed journal. It is best if there are multiple studies and look for consistently positive outcomes. This option should only be selected if planned activities are closely replicating the key components of the program described in the peer-reviewed journal.

Please note that the burden for determining the applicability and credibility of the findings falls on the local prevention planners. Even though the research is published, this category still requires local prevention planners to think critically about the evaluation methodology and determine whether the claimed results are warranted based on the evaluation design. Consider the scope of the evaluation, the measures used, and whether the claims of effectiveness exceed what the evaluation actually assessed.

What is a Peer Review Journal?

When researchers submit their research articles to a peer review journal, the journal subjects the research to the scrutiny of other experts in the field. These journals have a panel of experts in the field determine whether the research meets accepted standards for research methods, and has appropriately interpreted the research findings. Only articles that meet both of these standards are published in peer review journals.

It should be noted that the purpose of a peer review journal is scholarly and to further the area of research, which is very different from the purpose of a federal registry. Sometimes research findings that an intervention was not effective can be useful in helping plan future efforts. One may find that there were key components of the intervention that were left out that need to be included, or the findings might indicate that the theory of change was flawed and that it is necessary to explore other intervention options.

When using peer review journals to determine whether an intervention has evidence of effectiveness:

1. Review all relevant articles, not just those with positive results. If there is more than one study that reviews the intervention, there should be consistently positive results found.

2. One can feel more confident about articles written by authors who are not the developers of the program because they do not have a vested interest in the program’s success.

3. If available, use meta-analysis and literature review articles:
• Meta Analysis: In these articles, researchers conduct a review of as much research as possible published about an issue and use statistics to analyze and summarize results across multiple research studies. These types of articles can be extremely useful in making sense of multiple research studies about an issue.

• Literature Review: In these articles, researchers analyze and summarize results across multiple research studies and other scientific sources and create a narrative that summarized the research findings across studies.

How to Review a Peer Review Journal Article:

Research findings published in peer review journals are presented in a prescribed format with clearly defined sections. Each section provides information about the research study that can be used to assess the quality and relevance of the research presented.

Do not be intimidated. Breaking an article down into its sections allows one to determine the relevance of an article and to gather the information needed to make informed decisions. First, scan the abstract to determine whether the article is relevant to the planned work. If it seems relevant, skim the introduction and discussion section to further determine the relevance of the research. If the article still seems appropriate to aid in planning, it may warrant a full reading of the article.

A helpful article that provides thorough descriptions of the sections of a peer review journal article and how each section can provide useful information is included as Attachment 1. The following is a brief description of the sections:

1. Abstract: A summary of the key points in the article and the hypothesis being tested. This section is the first step in determining whether the article is relevant to the planned work.
2. Introduction: Provides the context of the study.
3. Methods: Explains how the researchers set about testing their hypothesis.
4. Results: Findings of the researchers are detailed in this section.
5. Discussion: A summary of the results, written in a narrative rather than statistical form. This section explains whether the results support the hypotheses and give suggestions for future research.

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.

**Key Elements to Support Documented Effectiveness**

Documentation to justify the inclusion of a particular intervention in a comprehensive community plan is important. Prevention planners are encouraged to provide as many types of documentation as are appropriate and feasible in order to provide strong justification of documented effectiveness.

The following are elements of documentation that might be provided to demonstrate an intervention has other sources of documented effectiveness and meets the four guidelines established by CSAP (HHS, 2009):

- Documentation that clarifies and explains how the intervention is similar in theory, content, and structure to interventions that are considered evidence-based by scientific standards.

- Documentation that the intervention has been used by the community through multiple iterations, and data collected indicating its effectiveness.

- Documentation that indicates how the intervention adequately addresses elements of evidence usually addressed in peer-reviewed journal articles. These elements
may include the nature and quality of the evaluation research design; the consistency of findings across multiple studies; and the nature and quality of the data collection methods, including attention to missing data and possible sources of bias.

- Documentation that explains how the intervention is based on an established theory that has been tested and empirically supported in multiple studies. This documentation should include an intervention-specific logic model that details how the intervention applies and incorporates the established theory.

- Documentation that explains how the intervention is based on published principles of prevention. This documentation should provide references for the principles cited and should explain how the intervention incorporates and applies these principles.

- Documentation that describes and explains how the intervention is rooted in the indigenous culture and tradition.

D. Community-Based Process Best-Practice

Activities conducted through formal coalitions, task forces, community-planning teams, or collaborative groups are necessary to foster prevention prepared communities. While this type of activity was not separately identified within the guidance from CSAP, it is a key component that Michigan recognizes for the success of comprehensive community plans addressing local conditions and targeting community-level change in risk behaviors.

Community-based process is an approach that enhances the efficacy of prevention efforts by working to breakdown silos, streamline services, and to engage the community in a comprehensive multi-layered plan. Community-based process includes activities such as: coordinating and managing coalitions, task forces, community planning teams, and/or collaborative groups.

1. Community-Based Process – Evidence and Importance

Because community-based process is designed to assist communities in implementing community-level interventions and to increase the community’s ability to provide prevention services, rather than target specific community problems, it does not require the same type of evidence.

- In order to effectively implement prevention practices, it is often necessary to engage in a community-based process. Planners may need to mobilize the community to implement a strategy as a component of a comprehensive, multi-layered prevention plan. For example, environmental interventions must be done through a community-based process in order to succeed. These are often efforts to make change to the larger environment through reduced access, changing
community norms, and influencing policy and enforcement. However, these activities do not meet evidence-based criteria in the way that an intervention targeting a certain issue would do so.

“Community Building” is not an intervention, nor is it expected to meet evidence-based criteria at affecting the targeted community problem. Keep in mind that the interventions completed through the community-based process should meet evidence-based criteria.

- Even programs that target individuals (such as a curricula-based program) can be more effective when conducted within a community-based process. By collaborating, a program’s reach and sustainability can be enhanced when it is done as a component of a larger community plan.

2. Collaborative activities should be considered under the following criteria:

   Leading a collaborative effort:
   - The intervention is conducted using community-based process (e.g. coalitions, collaborative, taskforces);
   - 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;
   - Planners are representing substance abuse prevention.

3. In addition to the above criteria, the following should be considered when conducting community-based processes:

   - Membership: The collaborative should be inclusive in its membership/make-up and engage key community stakeholders. The coalition should have appreciation for local involvement and authority in choosing and carrying out actions.

   - Evidence of Effectiveness: Interventions implemented through the community-based process effort need to show evidence of being effective at improving at least one of the following:
     - Contributing to the identified desirable outcome.
     - Impacting the identified community problem/consequence.
• Improving the ability of the prevention system to deliver substance abuse services.

• Clear Purpose: Interventions implemented through a community-based process effort should begin with a clear understanding of their purpose and should consider the following initiatives:

  ➢ Comprehensive services coordination - improving the nature and delivery of services.

  ➢ Community mobilization - generating community activism to address substance abuse and related problems/consequences.

  ➢ Behavior change - creating both system level change and individual behavior change.

  ➢ Community linkages - creating or connecting resources within a community and/or connecting persons to resources.

For more information about best-practice for community based process, please refer to the Community Anti-Drug Coalitions of America website at [www.cadca.org](http://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:

- SAMHSA National Registry of Evidence-Based Programs and Practices (NREPP) at [http://www.nrepp.samhsa.gov](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](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/](http://www.colorado.edu/cspv/).
• Stop Underage Drinking portal of federal resources at http://www.stopalcoholabuse.gov.

Peer Review Journal Research Sources - Searchable databases: these databases have a search feature for relevant research.

• Google Scholar at http://scholar.google.com/.
• 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.
  o American Journal of Public Health
  o Journal of Addiction Studies
  o Annual Review of Public Health
  o Journal on Studies of Alcohol
  o Preventive Medicine
  o Journal of School Health
  o Journal of Adolescent Health
  o Journal of the American Medical Association
  o 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 to 10 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).
VIII. References:


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 a aside. Sit down, take a look through the article and make the most of the information in your hand. – Evelyn Yang, USA

“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,

http://cadca.org/coalitionsOnline/article.asp?id=475
procedures, participants and analyses 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. Skip 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 5th 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

http://cadca.org/coalitionsOnline/article.asp?id=475

10/18/2004
### SAMPLE LOGIC MODEL

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Activities</th>
<th>Long-term Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change community norms and values.</td>
<td>Provide information to bar owners and event hosts about the dangers of meth use.</td>
<td>Decrease in meth use increases.</td>
</tr>
<tr>
<td>Reduce demand for meth.</td>
<td>Meth is increasingly available.</td>
<td>More meth available increases.</td>
</tr>
<tr>
<td>Treatment services are developed.</td>
<td>Treatment services are expanded.</td>
<td>More treatment services available increases.</td>
</tr>
<tr>
<td>Enhance access and reduce barriers to treatment for meth use.</td>
<td>Enhance access and reduce barriers to treatment for meth use.</td>
<td>More treatment services available increases.</td>
</tr>
</tbody>
</table>

### Theory of Change

When a community comes together and implements multiple strategies, young adults will be more likely to use less.

### Problem

**Problem:** Young adults are using meth.

**But why?** Meth is easy to make.

**But why?** Meth is easy to get.

### Source

Community Anti-Drug Coalitions of America (CADCA), National Coalition Institute's, Evaluation Primer
Guidance Document: Selecting, Planning, and Implementing Evidence-Based Interventions for the Prevention of Substance Use Disorders
### 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.

<table>
<thead>
<tr>
<th>Mission, Goals, Objectives</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does this program or practice fit your organization’s mission?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Does the program or practice fit with the values underlying your organization’s mission?</td>
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<tr>
<td>3. Is the program or practice compatible with the organization’s current focus?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Implementation Capacity</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Does your organization have the human resources to implement the program or practice?</td>
<td></td>
<td></td>
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<tr>
<td>5. Does your organization have the material resources to implement the program or practice?</td>
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<tr>
<td>6. Does your organization have the appropriate funding to implement the program or practice?</td>
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<tr>
<td>7. Can you implement the program or practice in the manner it was designed?</td>
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<tr>
<td>8. Does the program or practice take into account the readiness of the community and target population?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Cultural Relevance</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Is the program or practice appropriate for the community’s values and existing practices?</td>
<td></td>
<td></td>
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<tr>
<td>10. Is the program or practice appropriate for the culture and characteristics of the community being served?</td>
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<tr>
<td>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?</td>
<td></td>
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<tr>
<td>12. Has the program or practice shown positive results in areas that are important to your community?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Evidence Based and Effective</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Is the program or practice based on a well-fined theory or model?</td>
<td></td>
<td></td>
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<tr>
<td>14. Is there documented evidence of effectiveness (such as formal evaluation results)?</td>
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<tr>
<td>15. Have the results been replicated successfully by different researchers over time?</td>
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<tr>
<td>16. Has the program or practice been shown to be effective for areas similar to those you will address?</td>
<td></td>
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</tr>
</tbody>
</table>
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:
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 9\textsuperscript{th} – 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 every 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.
Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question
Criterion 1: Comprehensive Community-Based Mental Health Service Systems
Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring 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 coordinate the following services under comprehensive community-based mental health service systems?

a) Physical Health
   - Yes
   - No

b) Mental Health
   - Yes
   - No

c) Rehabilitation services
   - Yes
   - No

d) Employment services
   - Yes
   - No

e) Housing services
   - Yes
   - No

f) Educational Services
   - Yes
   - No

g) Substance misuse prevention and SUD treatment services
   - Yes
   - No

h) Medical and dental services
   - Yes
   - No

i) Support services
   - Yes
   - No

j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)
   - Yes
   - No

k) Services for persons with co-occurring M/SUDs
   - Yes
   - No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

One of the best practices implemented in Michigan that touches many of the items noted above is the implementation and sustainability of the Michigan Fidelity Assistance and Support Team (MIFAST). The MIFAST group reviews programs for the purpose of assisting them in developing and sustaining evidence-based programs with a high level of fidelity. MIFAST does this by conducting a technical assistance training to help agencies become appropriately trained in the models and programs. These are followed by an onsite visit by MIFAST members to determine the degree to which the agency has...
achieved implementation by fidelity scoring of the scorecard elements, and subsequent provision of technical assistance to aid in the improvement of areas that are shown to need further development. Currently MIFAST groups address DDCMHT, ACT, co-IDDT/ACT; Individual Placement and Support, and Family Psychoeducation.

3. Describe your state’s case management services

Targeted case management is a Medicaid covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist individuals in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes. Targeted case management services must be available for all children with serious emotional disturbance, adults with serious mental illness, persons with developmental disability, and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the Prepaid Inpatient Health Plan (PIHP), and/or are unable to independently access and sustain involvement with needed services. Determination of need for case management must occur at the completion of the intake process and through the person-centered planning process. Justification as to whether case management is needed or not must be documented in the individual’s record. Monitoring is completed by the case manager determining, on an ongoing basis, if the services and support have been delivered, and if they are adequate to meet the needs/wants of the individual. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the beneficiary’s health and welfare needs identified in the individual plan of services.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Through a contract with the PIHPs, it is the expectation effective and efficient operation of various programs and agencies in a manner consistent with all applicable federal and state laws, regulations and policies. As applied to services and supports, this includes assuring appropriate services, quality and the efficient and economic provision of supports and services are assured. Quality is measured by meeting or exceeding a set of outcomes specifications in individual’s plan of service, developed through a person-centered planning process. There are to be clear guidelines for decision making and program operations and the provision for monitoring. The PIHP must offer to direct assistance to explore and secure all applicable reimbursements and assist the individual to make the use of other community resources as available and appropriate. MDHHS encourages the use of natural supports to assist in meeting an individual’s need to the extent that family or friends who provide natural supports are willing and able to provide this assistance. The use of natural supports must be documented in the individual plan of service. Many of the specialty programs and services provided in Michigan are also intended to reduce hospitalization and hospital stays. For adults, these include Assertive Community Treatment, Clubhouse Psychosocial Rehabilitation, crisis residential programs, consumer run drop-in programs, intensive crisis stabilization, and Family Psychoeducation. Many of the integrated health projects are also focused on work with primary care providers to better coordinate services for individuals to return to the community as soon as medically possible and feasible.
In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state’s M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

<table>
<thead>
<tr>
<th>Target Population (A)</th>
<th>Statewide prevalence (B)</th>
<th>Statewide incidence (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adults with SMI</td>
<td>4.56%</td>
<td>349,000</td>
</tr>
<tr>
<td>2. Children with SED</td>
<td>6-12%</td>
<td>71,046 to 142,092</td>
</tr>
</tbody>
</table>

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.

Michigan’s estimated population was around 9,995,915 persons as reported by the July 1, 2018 United States Census Bureau. Of that number 78.3% were over the age of 18, constituting an estimate of 7,826,680 adults. Per the 2016-2017 data set (most recent available) provided by the National Survey on Drug Use and Health (NSDUH), 4.56% (349,000) of Michigan’s adult population are estimated to have serious mental illness, and there were 231,306 persons served through the Michigan mental health services system in 2017.

Prevalence data supplied by the Substance Abuse and Mental Health Services Administration’s (SAMHSA) 2013 National Outcome Measures Prevalence Report suggests 6-12% of the 1,184,104 children from ages 9 to 17 in Michigan could be identified as having a serious emotional disturbance (SED). That means anywhere from 71,046 to 142,092 children ages 9 to 17 might have been eligible for services in the public mental health system in 2013 alone. However, data compiled by MDHHS for FY17 indicates 43,314 children (ages 0 through 17) with SED were served in the public mental health system in Michigan.
**Criterion 3**

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

<p>| | |</p>
<table>
<thead>
<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td>a)</td>
<td>Social Services</td>
</tr>
<tr>
<td>b)</td>
<td>Educational services, including services provided under IDE</td>
</tr>
<tr>
<td>c)</td>
<td>Juvenile justice services</td>
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<tr>
<td>d)</td>
<td>Substance misuse prevention and SUD treatment services</td>
</tr>
<tr>
<td>e)</td>
<td>Health and mental health services</td>
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<tr>
<td>f)</td>
<td>Establishes defined geographic area for the provision of services of such system</td>
</tr>
</tbody>
</table>
a. Describe your state’s targeted services to rural population.

One way in which MDHHS/BHDDA is targeting efforts to reach the rural population in the state is through rural transportation projects with Mental Health Block Grant funding. These grants provide funding for transportation services for the individuals served at critical transitions in their care in rural areas. This ensures that individuals can attend their scheduled behavioral health appointments and reduces the risk of “no-shows”.

b. Describe your state’s targeted services to the homeless population.

MDHHS Children’s Services Agency ensures that homeless youth services are provided to youth ages 16-21 that require support for a longer period of time. Services include crisis management, community education, counseling, placement, and life skills. Services are provided statewide through contracted providers. Contracts were amended to require 25 percent of the youth served by transitional living programs to have been from foster care. In addition to the Runaway and Homeless Youth Services, MDHHS supports a transitional living program in the Upper Peninsula, which is funded through a federal Housing and Urban Development (HUD) grant. MDHHS provides a match for the federal funding. The current homeless youth contracted agencies provide crisis call services that are resource-based within their geographical area statewide.

c. Describe your state’s targeted services to the older adult population.

Older adults are eligible for the same service array as younger adults within the public behavioral health system. In FY17 over 11,728 older adults (65 and over) received public behavioral health services, which is approximately 5% of the total number of adults served. Approximately 4,028 of these individuals had an Intellectual/Developmental Disability, 6,530 had a mental illness, and 1,170 had both. MDHHS continues to partner with Lansing Community College to provide an annual Mental Health and Aging Conference and regional seminars focus on the mental health needs of elders. Other partnerships include collaborative work with the Michigan Assisted Living Association, providing materials, curriculum, and training on dementia care to staff of facilities whose residents include over half persons with dementia.
Narrative Question

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

**Criterion 5**

Describe your state’s management systems.

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

Assisted by block grant resources, Michigan has continued to make strides in improving our system of care to include the availability and delivery of many programs and practices. Among the strengths demonstrated across our State, efforts have continued to progress in the development and implementation of a range of SAMHSA-endorsed evidence-based practices (EBPs) and cross-cutting initiatives across our CMHSP provider system including training, fidelity review process, and monitoring. Block grant-supported projects targeting various adult service practice areas include: Assertive Community Treatment (ACT); Family Psychoeducation (FPE); Co-occurring Disorders (COD); Integrated Dual Disorders Treatment (IDDT); Motivational Interviewing; Individual Placement and Support; International Accreditation of Clubhouses; Jail Diversion; Veteran and Military Family Members strategic plan implementation; Consumer/Peer-Run Services and Advocacy; Integrated Physical & Behavioral Health; and Trauma-specific and Trauma-informed Services.
Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question
Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

   a) A full continuum of services

      i) Screening
      ○ Yes □ No
      ii) Education
      ○ Yes □ No
      iii) Brief Intervention
      ○ Yes □ No
      iv) Assessment
      ○ Yes □ No
      v) Detox (inpatient/social)
      ○ Yes □ No
      vi) Outpatient
      ○ Yes □ No
      vii) Intensive Outpatient
      ○ Yes □ No
      viii) Inpatient/Residential
      ○ Yes □ No
      ix) Aftercare; Recovery support
      ○ Yes □ No

   b) Services for special populations:

      Targeted services for veterans?
      ○ Yes □ No
      Adolescents?
      ○ Yes □ No
      Other Adults?
      ○ Yes □ No
      Medication-Assisted Treatment (MAT)?
      ○ Yes □ No
Criterion 2
**Criterion 3**

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?  
   - Yes  
   - No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?  
   - Yes  
   - No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?  
   - Yes  
   - No

4. Does your state have an arrangement for ensuring the provision of required supportive services?  
   - Yes  
   - No

5. Has your state identified a need for any of the following:  
   
   a) Open assessment and intake scheduling  
   - Yes  
   - No
   
   b) Establishment of an electronic system to identify available treatment slots  
   - Yes  
   - No
   
   c) Expanded community network for supportive services and healthcare  
   - Yes  
   - No
   
   d) Inclusion of recovery support services  
   - Yes  
   - No
   
   e) Health navigators to assist clients with community linkages  
   - Yes  
   - No
   
   f) Expanded capability for family services, relationship restoration, and custody issues?  
   - Yes  
   - No
   
   g) Providing employment assistance  
   - Yes  
   - No
   
   h) Providing transportation to and from services  
   - Yes  
   - No
   
   i) Educational assistance  
   - Yes  
   - No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   The state level Women’s Treatment Specialist works closely with regional Women’s Treatment Coordinators to ensure that all programs are meeting the requirements set forth in the state’s contract with the regional PIHPs, including the Women’s Treatment Policy. The regional coordinators visit each of their contracted PPW programs annually and any issues and concerns are discussed with the Women’s treatment Specialist, as well as the corrective actions needed. Initial visits to programs interested in becoming a PPW program are attended by both the state level Women’s Treatment Specialist and the regional Women’s Treatment Coordinator(s) to ensure the program meets the requirements to offer the PPW services.
**Criterion 4,5&6**

**Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
   a) 90 percent capacity reporting requirement  
   b) 14-120 day performance requirement with provision of interim services  
   c) Outreach activities  
   d) Syringe services programs  
   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation

2. Has your state identified a need for any of the following:
   a) Electronic system with alert when 90 percent capacity is reached  
   b) Automatic reminder system associated with 14-120 day performance requirement  
   c) Use of peer recovery supports to maintain contact and support  
   d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?

3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   The Office of Recovery Oriented Systems of Care monitors compliance for admission via the Priority Population Wait List Deficiency Reports and 90% Capacity Reports. In addition, the State Opioid Treatment Authority 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?

2. Has your state identified a need for any of the following:
   a) Business agreement/MOU with primary healthcare providers  
   b) Cooperative agreement/MOU with public health entity for testing and treatment  
   c) Established co-located SUD professionals within FQHCs

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 in dictate 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 Communicable Disease policy to include requirements related to appropriate services for persons with or at risk of contracting TB and other communicable disease.

**Early Intervention Services for HIV (for “Designated States” Only)**

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery?

2. Has your state identified a need for any of the following:
   a) Establishment of EIS-HIV service hubs in rural areas
b) Establishment or expansion of tele-health and social media support services

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c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS

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**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.C § 300x-31(a)(1)(F))?  
<table>
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<th>Yes</th>
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2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?  
<table>
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<th>Yes</th>
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3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?  
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<th>Yes</th>
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If yes, please provide a brief description of the elements and the arrangement

Programs use Substance Abuse Block Grant funds to provide counseling and care coordination types of services to PWID who use local Syringe Service Programs. The Office of Recovery Oriented Systems of Care and Public Health have used Substance Abuse Block Grant funds to expand Syringe Service Programming in local health departments, as well as expanding to additional areas of the state.
Criterion 8, 9 & 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independent Peer Review

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?

2. Has your state identified a need for any of the following:
   a) Workforce development efforts to expand service access
   b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services
   c) Establish a peer recovery support network to assist in filling the gaps
   d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)
   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
   f) Explore expansion of services for:
      i) MAT
      ii) Tele-Health
      iii) Social Media Outreach

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?

2. Has your state identified a need for any of the following:
   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services
   b) Establish a program to provide trauma-informed care
   c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education

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)?

2. Does your state provide any of the following:
   a) Notice to Program Beneficiaries
   b) An organized referral system to identify alternative providers?
   c) A system to maintain a list of referrals made by religious organizations?

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?

2. Has your state identified a need for any of the following:
   a) Review and update of screening and assessment instruments
   b) Review of current levels of care to determine changes or additions
c) Identify workforce needs to expand service capabilities

   Yes ☐ No ☐

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background

   Yes ☐ No ☐

**Patient Records**

1. Does your state have an agreement to ensure the protection of client records?

   Yes ☐ No ☐

2. Has your state identified a need for any of the following:

   a) Training staff and community partners on confidentiality requirements

      Yes ☐ No ☐

   b) Training on responding to requests asking for acknowledgement of the presence of clients

      Yes ☐ No ☐

   c) Updating written procedures which regulate and control access to records

      Yes ☐ No ☐

   d) Review and update of the procedure by which clients are notified of the confidentiality of their records 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 online. In addition, the contract between MDHHS and the PIHPs requires the PIHPs to also ensure that their substance abuse service providers meet licensure and accreditation requirements.

3. Has your state identified a need for any of the following:

   a) Development of a quality improvement plan

      Yes ☐ No ☐

   b) Establishment of policies and procedures related to independent peer review

      Yes ☐ No ☐

   c) Development of long-term planning for service revision and expansion to meet the needs of specific populations

      Yes ☐ No ☐

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?

   Yes ☐ No ☐

   If Yes, please identify the accreditation organization(s)

   i) ✔ Commission on the Accreditation of Rehabilitation Facilities

   ii) ✔ The Joint Commission

   iii) ✔ Other (please specify)

      Accreditation Association for Ambulatory Health Care
      National Quality Assurance
**Criterion 7&11**

**Group Homes**

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?  
   - Yes ☐  No ☑

2. Has your state identified a need for any of the following:
   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service  
      - Yes ☐  No ☑
   b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing  
      - Yes ☐  No ☑

**Professional Development**

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
   a) Recent trends in substance use disorders in the state  
      - Yes ☐  No ☑
   b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services  
      - Yes ☐  No ☑
   c) Performance-based accountability  
      - Yes ☐  No ☑
   d) Data collection and reporting requirements  
      - Yes ☐  No ☑

2. Has your state identified a need for any of the following:
   a) A comprehensive review of the current training schedule and identification of additional training needs  
      - Yes ☐  No ☑
   b) Addition of training sessions designed to increase employee understanding of recovery support services  
      - Yes ☐  No ☑
   c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services  
      - Yes ☐  No ☑
   d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort  
      - Yes ☐  No ☑

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
   a) Prevention TTC?  
      - Yes ☐  No ☑
   b) Mental Health TTC?  
      - Yes ☐  No ☑
   c) Addiction TTC?  
      - Yes ☐  No ☑
   d) State Targeted Response TTC?  
      - Yes ☐  No ☑

**Waivers**

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C. § 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
   a) Allocations regarding women  
      - Yes ☐  No ☑

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
   a) Tuberculosis  
      - Yes ☐  No ☑
   b) Early Intervention Services Regarding HIV  
      - Yes ☐  No ☑

3. Additional Agreements:
   a) Improvement of Process for Appropriate Referrals for Treatment  
      - Yes ☐  No ☑
b) Professional Development
   - Yes

c) Coordination of Various Activities and Services
   - Yes

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.
Substance Use Disorders: https://www.michigan.gov/lara/0,4601,7-154-89334_63294_30419-152686--,00.html
Environmental Factors and Plan

11. Quality Improvement Plan - Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019?
   - Yes
   - No

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

   No technical assistance is needed at this time.

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

Footnotes:
Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing “business as usual”? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma paper.

57 Definition of Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.

58 Ibid

<table>
<thead>
<tr>
<th>Please consider the following items as a guide when preparing the description of the state’s system:</th>
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<tbody>
<tr>
<td>1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues?</td>
</tr>
<tr>
<td>2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?</td>
</tr>
<tr>
<td>3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?</td>
</tr>
<tr>
<td>4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?</td>
</tr>
<tr>
<td>5. Does the state have any activities related to this section that you would like to highlight.</td>
</tr>
<tr>
<td>1) A training of group facilitators has been created for the many self-help groups conducted throughout the Michigan Consumer Run Drop-in Center network. These group facilitators are now all trained to be trauma-informed facilitators, regardless of the specificity of the topic and group being taught. Approximately 150 different self-help groups are conducted yearly in the drop-in center network. Approximately 80 facilitators have been trained in trauma informed care with inclusion in all self-help group required instruction.</td>
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<tr>
<td>2) The Children’s Trauma Initiative Learning Collaborative participants attend a 3-5 day training with topics focused on trauma</td>
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principles, Complex Trauma in children, Secondary Trauma and Trauma Screening. Assessment measures for children across the age range, as well as evidence based practices (TF-CBT), Resource Parent Training (group model for caregivers), and their implementation. They participate in consultation calls, twice per month for clinicians/supervisors and monthly consultation calls with supervisors to address supervisory issues. Learning Collaborative participants are invited to attend follow-up trainings to review cases, assessments/assessment processes, TFCBT implementation with special populations, and evaluation. The Learning Collaborative participants also complete monthly evaluation metrics to assure fidelity and outcomes which are entered on the online training site. In FY19, new Learning Collaborative, Child Parent Psychotherapy, has begun with clinicians and supervisors from seven (7) CMHSPs, being trained to provide this trauma specific evidence-based practice for young children, birth to 5 years of age, and their caregiver(s). In addition, conference calls with senior leadership (CMHSP Children’s Services Directors, Program Directors) regarding system implementation and potential agency barriers to implementation are facilitated by MDHHS staff.

This initiative has been supported with block grant funding for several years and has resulted in the participation of 44 out of 46 CMHSPs in Michigan. The initiative continues with the goal of having all CMHSPs trained and implementing trauma screening, assessment and evidence-based practices statewide for children with SED and their families.

As part of the Children’s Trauma Initiative, participating CMHSPs utilize Trauma Screening using an standardized, validated tool as well as Trauma d Assessment (University of California-Los Angeles Post Traumatic Stress Disorder Assessment (UCLA PTSD), the Young Child PTSD Checklist (YCPC) or the Trauma Symptom Checklist for Young Children (TSCYC)) 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, Trauma Informed Assessment (University of California-Los Angeles Post Traumatic Stress Disorder Assessment (UCLA PTSD), the Young Child PTSD Checklist (YCPC) or the Trauma Symptom Checklist for Young Children (TSCYC)) 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) and Child Parent Psychotherapy 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.
Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.

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.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

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

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

Footnotes:


60 http://csgjusticecenter.org/mental-health/
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**14. Medication Assisted Treatment - Requested (SABG only)**

**Narrative Question**

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], 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) ☑ Methadone
   b) ☑ Buprenorphine, Buprenorphine/naloxone
   c) ☐ Disulfiram
   d) ☐ Acamprosate
   e) ☑ Naltrexone (oral, IM)
   f) ☑ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*?  
   - Yes ☐  No ☐

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

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.

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. 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.

*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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15. Crisis Services - 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 M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.61 SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA’s publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises62.

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.


Please check those that are used in your state:

1. Crisis Prevention and Early Intervention
   a) □ Wellness Recovery Action Plan (WRAP) Crisis Planning
   b) □ Psychiatric Advance Directives
   c) □ Family Engagement
   d) □ Safety Planning
   e) □ Peer-Operated Warm Lines
   f) □ Peer-Run Crisis Respite Programs
   g) □ Suicide Prevention

2. Crisis Intervention/Stabilization
   a) □ Assessment/Triage (Living Room Model)
   b) □ Open Dialogue
   c) □ Crisis Residential/Respite
   d) □ Crisis Intervention Team/Law Enforcement
   e) □ Mobile Crisis Outreach
   f) □ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support
   a) □ Peer Support/Peer Bridgers
   b) □ Follow-up Outreach and Support
   c) □ Family-to-Family Engagement
   d) □ Connection to care coordination and follow-up clinical care for individuals in crisis
Follow-up crisis engagement with families and involved community members
Recovery community coaches/peer recovery coaches
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 related to this section.

Footnotes:
Environmental Factors and Plan

16. Recovery - Required

Narrative Question
The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports); purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual’s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

• Recovery emerges from hope;
• Recovery is person-driven;
• Recovery occurs via many pathways;
• Recovery is holistic;
• Recovery is supported by peers and allies;
• Recovery is supported through relationship and social networks;
• Recovery is culturally-based and influenced;
• Recovery is supported by addressing trauma;
• Recovery involves individuals, families, community strengths, and responsibility;
• Recovery is based on respect.

Please see SAMHSA’s Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:
a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?

b) Required peer accreditation or certification?

c) Block grant funding of recovery support services.

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state’s M/SUD system?

2. Does the state measure the impact of your consumer and recovery community outreach activity?

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 and substance use disorders. 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, MDHHS has 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.

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 finalized information for Certified Peer Recovery Coaches as a Medicaid provider.

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?

Beginning in 2016 a three-year Veteran and Military Members Strategic Plan was developed by BHDDA. One of the objectives of this plan was 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. This coordination has continued, primarily at the local level.

A Female Veteran Peer Support Group program was implemented in the third quarter of FY19 and will continue through FY 2020-2021. The group is open to any person that identifies as female, has served in the United States Armed Forces and is struggling with mental health concerns or substance use disorders. A facilitator manual/guide is available for review, if desired.

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

No technical assistance is needed at this time.

Footnotes:
Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court’s decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA’s mission to reduce the impact of M/SUD on America’s communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court’s Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state’s Olmstead plan include:
   - Housing services provided.
   - Home and community based services.
   - Peer support services.
   - Employment services.

2. Does the state have a plan to transition individuals from hospital to community settings?

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

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

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18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community. 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. 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.

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. 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.

According to data from the 2015 Report to Congress on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and
• residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

66The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

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?
   b) The recovery and resilience of children and youth with SUD?

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
   a) Child welfare?
   b) Juvenile justice?
   c) Education?

3. Does the state monitor its progress and effectiveness, around:
   a) Service utilization?
   b) Costs?
   c) Outcomes for children and youth services?

4. Does the state provide training in evidence-based:
   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?
   b) Mental health treatment and recovery services for children/adolescents and their families?

5. Does the state have plans for transitioning children and youth receiving services:
   a) to the adult M/SUD system?
   b) for youth in foster care?

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Michigan continues to work on supporting a foundation for a statewide system of care (SOC) for children with serious emotional disturbance (SED), substance use disorders (SUD) and all co-occurring disorders (COD). All public mental health providers in Michigan utilize a standard definition of SED and uniform access standards, as outlined in an attachment to the Michigan Department of Health and Human Services (MDHHS) contract with the Pre-Paid Inpatient Health Plans (PIHPs) and with the Community Mental Health Services Providers (CMHSPs). And in fiscal year 2009, the SOC planning process was formally incorporated into the public mental health system through the Program Policy Guidelines (PPGs) through which MDHHS requires CMHSPs to provide an assessment of their local SOC and how they planned to move forward in addressing these gaps. Michigan continues to work with PIHPs to provide technical assistance regarding progressing to more comprehensive SOCs. CMHSPs are also required to utilize a SOC planning process to prepare their applications for funding through the children's portion of the mental health block grant and/or in implementing the 1915(c) Waiver for children with SED (SEDW).

As indicated earlier in the application, legislation passed in Michigan required that each Coordinating Agency (CA) be incorporated into an existing PIHP to formally integrate mental health and substance use disorder services statewide by January 1, 2013. Some PIHPs had already placed a specific focus on training on COD for youth and these include Oakland and Central...
Michigan. Oakland County PIHP has held training in Motivational Interviewing in order to increase engagement of families in treatment, as well as addressing the mental health and substance use issues of adolescents and family members. CMH for Central Michigan also includes a specific COD focus on children/adolescents to assist with meeting goals around their substance use. Several other PIHPs use Multi-Systemic Therapy (MST) as a strategy for addressing CODs. Additionally, Michigan received a State Youth Treatment-Planning (SYT-P) grant in Fiscal Year 2015 to develop and expand the infrastructure for adolescent and transitional age youth treatment and recovery support services. Through the SYT-P grant, 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 FY20-21. In responding to Request for Proposals (RFP) for the children's portion of the federal mental health block grant for the past five years, CMHSPs were asked to take the lead with their community stakeholders including the other agencies (child welfare, juvenile justice, education, etc.) and family members to plan the SOC for children with SED and propose projects in their RFP submissions that would fill identified gaps in the local SOC. The most recent RFP was for CMHSPs to proposed collaborative mental health screening projects to identify youth with mental health needs who have come in contact with the juvenile justice system, or are at risk for becoming involved in that system, and refer them to appropriate services. The original seven funded projects plus the additional three newly funded projects are joint mental health and court and/or school projects. Michigan also continues to apply for and receive local SOC grants from SAMHSA and most recently were awarded several SOC expansion grants. Michigan was also awarded a Healthy Transitions grant to fund two pilot sites to implement the Transition to Independence model for transition age youth with SED/SMI. This grant is in its first year and MDHHS is very excited to learn from the pilot sites in hopes of improving the public mental health system for all transition age youth. However, many barriers remain in the development of a statewide comprehensive SOC and access to mental health services for children who need them. Human service agencies recognize that they need to continue to explore ways to reduce the duplication of services, especially case management and the provision of services through the use of the wraparound process and family-driven and youth-guided practice, to maximize the use of funds.

Historically in Michigan and currently, efforts have been made to move children into communities from more restrictive out-of-home placement, while still providing beneficial and helpful treatment interventions. This movement has continued and will continue to be supported with mental health block grant funding. The development and implementation of intensive community-based services has been crucial to moving children into the least restrictive environment without compromising treatment effectiveness. Mental Health Block Grant dollars were offered to the CMHSPs in FY18-19 for start-up of Intensive Crisis Stabilization Services (Mobile Crisis) and Crisis Residential for children/youth. These services are essential pieces of the continuum of service for children with SED and providers continue to work on establishing and supporting these services in sufficient capacity. A major part of Michigan’s transformation plan has been the incorporation of family-driven and youth-guided practice, which has led to increased consumer choice and treatment interventions that are designed as the child and family desires. The MDHHS child welfare residential transformation process that MDHHS has embarked upon with consultation from children’s mental health staff continues. MDHHS continues to consult with the Building Bridges initiative to determine how this approach may enhance residential treatment for the youth to whom it may be beneficial. MDHHS is also beginning the process to pilot Treatment Foster Care – Oregon in two urban communities and is in the process of onboarding an additional site. The hope is that these types of approaches will provide additional options for children requiring out of home care to receive appropriate treatment and return to their communities as soon as possible.

MDHHS has been a leader in increasing collaboration with other state agencies, local communities, and families. MDHHS participates in many interagency groups and emphasizes collaboration for children’s services. Through these groups, the SOC has improved through the elimination of duplicative efforts and new projects being planned with joint efforts in development, implementation, and evaluation of services. More work is being planned to further improve the SOC, increase parent leadership development, and increase and maintain youth involvement on interagency committees. FY20-21 continues to bring opportunities for collaborative efforts in the areas of juvenile justice, screening, identification and treatment of social/emotional/mental health issues in home and community-based environments, services to transition-aged youth and public/private collaboration to address the needs of children with SED (and often times SED along with a developmental disability and/or cognitive impairment) who repeatedly cycle through residential and psychiatric placements. MDHHS 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 140 youth in five 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 continues to support 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. Additionally, Michigan has been awarded a HRSA grant to expand MC3 in the state.

MDHHS has been particularly interested in increasing access to specialty mental health services and supports for Medicaid eligible children/youth with SED in child welfare (i.e., abuse/neglect, foster care and/or adopted children/youth) and juvenile justice. Also at the community level, interagency administrative groups serve to assure interagency planning and coordination. Of these various local committees, the most pivotal group is the Community Collaborative. All of Michigan’s 83 counties are served by a single county or multi-county Community Collaborative which functions to oversee the planning and development of children’s services. The local collaborative bodies are comprised of local public agency directors (public health, community mental health, child welfare, juvenile justice and substance abuse agencies), family court judges, prosecutors, families and sometimes a youth, private agencies and community representatives.

Key components of SOC (family-driven and youth-guided, cross system funding for services for child welfare foster care children with SED, etc.) have been the focus of interagency planning at the state level for many years, and great strides have been made in the past two years. As a result of participation in the February 2009 National Federation of Families for Children’s Mental Health’s Policy Academy on Transforming Children’s Mental Health through Family-Driven Strategies and continuing work by that team, an official MDHHS policy on Family-Driven and Youth–Guided Practice is utilized by PIHP/CMHSP providers to operationalize the concepts of family-driven and youth-guided service provision. A statewide Parent Support Partner training curriculum was developed in a partnership between the family organization and MDHHS, and training began in 2010 and will continue in FY20-21. The youth peer curriculum trainings have been operational since FY16 and continue to add Youth Peer Support Specialists to the public mental health workforce. The mental health block grant supports both these statewide training initiatives.

With regard to MDHHS monitoring progress made in and the effectiveness of public mental health services to children and youth with SED and their families and carrying out one of the activities specified in the authorizing statute of the MHBG (evaluating programs and services carried out under the plan), MDHHS will continue to contract with Michigan State University to procure the services of Dr. John Carlson and student assistants required to evaluate particular approaches and services and the system as a whole, at amounts not to exceed those listed next to each project annually, to ensure that public mental health services funded by all sources are producing optimal results for the required population. The Level of Functioning (LOF) Project ($35,621) evaluates functional assessment data collected on every child with SED served by the public mental health system. MSU LOF Project staff will work collaboratively with Multi-Health Systems (MHS), the purveyor of the CAFAS and PECFAS tools, to obtain functional assessment information entered into the FAS Outcomes system by direct service providers who serve children with SED in the Michigan public mental health system. This information is analyzed and used to generate reports that demonstrate the amount of improvement in functioning of children with SED served that has occurred under several pre-determined conditions. Special attention is given in analysis to the variables associated with positive outcomes as measured by both initial (from previous fiscal years) and most recent/exit CAFAS and PECFAS ratings. For those receiving evidence-based practices (EBPs), scores prior to receiving those services will be used to reflect the potential improvements resulting from the EBP. Reports are shared with CMHSPs/PIHPs annually to utilize in children’s mental health services quality improvement activities.

The following projects target specific EBPs and/or services for evaluation:

• Children’s Trauma Initiative Evaluation ($101,959): MSU and MDHHS Children’s Trauma Initiative staff work collaboratively with CMHSP direct service providers involved in the Michigan public mental health system’s Children’s Trauma Initiative to determine the effectiveness of the services being provided to children who have experienced trauma. Outcome and fidelity information is collected via the Research Electronic Data Capture (REDCap) system and analyzed. Information is analyzed on a regular basis and consultation provided to allow project staff to generate/create brief reports to be shared with the field across the year. An end of the fiscal year report for each of the three subprojects (TF-CBT, Screening, Caregiver Education) is generated as well.

• Parent Support Partner Evaluation ($88,822): MSU, MDHHS, ACMH and direct Parent Support Partner (PSP) service provider agencies work together to collect and analyze information being submitted via REDCap about the provision of the PSP service to parent participants who are receiving PSP services in the public mental health system. Providers can access the online system for real-time data review and additional analysis through the availability of report features to monitor service provision and outcomes. Through a peer-parent relationship, parents/caregivers feel increased hope and confidence and are empowered to find and use their voices so, in partnership with providers, they can inform services and supports for their child/youth—thus leading to better outcomes.

• Wraparound Evaluation ($141,588): MSU, MDHHS and direct Wraparound service providers work together to determine and demonstrate the effectiveness of Wraparound services being provided to children with SED in the public mental health system across the state of Michigan. The purpose of this analysis is to examine the effectiveness and fidelity/acceptability of services currently being delivered under the leadership of Wraparound facilitators. Information regarding outcomes gathered from Wraparound facilitator ratings on the Family Status Reports (FSR) is submitted via REDCap and analyzed regularly and full feedback reports are completed semi-annually. Analysis involves looking at outcome variables over time for improvement and the relationship between outcome data and fidelity data to determine if certain Wraparound practices and services are leading to improved outcomes.

• Children with Serious Emotional Disturbance (SED) and Neuro–developmental Disorders (NDD) Strategies Evaluation ($50,021): MSU SED/NDD Strategies staff work collaboratively with MDHHS and CMHSP/PIHP participants that are serving children with
SED/NDD in the public mental health system using specified techniques to determine if these techniques improve outcomes for this population and to inform treatment for children with SED/NDD in the entire system. Outcome and fidelity variables are collected from CMHSP/PIHP direct service providers via REDCap. An annual report for each of the treatment initiatives (e.g., screening and assessment, Families moving Forward, SED/NDD Strategies) is provided annually to be shared with MDHHS, the sites and the entire public mental health system.

- Infant and Early Childhood Mental Health Consultation (IECMHC) Evaluation ($70,000): MSU IECMHC staff work collaboratively with MDHHS and CMHSP/PIHP IECMHC participants that are serving children with SED to determine the effectiveness of the intervention. Evaluation includes assessment of program impact on (1) child care provider caregiving practices, (2) the impact of these practice changes on young children’s social and emotional development, (3) the impact of these practice changes on program/child expulsion rates, (4) caregiver reflective capacity; (5) carrying out the IECMHC model as intended (fidelity), and (6) perceptions of program acceptability. Reports of outcomes and trends are provided on an annual basis.

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

7. Does the state have any activities related to this section that you would like to highlight?
   Please see information provided above.
   Please indicate areas of technical assistance needed related to this section.

   No technical assistance is needed at this time.

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

Footnotes:
Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question
Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state’s suicide prevention plan in the last 2 years?
   - [ ] Yes
   - [ ] No

2. Describe activities intended to reduce incidents of suicide in your state.
   The Michigan Association for Suicide Prevention has recently released a state suicide prevention plan. However, it has not been adopted by MDHHS as the official update to the 2005 state plan.

   The Michigan Department of Health and Human Services has received a new five-year SAMHSA-funded state youth suicide prevention grant, which started on June 30, 2019. A number of activities will be taking place under that grant including:
   - Expansion of the suicide risk screening program for youth entering foster care developed under our previous grant.
   - Development of a statewide network of general medicine emergency departments implementing evidence-based assessment, intervention, continuity of care, and follow-up strategies for youth at risk of suicide and their families.
   - Supporting local communities to implement suicide best practices tailored to community needs via technical assistance, training, education, and funding opportunities.
   - Continuation of support for ASIST (Applied Suicide Intervention Skills Training) and AMSR (Assessing and Managing Suicide Risk) workshops for communities statewide.
   - Continuation of support for the annual Suicide Prevention Community Technical Assistance meeting that is open to anyone interested in suicide prevention at the local level.

   MDHHS has also supported Zero Suicide implementation activities through our previous SAMHSA grant. These activities included initial work to establish the Zero Suicide model in one local health department and one community mental health agency. The grant also supported training and the development of a Zero Suicide Network for a large urban county in the state.

3. Have you incorporated any strategies supportive of Zero Suicide?
   - [ ] Yes
   - [ ] No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?
   - [ ] Yes
   - [ ] No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted?
   - [ ] Yes
   - [ ] No

   If so, please describe the population targeted.

   We have not started any new initiatives since the submission of the last plan, although some will begin in the near future with our new youth suicide prevention SAMHSA funding.

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

   No technical assistance is needed at this time.

Footnotes:
Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question
The success of a state’s MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state’s office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state’s ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?  
   - No

2. Has your state identified the need to develop new partnerships that you did not have in place?  
   - Yes

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 Bureau of Services to Blind Persons; 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 Disabilities 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 (CMHSPs) 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 a county-based community mental health services programs (CMHSPs). Michigan Department of Health and Human Services (MDHHS), along with 46 regional Community Mental Health Services Programs (CMHSPs) and 10 Pre-paid 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 Prepaid Inpatient Health Plans (PIHPs), three of which are single county Pre-paid Inpatient Health Plans (PIHPs) and seven of which are regional entities. Substance Abuse services are purchased through the 10 Pre-paid Inpatient Health Plans (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 Prepaid Inpatient Health Plans (PIHPs) and their Community Mental Health (CMH) 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.

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 believed 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 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.

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

Footnotes:
Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S.C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council’s comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.69

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.


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

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

       The state developed and published an Office of Recovery-Oriented Systems of Care (OROSC) Strategic Plan (FY18 - FY20), 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 substance exposed births
         - Increasing youth awareness of Gambling Disorder
         - Reducing the effects of parental substance use on youth

       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 misuse and abuse
         - Reducing misuse and abuse of alcohol, opioid medications, and illicit drugs
         - Reducing barriers to accessing treatment for opioid use disorders
         - Increasing longevity and quality of life, by reducing health disparities and improving self-management

       Health Services: Transform the Healthcare System by:

         - Continuing the implementation of a recovery-oriented system of care across the lifespan
         - Expanding integrated behavioral health and primary care services for persons at risk for and with substance use and mental health disorders
         - Promoting opportunities for individuals with mental health disorders to self-direct their services and supports
         - Promoting and 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
         - Increasing the number of individuals certified as peer support specialist and recovery coaches
         - Providing training and continuing education to strengthen skills of CPSS and CPRC
         - Expanding employment opportunities for Certified Peer Recovery Coaches and Certified Peer Support Specialists in
primary and integrated care settings
- Increasing the capacity of prevention efforts to address Gambling Disorder

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The duties and responsibilities of the BHAC are included in the bylaws that have been uploaded as an attachment to this section. The BHAC membership includes persons in recovery, family members, advocates, and other individuals who are important to this diverse council.

If additional input is requested or needed from other individuals, the BHAC may create special committees or workgroups with persons appointed to serve who are outside the Council membership. The BHAC is also listed on the department’s website with meeting dates, copies of the minutes, and contact information for the BHAC liaison. All meetings of the BHAC are open to the public, which creates another avenue for individuals to provide input.

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

No technical assistance is needed at this time.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.70

70There 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.
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: (a) advise the Michigan Department of Health and Human Services (MDHHS) 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; and (b) engage in advocacy external to the department regarding mental health and substance use disorder issues.

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 Health and Human Services 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 Health and Human Services, other elements of the executive branch, the Legislature, and the general public as to service system needs for persons with behavioral health problems.

3. The Director of the Department of Health and Human Services may suggest additional areas of responsibilities to the Council.

ARTICLE III
Members
1. Members shall be appointed by the Director of the Michigan Department of Health and Human Services 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 advocates or individuals who are or were
      service recipients or their family members.
   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 the Council when unable to attend a
      scheduled meeting.
   b. Absent members who do not provide notification to be excused from a meeting and
      do not send an alternate shall be noted as un-excused.
   c. Monitoring and enforcing attendance requirements shall be a responsibility of the
      executive committee.
   d. Two un-excused absences during a member’s term shall trigger an interview of the
      member by the executive committee to determine the member’s continued status on
      the Council
   e. 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 status on the
      Council.

7. Vacancies: Vacancies on the Council shall be filled by appointment by the Director of the
   Department of Health and Human Services 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 department’s 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 Secretary, who shall be elected by the Council.

2. Officers shall be members of 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 3 consecutive terms.

4. 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 3 consecutive terms.

5. The 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 3 consecutive terms.

6. 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.

7. Nominations shall be submitted to the Council 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 such nomination. Nominees may vote in election of officers.

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 Health and Human Services, Council Chairperson or a minimum of 6 members may call a special meeting of the Council as necessary.

4. A quorum shall be more than ½ of the number of members serving on the Council at the time of the vote.

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

6. The current edition of Robert's Rules of Order shall govern the conduct of all meetings.

7. Members of the Council or any Council committee may participate in a meeting of the Council or a committee by means of conference telephone or similar communications equipment by which all persons participating in the meeting can communicate with each other. Participation in a meeting pursuant to this provision shall constitute presence at such meeting and carry voting privileges.

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 an advocate, a current or former service recipient, or the family member of a recipient, then such a 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, 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/family member representation that is needed. 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.

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 November 17, 2017.
Behavioral Health Advisory Council
Bylaws

ARTICLE I
Name
1. The name of this unincorporated association shall be the Behavioral Health Advisory Council.

ARTICLE II
Function
1. The purpose of the Behavioral Health Advisory Council shall be to: (a) advise the Michigan Department of Health and Human Services (MDHHS) 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; and (b) engage in advocacy external to the department regarding mental health and substance use disorder issues.

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 Health and Human Services 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 Health and Human Services, other elements of the executive branch, the Legislature, and the general public as to service system needs for persons with behavioral health problems.

3. The Director of the Department of Health and Human Services may suggest additional areas of responsibilities to the Council.

ARTICLE III
Members
1. Members shall be appointed by the Director of the Michigan Department of Health and Human Services 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 advocates or individuals who are or were service recipients or their family members.
   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 the Council when unable to attend a scheduled meeting.
   b. Absent members who do not provide notification to be excused from a meeting and do not send an alternate shall be noted as un-excused.
   c. Monitoring and enforcing attendance requirements shall be a responsibility of the executive committee.
   d. Two un-excused absences during a member’s term shall trigger an interview of the member by the executive committee to determine the member’s continued status on the Council.
   e. 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 status on the Council.

7. Vacancies: Vacancies on the Council shall be filled by appointment by the Director of the Department of Health and Human Services 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 department’s 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.
Behavioral Health Advisory Council
Bylaws

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 Secretary, who shall be elected by the Council.

2. Officers shall be members of the Council.

3. 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 3 consecutive terms.

4. 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 3 consecutive terms.

5. The 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 3 consecutive terms.

6. 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.

7. Nominations shall be submitted to the Council 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 such nomination. Nominees may vote in election of officers.

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 Health and Human Services, Council Chairperson or a minimum of 6 members may call a special meeting of the Council as necessary.

4. A quorum shall be more than ½ of the number of members serving on the Council at the time of the vote.

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


7. Members of the Council or any Council committee may participate in a meeting of the Council or a committee by means of conference telephone or similar communications equipment by which all persons participating in the meeting can communicate with each other. Participation in a meeting pursuant to this provision shall constitute presence at such meeting and carry voting privileges.

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 an advocate, a current or former service recipient, or the family member of a recipient, then such a 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.
Behavioral Health Advisory Council
Bylaws

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, 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/family member representation that is needed. 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.

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 November 17, 2017.
Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Membership*</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
<th>Email(if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julie Barron</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>3333 Moores River Drive Lansing MI, 48911 Ph: 517-346-9600</td>
<td><a href="mailto:barron@ceiemh.org">barron@ceiemh.org</a></td>
<td></td>
</tr>
<tr>
<td>Kim Batsche-Mckenzie</td>
<td>State Employees</td>
<td>235 S. Grand Avenue Lansing MI, 48909 Ph: 517-241-5765</td>
<td><a href="mailto:batsche-mckenzie@michigan.gov">batsche-mckenzie@michigan.gov</a></td>
<td></td>
</tr>
<tr>
<td>Linda Burghardt</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>1907 Atherton Way Okemos MI, 48864 Ph: 517-347-1077</td>
<td><a href="mailto:LBurghardt@comcast.net">LBurghardt@comcast.net</a></td>
<td></td>
</tr>
<tr>
<td>Karen Cashen</td>
<td>State Employees</td>
<td>Behavioral Health and Developmental Disabilities Administration Lansing MI, 48913 Ph: 517-335-5934</td>
<td><a href="mailto:cashenk@michigan.gov">cashenk@michigan.gov</a></td>
<td></td>
</tr>
<tr>
<td>Elmer Cerano</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>6737 Landsdown Dimondale MI, 48821 Ph: 586-940-0368</td>
<td><a href="mailto:ecerano@aol.com">ecerano@aol.com</a></td>
<td></td>
</tr>
<tr>
<td>Mary Chaliman</td>
<td>State Employees</td>
<td>Child Welfare Medical Unit Lansing MI, 48933 Ph: 517-898-0707</td>
<td><a href="mailto:Chalimanm2@michigan.gov">Chalimanm2@michigan.gov</a></td>
<td></td>
</tr>
<tr>
<td>Becky Cienki</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>Michigan Health Endowment Fund</td>
<td><a href="mailto:becky@mihealthfund.org">becky@mihealthfund.org</a></td>
<td></td>
</tr>
<tr>
<td>Norm DeLisle</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>Michigan Disability Rights Coalition</td>
<td><a href="mailto:ndelisle@ymdrc.org">ndelisle@ymdrc.org</a></td>
<td></td>
</tr>
<tr>
<td>Erin Emerson</td>
<td>State Employees</td>
<td>Medical Services Administration Lansing MI, 48933 Ph: 517-284-1132</td>
<td><a href="mailto:emersone@michigan.gov">emersone@michigan.gov</a></td>
<td></td>
</tr>
<tr>
<td>Kevin Fischer</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>National Association on Mental Illness</td>
<td><a href="mailto:kfischer@namimi.org">kfischer@namimi.org</a></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Contact Information</td>
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<tr>
<td>Jennifer Hirst</td>
<td>State Employees</td>
<td>Michigan Department of Health and Human Services, Lansing MI, 48933, PH: 517-275-1237</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><a href="mailto:henst@michigan.gov">henst@michigan.gov</a></td>
<td></td>
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<tr>
<td>Greg Johnson</td>
<td>State Employees</td>
<td>Michigan Department of Corrections, Huron Valley Correctional Facility, Ypsilanti MI, 48197</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><a href="mailto:johnsong16@michigan.gov">johnsong16@michigan.gov</a></td>
<td></td>
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</tr>
<tr>
<td>Benjamin Jones</td>
<td>Providers</td>
<td>National Council on Alcoholism and Drug Dependence, 2400 E. McNichols, Detroit MI, 48212</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>PH: 313-868-1340</td>
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<tr>
<td></td>
<td></td>
<td><a href="mailto:president@ncadd-detroit.org">president@ncadd-detroit.org</a></td>
<td></td>
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<tr>
<td>Arlene Kashata</td>
<td>Representatives from Federally Recognized Tribes</td>
<td>Tribal Behavioral Health Communication Network, 2815 Hilltop Court, Traverse City MI, 49686</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>PH: 231-735-0491</td>
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<td></td>
<td></td>
<td><a href="mailto:akashata@hotmail.com">akashata@hotmail.com</a></td>
<td></td>
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</tr>
<tr>
<td>Michael Leathead</td>
<td>State Employees</td>
<td>Department of Education, 608 W Allegan St, Lansing MI, 48933, PH: 517-241-1500</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><a href="mailto:williamsS8@michigan.gov">williamsS8@michigan.gov</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mark Maggio</td>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td>1106 Ethel Ave, Hancock MI, 49930, PH: 906-281-1909</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><a href="mailto:markmaggio88@yahoo.com">markmaggio88@yahoo.com</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kevin McLaughlin</td>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td>2673 Oakleigh Rd, Middleville MI, 49333, PH: 616-262-8531</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><a href="mailto:kevin@recoveryallies.us">kevin@recoveryallies.us</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paula Nelson</td>
<td>Providers</td>
<td>Sacred Heart Rehabilitation Center, 400 Stoddard Rd, Richmond MI, 48062, PH: 810-392-2167</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><a href="mailto:pnelson@sacredheartcenter.com">pnelson@sacredheartcenter.com</a></td>
<td></td>
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</tr>
<tr>
<td>Malkia Newman</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>279 Summit Drive, Waterford MI, 48328, PH: 248-871-1482</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><a href="mailto:mnewman@cnshealthcare.org">mnewman@cnshealthcare.org</a></td>
<td></td>
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</tr>
<tr>
<td>Stephanie Oles</td>
<td>State Employees</td>
<td>Michigan State Housing Development Authority, 735 E. Michigan Ave, Lansing MI, 48912, PH: 517-241-8591</td>
<td></td>
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<td></td>
<td></td>
<td><a href="mailto:OlesS@michigan.gov">OlesS@michigan.gov</a></td>
<td></td>
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</tr>
<tr>
<td>Jamie Pennell</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>211 Butler Street, Leslie MI, 49251, PH: 517-589-9074</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><a href="mailto:jpenell00@yahoo.com">jpenell00@yahoo.com</a></td>
<td></td>
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</tr>
<tr>
<td>Eva Petoskey</td>
<td>Representatives from Federally Recognized Tribes</td>
<td>Inter-Tribal Council of Michigan, 2848 N. Setterbo Road, Peshawbestown MI, 49682, PH: 231-357-4886</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><a href="mailto:epetoskey@centurytel.net">epetoskey@centurytel.net</a></td>
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<tr>
<td>Mark Reinstein</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>Mental Health Association, 3 Medford Circle, Ann Arbor MI, 48104, PH: 734-646-8099</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><a href="mailto:msrmha@aol.com">msrmha@aol.com</a></td>
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<tr>
<td>Michelle Roberts</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>Michigan Protection and Advocacy Services, 4095 Legacy Parkway, Lansing MI, 48911, PH: 517-487-1755</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><a href="mailto:mroberts@mpas.org">mroberts@mpas.org</a></td>
<td></td>
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</tr>
<tr>
<td>Kristie Schmiege</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>Michigan Rehabilitation Services, Lansing MI, 48933, PH: 517-275-1237</td>
<td></td>
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</tr>
<tr>
<td>Name</td>
<td>Membership Type</td>
<td>Agency/ Organization</td>
<td>Address</td>
<td>Phone</td>
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<tr>
<td>Larry Scott</td>
<td>State Employees</td>
<td>Michigan Department of Health and Human Services</td>
<td>Lansing MI, 48913</td>
<td>PH: 517-335-0174</td>
</tr>
<tr>
<td>Jane Shank</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>Association for Children's Mental Health</td>
<td>6017 W St Joe Hwy Lansing MI, 48917</td>
<td>PH: 231-383-1595</td>
</tr>
<tr>
<td>Patricia Smith</td>
<td>State Employees</td>
<td>Michigan Department of Health and Human Services</td>
<td>109 W Michigan Ave Lansing MI, 48913</td>
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<tr>
<td>Sally Steiner</td>
<td>State Employees</td>
<td>Michigan Department of Health and Human Services</td>
<td>Office on Aging Lansing MI, 48909</td>
<td>PH: 517-284-0164</td>
</tr>
<tr>
<td>Maxine Thome</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>NASW (MI)</td>
<td>741 N Cedar St Lansing MI, 48906</td>
<td>PH: 517-487-1548 ext 14</td>
</tr>
<tr>
<td>Jeff VanTreese</td>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td></td>
<td>665 136th Avenue Holland MI, 49424</td>
<td>PH: 616-795-9969</td>
</tr>
<tr>
<td>Dawne Velianoff</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>Michigan Primary Care Association</td>
<td>7215 Westshire Dr. Lansing MI, 48917</td>
<td>PH: 517-827-0875</td>
</tr>
<tr>
<td>Brian Wellwood</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td>520 Cherry St Lansing MI, 48933</td>
<td>PH: 517-371-2221 ext 313</td>
</tr>
</tbody>
</table>

*Council members should be listed only once by type of membership and Agency/organization represented.

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

**Footnotes:**
### Environmental Factors and Plan

#### Advisory Council Composition by Member Type

<table>
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<tr>
<th>Start Year:</th>
<th>2020</th>
<th>End Year:</th>
<th>2021</th>
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<table>
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<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage of Total Membership</th>
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<tbody>
<tr>
<td><strong>Total Membership</strong></td>
<td>33</td>
<td>100%</td>
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<tr>
<td>Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)</td>
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<tr>
<td>Family Members of Individuals in Recovery* (to include family members of adults with SMI)</td>
<td>5</td>
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<tr>
<td>Parents of children with SED/SUD*</td>
<td>0</td>
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<tr>
<td>Vacancies (Individuals and Family Members)</td>
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</tr>
<tr>
<td>Others (Advocates who are not State employees or providers)</td>
<td>8</td>
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<tr>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Representatives from Federally Recognized Tribes</td>
<td>2</td>
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</tr>
<tr>
<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
<td>20</td>
<td>60.61%</td>
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<tr>
<td>State Employees</td>
<td>11</td>
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<tr>
<td>Providers</td>
<td>2</td>
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<tr>
<td>Vacancies</td>
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<tr>
<td><strong>Total State Employees &amp; Providers</strong></td>
<td>13</td>
<td>39.39%</td>
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<tr>
<td>Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations</td>
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<tr>
<td>Providers from Diverse Racial, Ethnic, and LGBTQ Populations</td>
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<tr>
<td><strong>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</strong></td>
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</tr>
<tr>
<td>Youth/adolescent representative (or member from an organization serving young people)</td>
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</tr>
</tbody>
</table>

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

---

**Footnotes:**

There are several diverse racial, ethnic, or LGBTQ members of the BHAC. They were included in other categories than separated out. In addition, there is one member of the BHAC who is a provider that fits this criteria. This provider was not separated out from the other providers.
Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question
Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
   a) Public meetings or hearings?
      Yes  No
   b) Posting of the plan on the web for public comment?
      Yes  No
      If yes, provide URL:
      https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4902-359929--,00.html
   c) Other (e.g. public service announcements, print media)
      Yes  No

Footnotes:

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