



**PRACTICE IMPROVEMENT STEERING
COMMITTEE**



**PRACTICE IMPROVEMENT STEERING COMMITTEE MEETING
NOVEMBER 9, 2009**

Compendium of Michigan's Evidence-based Best and Promising Practices:

Michigan's Public Mental Health System
Advance Directives for Mental Health Care
Anti-Stigma Steering Committee
Assertive Community Treatment
Certified Peer Support Specialists
Cognitive Behavioral Therapy for Older Adults
Co-occurring Mental Health and Substance Abuse Use Disorders Treatment
Cultural Competency
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Recovery
Supported Employment
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Trauma Focused Cognitive Behavioral Therapy
Virtual Team
Virtual Team Form
Wraparound Model

MICHIGAN'S PUBLIC MENTAL HEALTH SYSTEM

It is the vision of the Michigan Department of Community Health (MDCH) that: "Michigan's children, families and adults will have access to a public mental health and substance abuse service system that supports individuals with mental illness, emotional disturbance, developmental disabilities and substance use disorders by promoting good mental health, resiliency, recovery, and the right to control one's life within the context of the benefits and responsibilities of community."

Together with consumers, providers, families, advocates, community stakeholders, and policy makers, the MDCH is engaged in a system transformation process aimed at achieving the vision. In May 2005, the MDCH used federal Community Mental Health Block Grant funds to issue a request for proposals (RFP) to the state's 18 Prepaid Inpatient Health Plans (PIHPs) for Medicaid Specialty Mental Health and Substance Abuse Services and Supports. The RFP invited PIHPs to partner with MDCH and affiliate community mental health services programs to improve practices in the public mental health system. All 18 PIHPs responded to this invitation and agreed to use funding to convene Improving Practices Leadership Teams (IPLTs) and join in statewide practice improvement. The formation of the IPLTs was aimed at fostering a learning organization within the public mental health system so that emerging, promising and evidence-based practices quickly became part of the choices available to consumers during the person-centered planning process.

The MDCH charged IPLTs to:

- Adopt a vision for a transformed system of care for adults and children;
- Establish leadership capabilities and organizational capacity to communicate the vision and lead the transformation;
- Create an environment or climate of working that is receptive and amenable to the transformation;
- Develop and communicate a strategy that is tailored to the context and the roles, capabilities, and interests of the stakeholder groups involved in the public mental health system;
- Identify and mobilize program leaders or change agents within the organization to implement the activities required to achieve the desired outcomes;
- Develop an ongoing process to maximize opportunities and overcome obstacles; and monitor outcomes and adjust processes based on learning from experience.

IPLTs are expected to:

- Align relevant persons, organizations, and systems to participate in transformation process;
- Support membership of a consumer/Certified Peer Support to represent the PIHP on the Recovery Council of Michigan
- Assess parties' experience with change;
- Establish effective communication systems;
- Ensure effective leadership capabilities;
- Enable structures and process capabilities;

- Improve cultural capacity; and
- Demonstrate their progress in system transformation by implementing evidence-based, promising and new and emerging practices.
- Communicate statewide information as a feedback loop to representative agencies including board of directors, Executive Director, agency staff, consumers, advocates and community stakeholders.

IPLT membership includes:

- An Improving Practice Leader
- Specialists in each of these areas: services for individuals with serious mental illness; services for children with serious emotional disturbance; and services for people with a developmental disability
- Finance
- Data
- Evaluation
- Consumer employed by the PIHP or subcontract agency
- Family member of a child receiving PIHP services
- An identified program leader for each practice being implemented by the PIHP
- An identified program leader for peer-directed or peer-operated services
- A Certified Peer Support Specialist
- This document highlights some of the statewide accomplishments in fostering:
 - A system of care based in recovery for adults with mental illness
 - A system of care for children; and
 - Improved practices for delivering services and supports for people with developmental disabilities

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The MDCH leader for Improving Practices Leadership Teams is: Irene Kazieczko, (517) 335-0252, or kazieczko@michigan.gov

MDCH key contacts for IPLTs are: Patty Degnan, (517) 373-2845, or degnanp@michigan.gov, and Tison Thomas, (517) 241-2616, or thomasti@michigan.gov

ADVANCE DIRECTIVES FOR MENTAL HEALTH CARE

On January 3, 2005, Advance Directives for Mental Health Care became law in Michigan. The legal reference is contained in the Estates and Protected Individuals Code, PA 1998 No. 386, as amended by PA 2004 No. 532. The statutory citation is MCL 700.5506 et seq.

The Michigan Department of Community Health (MDCH) published a pamphlet that was written by Bradley Geller, Esq., in partnership with the Michigan Recovery Council. The document is based on providing information and forms to assist adults with mental illness in developing an advance directive that documents their wishes and choices about care provided. In Michigan, an advance directive for mental health care, also referred to as a durable power of attorney for mental health care, is a document in which you appoint another individual to make mental health decisions for you in the future. Individuals can choose to have a durable power of attorney for health care, an advance directive for mental health care or no durable power at all.

To provide additional technical assistance in conjunction with the pamphlets and brochures, MDCH, in partnership with Michigan Protection and Advocacy Services, completed a variety of trainings around the state for consumers, families, providers and other stakeholders. This included six regional trainings for consumers, administrators, and staff; a workshop at the annual Consumer Conference which over 500 consumers attended; and the Upper Peninsula consumer conference also held a session on Advance Directives for consumers, families, and staff.

Michigan is one of several states to support recovery by providing the right to have an advance directive. Specific information on each state is available at the website hosted by the National Resource Center for Psychiatric Advance Directives (PAD). This website provides an important voice with quotes from adults with mental illness who have chosen to develop an advance directive. Some of the listed quotes include:

- “it was really crowded in the ER so I showed intake my psychiatric advance directive and told them that I needed to go somewhere quiet....so that I could calm down....The intake nurse sat with me in a quiet room until I calmed down.”
- “I would recommend PADs because people can have you committed and you don’t have a say about anything, and at least this way you do have some say in your treatment, if its read and people see it and it’s legal.”
- “My therapist suggested I make copies of my PAD, so I did that, and gave a copy to everyone I wanted to. There is a copy of file at the hospital, just in case, along with my general healthcare directive. I don’t want any mistakes made...Those are my wishes and that’s a legal document, and it must be followed.”
- “This time, with a PAD, I did not receive any treatments that I did not want. They were respectful. I really felt like the hospital took better care of me because I had my PAD in fact, I think it’s the best care that I’ve ever received.”

The quotes above are proof that an advance directive is beneficial and addresses freedom, liberty or independence that is central to dignity. For further information on

advance directives in Michigan, visit the MDCH website at:
http://www.michigan.gov/mdch/0,1607,7-132-2941_4868_41752---,00.html

Assisting individuals in determining choices and options in developing an advance directive during the person-centered planning process is a fundamental need for strengthening initiatives for practice improvement.

Contact Person: Colleen Jasper, (517) 373-1255, or jasper@michigan.gov

ANTI-STIGMA STEERING COMMITTEE

Overview:

In March of 2009, the Michigan Department of Community Health (MDCH) appointed an Anti-Stigma Steering Committee made up of consumers, providers, and other stakeholders. They have been asked to work over a two-year period to:

- Examine current anti-stigma efforts and activities connected to other parties already engaged in anti-stigma work
- Learn more about efforts and directions in other states and countries
- Evolve the best set of principles and goals for Michigan's anti-stigma work
- Gauge the extent of efforts and the outcomes achieved

Once the Steering Committee has outlined and established an effective anti-stigma approach at the state level, MDCH can set the example for local CMHSPs, providers, and advocates to partner with those they support to develop successful approaches to combating stigma within their systems and their communities. Accountability for program success will be a primary guiding principle for this effort.

Summary:

In order to effectively combat stigma throughout Michigan, we must first focus on the stigma within the system. When MDCH has set the example by confronting its internal organizational stigma, it can more effectively provide needed support and resources to other programs throughout Michigan and empower both providers and consumers. The appointed Steering Committee will be instrumental in identifying and establishing methods that will move toward eliminating stigma. By doing so, consumers will receive better care and will have more success in recovering from mental illness.

Contact People: *Colleen Jasper, (517) 373-1255, or jasper@michigan.gov, or Stephanie Harris, (517) 335-3845, or harriss5@michigan.gov*

ASSERTIVE COMMUNITY TREATMENT

The challenge to the evidence-based practice (EBP) of Assertive Community Treatment (ACT) is not implementing ACT, but creating and sustaining an environment which looks at the practice, identifies needed improvements to attain the essential elements of ACT, and applies and maintains them. Implemented in Michigan approximately 20 years ago, over time many ACT teams drifted away from the model. Attention to adhering closely to the model while focusing on recovery has increased as the Improving Practices Initiative continues. ACT Medicaid requirements now call for ACT specific training for each ACT team member including doctors and nurse practitioners. To address concern about program drift throughout the state, a study was completed, team and consumer needs were identified and a tool (The Field Guide to Michigan ACT) created. Additionally, an ACT Subcommittee will be convened to get a broad range of perspectives on how best to maintain and improve ACT services in the state.

The Field Guide to ACT (FG), now in near final draft, was developed to take into account recovery, fidelity, Medicaid, best practice and feedback from field visits; it is a self assessment tool that can be used by teams, agencies and PHIPs to improve ACT service delivery, support consumers in their recovery journey and facilitate quality outcomes for the consumers served. The FG integrates Michigan Medicaid and the SAMHSA (Substance Abuse and Mental Health Services Administration) ACT Implementation Resource Kit evidence based standards. The Field Guide is a tailored combination of these sources that takes into account Michigan's unique environment and history in provision of ACT services. Michigan ACT teams provide services to a largely rural population and the Michigan expectation is an average team size much smaller than the team size on which the SAMHSA toolkit is based.

Several modifications to the Michigan Medicaid requirements have been made to improve ACT services; it is planned that other changes, including an allowance for a Nurse Practitioners to be a team member working in collaboration with the ACT doctor, will become a part of Medicaid.

Originated in the 1970's in Wisconsin as a 'hospital without walls,' the Programs of Assertive Community Treatment (PACT) model, as advocated by the federal Substance Abuse Mental Health Administration (SAMHSA), proved difficult to fund and sustain across the nation. As an early adopter, ACT was moved into Michigan, in concert with Madison, Wisconsin and Harbinger Clinic in Grand Rapids. Adaptations were made to address the treatment needs of consumers in our state. The primary differences between ACT and PACT are team size (ACT 4-8 staff with a 1:10 staff to consumer ratio, PACT at least 10 staff with a 1:10 staff to consumer ratio), multiple team shifts (PACT), team qualifications (specific set of professionals (PACT), provision of all needed services within the team (PACT), or the provision or brokering of services by smaller teams (ACT). In the most recent fiscal year, 6,148 individuals received ACT services in Michigan.

Contact Person: Alyson Rush, (517) 335-0250, or rusha@michigan.gov

CERTIFIED PEER SUPPORT SPECIALISTS

Overview:

In the past decade, a variety of national policy documents and initiatives have outlined and delineated the positive outcomes of employing a peer workforce in the public mental health system. Some of these initiatives include the Americans with Disabilities Act, Surgeon General's report on Mental Health, President's New Freedom Commission on Mental Health, and the Center for Medicare and Medicaid Services' (CMS) letter of peer support guidance to Medicaid Directors stating that peer support is an evidence-based practice.

Michigan has forged a parallel track with several state initiatives supporting policy development and requirements for peer support services. In March 2006, Peer Support Specialists became a Medicaid-covered service under the 1915 b(3) waiver authority. Michigan was one of the first states to use Medicaid funding for Peer Support Specialists. CMS has recommended Michigan as a resource to other states for an example of exemplary peer practices.

The description of services provided by Certified Peer Support Specialists (CPSS) is based on activities that promote community inclusion and participation, independence, productivity and recovery. Some examples of services that peers provide in partnership with individuals served by the public mental health system include:

- Vocational assistance
- Housing assistance
- Facilitation of the person-centered planning process
- Developing and applying arrangements that support self-determination
- Sharing stories of recovery and/or advocacy involvement
- Accessing entitlements
- Developing wellness plans
- Developing advance directives
- Learning about and pursuing alternatives to guardianship
- Providing supportive services during crises
- Developing, implementing and providing ongoing guidance for advocacy and support groups

MDCH continues to work closely with the 46 Community Mental Health Services Programs (CMHSPs) and 18 Prepaid Inpatient Health Plans (PIHPs) to support peer specialists as part of systems transformation efforts to a recovery-based system of care. Liaisons from CMHSPs and PIHPs meet every other month to discuss strengths and barriers of employing a peer workforce and brainstorming solutions for improved outcomes. Each meeting highlights innovative programs with presentations provided on promising and best practices. Information from the meetings is shared collaboratively among participating agencies.

Accomplishments:

- Over 643 individuals have been trained and certified in 2009.
- In partnership with VA medial centers, over 25 veterans have been trained and certified as part of Michigan's workforce.
- Three elective credit hours are awarded from Lansing Community College once certification requirements are met.
- The first national pilot for peer whole health was held in Michigan.
- Over 100 CPSS are trained in Personal Action Toward Health (PATH), an evidence-based practice from Stanford University.
- 20 CPSS have achieved Master Trainer status in PATH awarded by Stanford University.
- In June 2009, the first annual Peer Support Specialist conference was held with over 400 individuals attending.
- Developed a collaborative relationship with the peer specialist network in Canada.
- In 2010, Michigan will be part of a national peer research study with Boston University Center of Psychiatric Rehabilitation to measure the effect of peer services in assisting people with their vocational dreams and goals.

Plans for FY10:

To grow, strengthen and support the peer trained workforce by providing leadership, direction and policy development.

Provide 6 additional trainings increasing the workforce to 800 CPSS.

- Develop a statewide brochure on peer services.
- Complete guidelines on continuing education requirements to maintain certification.
- Expand training in the area of health and wellness with additional peer-led initiatives replicated statewide.
- Increase opportunities for CPSS to receive training in evidence-based practices.
- Continue to utilize MH Block Grant funds for low cost training and technical assistance activities.
- Provide leadership and policy direction in employing Peer Support Specialists in the public mental health system.
- Increase the national presence and provide technical assistance to assist other states and countries in developing peer specialist services.

Contact Person: Pam Werner, (517) 335-4078, or wernerp@michigan.gov

COGNITIVE BEHAVIORAL THERAPY (CBT) FOR OLDER ADULTS

People who are age 65 and older, and who have a serious mental illness, continue to be recognized as an underserved population in the public mental health system. Additionally they may be at risk of suicide, experience dementia with depressed mood, behavioral disturbances or delusions, or have co-occurring problems with substance use or dependence, and often there are other complicating factors that can include multiple medical conditions that may mask psychiatric conditions, multiple medication interactions, age-related changes to physical and mental functioning, and increasing isolation.

Older adults have greater mental health needs than are currently being served. The Michigan Mental Health Commission Report of 2004 stated that, "Special outreach efforts need to be targeted to older adults, persons with dementia, and their caregivers." The President's New Freedom Commission recognized the need for increased workforce development. This initiative addresses workforce development but not penetration rates or outreach or service efforts.

Cognitive Behavioral Therapy (CBT), as modified for older adults, is an evidence-based practice (EBP) supported by the department to build capacity in the workforce. The model has been adapted to older adults, and fidelity assessments occur within the supervision activities.

Selected Community Mental Health Services Program (CMHSP) older adult treatment staff was offered training in CBT. Training includes an initial two-day session with lecture, discussion and practice, monthly individual viewing of provider submitted tapes for supervision and feedback, with additional technical assistance available as needed, and one additional training day at the end of the year. October 2009 began year 3 of this initiative. New CMH and contract staff working with older adults who have symptoms of serious mental illness will receive CBT training, previously trained staff who have completed the training, sent in tapes and who wish to participate in a train-the-trainer model will also be a part of year 3 training.

Contact Person: Alyson Rush, (517) 335-0250, or rusha@michigan.gov

INTEGRATED TREATMENT FOR INDIVIDUALS WITH CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Approximately 50 to 70 percent of people served by the public mental health and substance use disorder systems have co-occurring disorders. While mental illness and substance use disorders are closely related, Michigan historically has had a parallel and/or sequential system of treatment for individuals with co-occurring disorders. Individuals requiring both mental health and substance use services are often seen by two or more separate providers in their community without any coordination, much less integration, of care. The MDCH believes, and research demonstrates, that this is an inefficient and ineffective use of resources and contributes to less than desirable outcomes for people with co-occurring disorders.

MDCH places a high priority on the development and implementation of integrated services for persons with co-occurring mental health and substance use disorders. The department has worked to implement *Co-occurring Disorders: Integrated Dual Disorder Treatment (COD: IDDT)*, a nationally-recognized evidence-based practice for treating individuals who have a serious mental illness and a substance use disorder, throughout the state. MDCH recognized that there are many individuals who may not receive IDDT level of enhanced services. To that end, MDCH encouraged PIHPs/CMHSPs to use the principles of the Comprehensive, Continuous, Integrated System of Care (CCISC) model developed by Dr. Ken Minkoff and Dr. Chris Cline to effectively change the system. To develop this kind of successful and sustainable change, the public mental health system must look at the entire system of care and develop a comprehensive plan that addresses co-occurring disorders and integrated treatment. Currently the majority of the PIHPs and CAs are involved in this system wide effort.

In recognizing the need for integrated treatment services, the BSAAS (then ODCP) initiated changes to the substance abuse administrative rules that resulted in integrated treatment being added to the rules as a service category that can be added to an existing treatment license. Approximately 375 programs through out the state are licensed to provide integrated treatment. Through contract requirements, all coordinating agencies are required to have integrated treatment services available in their provider networks by the end of FY 2009. The PIHP/CMHSP FY10 contract requires the public mental health system to provide co-occurring capable services to all individuals who have a co-occurring disorder. Also, the contract requires that IDDT services must be available as a choice during the person-centered planning process.

MDCH recognizes that in order to sustain and improve a transformed mental health and substance use disorder services system, all stakeholders must work together to identify and take steps to improve the quality of services provided to all Michigan residents in need of public mental health and substance use services. To this end, the MDCH established an Integrated Treatment Committee (ITC) with representatives from a diverse group of stakeholders in the mental health and substance use services systems and Medicaid, and an Internal Integrated Treatment Group (IITG) to oversee the ITC work within the department. The overall mission of the IITG is to create a framework to enhance the consistency both of internal policy making and of external communications.

Whereas the COD:IDDT Subcommittee is focused on persons with a *serious* mental illness and a co-occurring substance use disorder in the public mental health system, the ITC, and change agent teams are focused on integrating treatment for *all* populations with a co-occurring mental illness and substance use disorder. The department's Internal Integrated Treatment Group was created to provide overall direction to this initiative and to create a framework to enhance the consistency both of internal policy making and of external communications. The ITC recently approved a strategic plan to address all issues related to co-occurring disorders.

The ITC strategic plan goals for the system are as follows:

- The infrastructure of the public mental health and substance use disorder systems will support the recovery of individuals with co-occurring disorders.
- Individuals with co-occurring disorders will easily access and engage in effective integrated treatment services that support their recovery.

The ITC members are meeting with various statewide groups and sharing the strategic plan and receiving input to develop a comprehensive work plan.

Summary of Accomplishments:

To date, approximately 78 teams have been identified as providing COD: IDDT throughout the state. Most of these teams are at varying degrees of implementation. MDCH, through federal block grant funding, is supporting a peer review process for fidelity monitoring and technical assistance for these IDDT teams. This peer review team, called Michigan Fidelity Assessment Support Team (MiFAST), is staffed by more than twenty trained staff from different CMHSPs. To date, fidelity assessments were completed for more than 40 IDDT teams. There are more than 35 Dual Recovery Anonymous (DRA) groups for people with co-occurring disorders in the state.

The MiFAST team is providing on-site and off-site technical assistance (TA) and training for PIHP and CMHSP staff. The COD: IDDT Subcommittee coordinates a "Learn and Share" quarterly meeting, in which each IDDT teams share what they learned and how they address barriers. MDCH identified two modifier codes and issued instructions to both mental health and substance abuse systems on how to report COD: IDDT and other integrated services. MDCH redefined the disability designation field in the quality improvement file to better capture individual substance use disorder data in the public mental health system. To date more than 4,000 staff from different PIHPs/CMHSPs and CAs are trained in integrated treatment services at the state level.

In order to promote integrated treatment at every level of care and the entire service array within the PIHP/CMHSP region and ensure better coordination and collaboration with the Coordinating Agencies (CA), a group of approximately 250 change agents were identified from across the PIHP and CA regions and trained by Drs. Minkoff and Cline. Local change agent teams representing PIHPs and CAs have been charged with working within their communities to become an enduring statewide team of clinical and administrative change agents to promote and support the implementation of co-occurring capability, integrated services, and co-occurring clinical competency into every layer of the system of care infrastructure.

Contact People: Tison Thomas, (517) 241-2616, or thomasti@michigan.gov, or Patricia Degnan, (517) 373-2945, or degnanp@michigan.gov

CULTURAL COMPETENCY

The Michigan Department of Community Health (MDCH) is committed to creating a system of care that creates an environment of inclusion and diversity for all of the individuals and families it serves. Recovery, resiliency and habilitation are more likely to occur where systems, services, and providers have and utilize knowledge and skills that are culturally competent and compatible.

Michigan's population is growing and changing dramatically. Present and projected changes in Michigan's ethnic composition challenge the capabilities of our mental health and substance abuse systems. Shifts in ethnic diversity are not just about numbers, but also about the impact of cultural differences. Cultural diversity and competency have primarily been associated with race and ethnicity, but diversity also includes the socio-cultural experiences of people of different genders, social classes, religious and spiritual beliefs, sexual orientations, ages, deaf and hard of hearing, and physical and mental abilities, and reaching out to populations of color.

Accomplishments: Ensuring the provision of culturally competent services to clients places a great deal of responsibility upon the system. In particular, there are a number of generally expected levels of knowledge, skills and attributes that are essential to providing culturally competent services. MDCH, through a contract with the Michigan Association of Community Mental Health Boards and Wayne State University, developed a training curriculum to address cultural competency. Along with the National Center for Cultural Competency, a new cultural competency assessment tool is developed for use of the public system.

Through a survey that was done recently, the point persons and/or cultural competency coordinators from most of the community mental health programs were identified. MDCH invited all of the public mental health and substance abuse systems in Michigan and provided two one-day trainings on cultural competency to the CMHSP/CA identified point persons and/or cultural competency coordinators. MDCH as a follow up to that training also offered technical assistance and training regarding the assessment tools, developing work plans, and identifying training and technical assistance needs and resources for your system.

Expected Outcomes: It is expected that once the coordinators and/or point persons are trained on cultural competency, they will provide training to other staff on cultural competency, identify gaps in the system using the assessment tools, and develop an action plan to address the gaps.

Contact People: *Tison Thomas, (517) 241-2616, or thomasti@michigan.gov, or Patricia Degnan, (517) 373-2945, or degnanp@michigan.gov*

INITIATIVES FOR INDIVIDUALS WITH DEMENTIA AND THEIR CAREGIVERS

The Michigan Department of Community Health (MDCH) is enhancing efforts to improve identification of older adults in all settings who exhibit significant changes and disturbances in mood, cognition, or behavior and to improve integration of services to persons with dementia and serious mental illness among primary, long-term, and mental health care. Family caregivers of isolated older adults with mental illness or progressive disabling medical conditions are also the focus of interventions designed to improve coping skills, mental health needs, and reduction of stress, burden, depression, and family conflicts. Wraparound pilot projects have developed family teams that focus on strengths of natural supports and goals of the person with dementia and their family caregivers. Networks of support are developed for the families and with a Community Team, which is a collaborative group of community-based resources. These Community Teams have been tremendously successful at building relationships and sharing information and resources. Currently, three pilot sites are funded through federal mental health older adult block grants. The projects have added Savvy Caregiver training for family caregivers, an evidence-based caregiver education program, which is offered to both Wraparound-enrolled families and community family members. In addition, the projects have extended Family Team support beyond the death or placement of the person with dementia to provide grief and loss support. We are also supporting and sharing findings and training with two projects that obtained community funding. Efforts are being made to identify sources of funding for Wraparound and respite services following grant funding.

Outreach strategies include traditional and innovative techniques to establish trust, rapport, acceptance, and increased use of mental health services by older adults at-risk. Outreach services provide in-home assessments, treatment plans, and education to caregivers and clients, particularly those who have not been able to meet their mental health needs due to living in a rural area. In addition, community awareness and education regarding symptoms, intervention techniques, resources, and the recovery process for those who suffer from Alzheimer's disease and other serious mental illnesses are held, especially to help local service providers and community organization staff detect and refer elderly persons for mental health services. Plans are underway to bring together project personnel to discuss lessons learned and to identify most effective programming. Expertise developed to increase community mental health clinicians' knowledge and use of cognitive impairment assessment tools and intervention protocols is completed and work will continue on dissemination.

Challenges include recent elimination of the state general fund line items for funding Alzheimer's caregiver education and Alzheimer's respite care. Department staff will continue efforts to collaborate with statewide partners to maintain and extend dementia care education, resources, and programming.

Contact Persons: *Patricia Degnan, (517) 373-2845, or degnanp@michigan.gov, or Marci Cameron, (517)335-0226, or CameronM@michigan.gov*

DIALECTICAL BEHAVIOR THERAPY (DBT)

Dialectical Behavior Therapy (DBT) is structured treatment and support activities provided by a DBT team and designed to provide a set of supports and services. Services may be used to avert an inpatient psychiatric admission and/or other crisis services. DBT team serves individuals who are suicidal, engage in suicide attempts or other self-harm, frequently have multiple diagnoses, and have difficulty remaining engaged in treatment. The services are delivered in a bundled fashion. Individuals in the program receive the entire DBT package of services that includes individual therapy, skills training, and 24/7 on-call response. Staff must receive supervision and team consultation. Treatment and support services are provided to the individuals based on the scope of practice. In order for a program to be considered DBT, all of these elements must be provided. Specific components are not provided *ala carte*.

The Michigan Department of Community Health (MDCH), along with Behavioral Tech LLC, has provided several trainings to implement DBT systematically. Since FY 2007, 35 DBT teams are in different stages of implementing this treatment modality. Approximately 350 staff from community mental health programs has been trained intensively on this modality. MDCH also issued a directive in 2008 regarding approval of the program, expectations of a DBT program, and how to report DBT to the state's data warehouse. It is expected that all the DBT teams have a peer support specialist as part of their team.

Expected Outcomes:

Through this initiative, it is expected there will be a consistent statewide approach for implementation and support of DBT. It is expected that all the teams will continue providing services based on the fidelity of the program, and consumers will be able to receive DBT as a choice during person-centered planning throughout the public mental health system.

Contact People: Tison Thomas, (517) 241-2616, or thomasti@michigan.gov, or Patricia Degnan, (517) 373-2945, or degnanp@michigan.gov

EVIDENCE-BASED PRACTICES MEASUREMENT WORKGROUP

Overview: This workgroup was convened in order to create a forum to discuss issues specific to the measurement of evidence-based practices (EBPs). The work of the Measurement Workgroup includes the development of performance indicators specific to EBPs, developing approaches for improved data collection of consumer characteristics and reporting of EPBs, and the discussion of the training and consulting needs specific to measurement. The work of the group has been based on the following set of guiding principles:

Guiding Principles:

- Measurement is an essential strategy for promoting systems change, informing learning organizations, and supporting implementation of EBPs.
- Measurement adds value to practice and management when it generates information that is useful for informing decisions.
- Measurement must be based on data that is explicitly defined, readily accessible, and on measurement instruments that are valid and reliable.
- Measurement methods must be standardized and implemented with consistency across systems.
- Measurement requirements must be designed to be efficient, minimizing imposition on the time and resources of consumers, providers, and managers while maximizing the utility of the information generated.

Tasks and Accomplishments of Workgroup:

- A review of data elements currently collected by the Michigan Department of Community Health (MDCH) for mental health and coordinating agencies.
 - The group routinely reviews the reporting of selected EBPs to the state's encounter data file including family psychoeducation, parent management training, and integrated dual diagnosis treatment.
 - The group reviews the completeness of reporting in numerous key demographic items including employment, residential living situation, and involvement with the criminal justice system. One demographic item that the group has focused on is the reporting of substance use disorder, which was shown to be substantially underreported. MDCH staff has worked with the Prepaid Inpatient Health Plan Information Technology staff to improve reporting of this item. Also, the workgroup has redesigned the approach for measuring substance abuse disorders as collected in the Quality Improvement data file reported to the state.
- Prioritized and selected 'key' measurements for implementation.
 - The workgroup compiled an extensive list of performance indicators for EBP that were taken from various sources including the state's performance measurement system, SAMHSA's National Outcomes Measures, and Substance Abuse Prevention and Treatment (SAPT).
 - Based on these indicators, MDCH has reviewed the relationship between the presence of co-occurring disorder and various demographic factors such as residential living situation, employment, and involvement with the criminal justice system.

- MDCH and Wayne State University have received a grant from SAMHSA for FY08-10 to develop training programs that provide education on how to use measurement in clinical decision-making, and provide instructions on how to implement measurement. As part of this grant, Wayne State, MiFAST, MDCH, and MACMHB have worked together to develop the April 1-2 2009 conference entitled “Building the Bridge: Integrating Hope and Recovery.” This conference includes presentations by PIHP and CMHSP quality improvement staff on uses of measurement and outcomes monitoring for IDDT and other EBPs. National speakers include Carlos DiClemente and Patrick Boyle.
- For FY 10, each meeting will focus on the measurement activities of a particular PIHP or CMHSP. Presenters are asked to discuss approaches used to measure evidence-based and promising practices at their agency.

Contact Person: Kathleen Haines, (517) 335-0179, or haineskate@michigan.gov

EVIDENCE-BASED USE OF PSYCHOTROPIC MEDICATIONS, ALSO KNOWN AS THE MICHIGAN MENTAL HEALTH EVIDENCE-BASED PRACTICE INITIATIVE (MiMHEBPI)

Overview: MiMHEBPI is a quality improvement project to improve mental health treatment by translating evidence-based medication algorithms into daily clinical practices that promote recovery for persons with schizophrenia, major depression, and bipolar disorder. The Michigan Department of Community Health (MDCH) has been a major partner in the development of this initiative, made possible by funding from the Flinn Foundation and by the support of numerous community and academic organizations.

Rapid advances in clinical neuroscience during the past several decades have challenged the capacities of individual physicians and practitioners to assimilate an expanding knowledge base and to devise optimal therapeutic strategies that rely on the most current evidence. Guidelines and algorithms are important tools in managing large amounts of new information and keeping everyday medical practice in step with current research. In routine practice, however, guidelines and algorithms are significantly under-utilized, primarily due to limits in their immediate availability and ease of use at the point of care.

The effort began in 2002. In phase I of the project, major strategies for achieving these goals, summarized in [Closing the Quality Gap in Michigan: A Prescription for Mental Health Care \(Public Sector Consultants, Inc. 08/04\)](#), were developed by a panel of 25 experts, who identified an optimal set of algorithms, known as the Texas Implementation of Medication Algorithms, and modified them as the Michigan Implementation of Medication Algorithms (MIMA). In phase II, six projects were selected through a competitive, peer-review process, for implementation of these algorithms at test locations beginning in 2005. Phase III will involve implementation throughout the state using web-based software currently in development.

Accomplishments to Date: Phase I of the project is summarized in [Closing the Quality Gap in Michigan: A Prescription for Mental Health Care \(Public Sector Consultants, Inc. 08/04\)](#). Phase II has completed data collection at six sites, viz., Henry Ford Health System et al.; Huron Valley Physician Association, St. Joseph Mercy Health System, Care Choices HMO, Eastern Michigan University; LifeWays Community Mental Health Authority (CMHA) et al.; Network et al.; Washtenaw Community Health Organization, University of Michigan, St. Joseph Mercy Hospital; and Wayne State University, et al. Individual program evaluations have been submitted and analysis of data from the six sites, compiled by a team at the University of Michigan (Fred Blow, PhD, et al.) is in progress. A publication in a peer-reviewed journal has summarized the largest of the pilot projects (Milner et al.: State mental health policy: implementation of computerized medication prescribing algorithms in a community mental health setting. *Psychiatric Services* 60:1010, 2009; abstract at <http://www.ncbi.nlm.nih.gov/sites/entrez>). Preliminary data indicate that a key element in successfully implementing medication algorithms will be development of user-friendly software that guides the clinician through the algorithm process and that produces documentation for the medical record without expanding the time required to complete a consumer visit.

Expected Outcomes: As phase II completes data analyses, phase III is already in progress. Michael Fauman, MD, with support from the Flinn Foundation, is developing ACCESS-based prototype software that will serve as the model for development of a similar program on a more robust database platform. The software would eventually reside on a central server or servers and interact with prescribers throughout the state, allowing any clinician with internet access to employ the algorithms and document treatment using this software.

Contact Person: *Jim Dillon, (517) 241-0678, or Dillonje@michigan.gov*

FAMILY PSYCHOEDUCATION

Family Psychoeducation (FPE) provides consumers and families with education about what mental illness is and is not, how mental illnesses are treated and what a consumer or family member can do to cope with mental illness. FPE teaches how to make the most of available mental health and physical health services and engenders hope in consumers, rather than desperation and demoralization, for continued recovery when under stress. Common issues addressed through FPE include participation in outpatient programs, understanding prescribed medication, dealing with alcohol and/or other drug abuse, and managing symptoms of mental illness that affect the consumer. Tools for problem solving are taught and learned so people who have symptoms of mental illness can learn to take better control of the symptoms and move forward to achieve their hopes and dreams. FPE is a long-term treatment model. Increasingly sophisticated coping skills for handling problems posed by mental illness are taught and learned. Consumer, family and practitioner work together to support recovery. FPE respects and incorporates individual, family and cultural perspectives.

FPE services in Michigan have been implemented as an evidence-based practice (EBP) under our federal community mental health block grant consistent with the federal Substance Abuse Mental Health Administration (SAMHSA) FPE toolkit. FPE has over twenty years of controlled research that supports the efficacy and effectiveness in reducing psychiatric hospitalizations, increasing consumer employment and/or return to formal education and cost reductions. FPE programs follow the McFarlane model with regard to consumer recruitment and joining activities, FPE facilitator's role, content of FPE sessions and other aspects of this proven method of intervention. Anecdotal evidence in Michigan shows that the model has also helped to develop more collaborative relationships with family and consumer advocacy groups. In fiscal year 2010, all PHIPs are required by contract to include FPE as a part of the service array.

The FPE Subcommittee is developing FPE certification and credentialing guidelines. Training, supervision and fidelity considerations for sustainability are under development by subcommittees. Billing consistency throughout the state will be addressed in the quarterly meetings of the FPE Learning Collaborative. A proposed part-time statewide FPE manager will ensure trainings are available, create and maintain a list of all approved facilitators, advanced facilitators and supervisors/trainees, maintain lists of supervisees, work with the FPE Learning Collaborative, coordinate fidelity reviews and in general support the FPE implementation.

FPE Subcommittee minutes from July 21, 2009, indicate the following numbers of staff sent by Michigan agencies to FPE training through June 2009: FPE Facilitators - 693, FPE Advanced Facilitators - 90 and FPE Trainers/Supervisors - 78. Currently the FPE committees are working on the next steps for statewide implementation of FPE.

To assist consumers, family members and staff to become familiar with FPE, a FPE group provided an informational session at the Recovery Council meeting, at the Fall Board Association Conference and at the Advisory Council on Mental Illness.

Contact Person: Alyson Rush, (517) 335-0250, or rusha@michigan.gov

HOUSING AND HOMELESSNESS PROGRAMS/PARTNERSHIPS

The Supportive Housing Program and Ending Homelessness Partnership is in its 10th year and continues to produce more than 100 units per year in 9 counties. This program is supported by a set-aside of low-income housing tax credits for people with special needs. An additional 10% of all low income housing tax credit units are required to be set-aside for people with special needs.

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

The MDCH Homeless Programs consist of Housing Opportunities for People Living with AIDS, PATH, Shelter Plus Care, and Supportive Housing Program grant programs in addition to a program of training and technical assistance made available to sub-grantees. All of these programs provide outreach to people who are homeless with linkages to support to find and sustain housing.

MDCH has also utilized some of its PATH funds to fund the SSI/SSDI Outreach, Access and Recovery (SOAR) initiative. This is a program that trains persons working with homeless people with disabilities to more quickly and successfully obtain benefits.

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

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

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

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

Contact People: *Dave Verseput, (517) 335-6019, or verseput@michigan.gov, or Sue Eby, (517) 241-7060, or ebys@michigan.gov*

INTEGRATING PHYSICAL HEALTH AND MENTAL HEALTH

In a recovery-oriented mental health system, physical health care is as central to an individual's goals as housing, employment and education. Individuals with serious mental illness (SMI) often have co-morbid medical conditions, take several medications, and see multiple health providers. The provision of services to individuals whose needs span multiple service systems has long been recognized by the public mental health system as a huge challenge. Individuals with multiple medical and social needs have had to navigate through a complex and fragmented system of care.

Mental health recovery requires overall wellness and is critical to overall health. The Michigan Department of Community Health (MDCH) envisions that the public mental health system address every consumer's health needs through a person-centered planning process that focuses on the individual consumer's needs and not that of the agency. Through the person-centered planning process, the system must navigate and negotiate the needs of the individual consumer. Research indicates that individuals with SMI die an average of 25 years earlier than those individuals who don't have SMI.

Since October 2008, MDCH has been working with 10 community mental health programs on an initiative to integrate physical health and mental health. The goal is to develop better coordination and integration of mental health and physical health at the service encounter level. This includes partnering with different stakeholders, including Medicaid Health Plans, federally qualified health centers, primary care physicians, substance abuse agencies, hospitals, and others. MDCH provided four one-day technical assistance meetings for all the Community Mental Health programs that were well attended. The trainings and technical assistance were provided by national and state experts.

In FY 09, MDCH was awarded a TTI grant through NASMHPD, which encompasses the following goals:

- Support and provide additional state-level staff resources to oversee coordinate and strengthen the mental health and physical health services integration initiative.
- Provide education, training and support on the foundation of recovery including trauma-informed care for stakeholders involved in the physical and mental health integration initiative projects.
- Ensure a foundation of health care integration by providing a comprehensive peer-led "Whole Health Initiative" to address morbidity and mortality statistics.
- Determine opportunities and prepare necessary amendments for incorporating certain primary care integration models including disease/management protocols and a "medical home" into the state's concurrent 1915(b)(c) Medicaid Specialty Services Waiver.

Through the TTI initiative, MDCH provided funding for four CMHSPs to implement the peer Whole Health Initiative. Through this initiative CMHSPs are able to hire peers to the team to provide variety of services related to this initiative. Through the TTI initiative MDCH is providing statewide technical assistance and training on the (Personal Action

Towards Health) PATH curriculum. MDCH selected and trained several peers as master trainers on the PATH curriculum and expects that they in turn train other peers. The PATH training will help peers help other peers to manage their medical conditions by providing proven tips, helpful suggestions, setting goals, making decisions, finding resources, healthy eating, strategies to deal with chronic medical problems, information about exercises and support.

Expected Outcomes:

It is expected that through this initiative, consumers will receive services and supports that are integrated and coordinated.

Contact People: *Tison Thomas, (517) 241-2616, or thomasti@michigan.gov, Pam Werner, (517) 335-4038, or wernerp@michigan.gov, or Stephanie Harris, harriss5@michigan.gov*

JAIL DIVERSION SERVICES

Jail diversion services, both at pre-booking and post-booking, are provided by all of the CMHSPs. CMHSPs are evaluating their jail diversion operations and updating interagency agreements with law enforcement and courts as needed. Training of local law enforcement continues. Many CMHSPs are introducing peer support specialists into their jail diversion teams. In addition, some peer support specialists serve as liaisons for individuals when they are released from jail and assist in accessing needed community resources.

Some CMHSPs have developed a mental health court as an option for offenders with mental health needs. Block grant funding is supporting a mental health court and several other CMHSPs are in varying stages of developing mental health courts. Currently there are nine mental health pilot courts developing under a joint State Court Administrative Office and MDCH effort. All of these strategies combine at the local level to form a community based strategy to assist in diverting individuals from incarceration who have been determined to have a mental health need. CMHSPs are continuing their efforts to provide cross-training and to incorporate best practices into their work to provide alternatives to incarceration where appropriate.

Expected Outcomes:

It is expected that across the state CMHSPs will continue to collaborate with one another to share strategies that work and develop plans to divert from jail those people who are better served by the mental health system than by the jail system. CMHSPs and PIHPs will continue to seek best practices, identify model programs and take advantage of any cross training or resource development available. It is also anticipated that peer support specialists will be increasingly involved in local diversion activities.

Contact Persons: Michael Jennings, (517) 335-0126), or Jennings@michigan.gov and Patty Degnan, (517) 373-2845, or Degnanp@michigan.gov

MOTIVATIONAL INTERVIEWING TRAIN THE TRAINER MODEL

Overview:

The Mental Health and Substance Abuse Administration have been involved in the development of a statewide capacity for Motivational Interviewing (MI). Many provider agencies across the state have chosen to train their staff in the application of MI, an evidence-based practice model proven to be effective with individuals who have a substance use or a mental health disorder, or co-occurring disorders. The training project supported six phases of rigorous MI training to develop regional clinical staff/supervisor expertise in motivational interviewing. The staff who complete the training receives the “Michigan Train-the-Trainer” (MTT) status.

Summary of Accomplishments:

The training was open to staff from both the mental health and substance abuse provider networks. Approximately 200 staff from both mental health and substance abuse provider networks was accepted to these trainings. After 6 phases of trainings, to date, 37 staff was awarded a regionally limited, Michigan-specific Motivational Interviewing training credential. It is expected that these 37 staff train others in the system on MI. During last two years, several supervisors and managers were also trained on Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency (MIA: STEP).

To increase the capacity of individuals who can train their respective system, MDCH is planning to continue the train the trainer model training for staff from both mental health and substance use disorder systems during FY10.

Contact People: *Tison Thomas, (517) 241-2616, or thomasti@michigan.gov, or Patricia Degnan, (517) 373-2945, or degnanp@michigan.gov*

MULTIDIMENSIONAL TREATMENT FOSTER CARE (MTFC)

The goal of the MTFC program is to decrease problem behavior and to increase developmentally appropriate normative and pro-social behavior in children and adolescents who are in need of out-of-home placement. Youth come to MTFC via referrals from the juvenile justice, foster care, and mental health systems.

MTFC treatment goals are accomplished by providing:

- close supervision
- fair and consistent limits
- predictable consequences for rule breaking
- a supportive relationship with at least one mentoring adult
- reduced exposure to peers with similar problems

The intervention is multifaceted and occurs in multiple settings. The intervention components include:

- behavioral parent training and support for MTFC foster parents
- family therapy for biological parents (or other aftercare resources)
- skills training for youth
- supportive therapy for youth
- school-based behavioral interventions and academic support
- psychiatric consultation and medication management, when needed

MTFC is currently available through AuSable Valley CMH and Monroe Community Mental Health.

Contact Person: *Connie Conklin*, (517) 241-5765, or conklinc@michigan.gov

MULTISYSTEMIC THERAPY (MST)

MST is a pragmatic and goal-oriented treatment that specifically targets those factors in each youth's social network that are contributing to his or her antisocial behavior. Thus, MST interventions typically aim to improve caregiver discipline practices, enhance family affective relations, decrease youth association with deviant peers, increase youth association with pro-social peers, improve youth school or vocational performance, engage youth in pro-social recreational outlets, and develop an indigenous support network of extended family, neighbors, and friends to help caregivers achieve and maintain such changes. Specific treatment techniques used to facilitate these gains are integrated from those therapies that have the most empirical support, including cognitive behavioral, behavioral, and the pragmatic family therapies.

MST services are delivered in the natural environment (e.g., home, school, community). The treatment plan is designed in collaboration with family members and is, therefore, family-driven rather than therapist-driven. The ultimate goal of MST is to empower families to build an environment, through the mobilization of indigenous child, family, and community resources that promotes health. The typical duration of home-based MST services is approximately 4 months, with multiple therapist-family contacts occurring each week.

Although MST is a family-based treatment model that has similarities with other family therapy approaches, several substantive differences are evident. First, MST places considerable attention on factors in the adolescent and family's social networks that are linked with antisocial behavior. Hence, for example, MST priorities include removing offenders from deviant peer groups, enhancing school or vocational performance, and developing an indigenous support network for the family to maintain therapeutic gains. Second, MST programs have an extremely strong commitment to removing barriers to service access (see e.g., the home-based model of service delivery). Third, MST services are more intensive than traditional family therapies (e.g., several hours of treatment per week vs. 50 minutes). Fourth, and most important, MST has well-documented long-term outcomes with adolescents presenting serious antisocial behavior and their families. The strongest and most consistent support for the effectiveness of MST comes from controlled studies that focused on violent and chronic juvenile offenders.

Providers of Multisystemic Therapy: MST is available through the following Community Mental Health Service Programs (CMHSP's): CMH for Central Michigan, Berrien Mental Health Authority, Summit Pointe, network180, Genesee County CMH Services, and LifeWays. In many of these CMHSP's, MST is jointly funded between the local court and the CMHSP.

Contact Person: *Connie Conklin, (517) 241-5765, or conklinc@michigan.gov*

PARENT MANAGEMENT TRAINING – OREGON MODEL (PMTO)

Overview:

The Michigan Department of Community Health's (MDCH) Division of Mental Health Services to Children and Families has been supporting the statewide implementation of PMTO. PMTO is an evidence-based best practice approach that recognizes the vital role parents play as being the primary change agents within their family. PMTO is tailored for serious behavior problems for youth from preschool through adolescence. In addition, PMTO can be applied to families with complex needs and challenges, e.g. mental health issues, poverty, divorce, etc. Parents are supported and encouraged as they learn skills they can utilize to provide appropriate care, instruction and supervision for their children. Clinicians utilize role-play and problem solving to promote the development of parents' skills. There are 5 core components to the PMTO model. They are; encouragement, limit setting, problem solving, monitoring and positive involvement.

The core training is 18 days that is broken down into six phases of training. Individual and team coaching is a vital component to this model. There are also extensive model fidelity tools and assurances that are built the state model.

Summary of Accomplishments:

Direct service staff trained/certified to provide service: over 100 trained, 34 certified therapists and 5 certified to rate fidelity to the PMTO model. There is a contracted state coordinator and regional coordinators that cover most of the state and provide leadership and oversight. Approximately, $\frac{3}{4}$ of the state have clinicians trained or being trained. The development of a web-based portal has contributed to a more seamless way to assist with ensuring model fidelity.

MDCH is also working with the Oregon Social Learning Center and Dr. Kay Hodges of Eastern Michigan University to enhance our evaluation of this model. MDCH has built state infrastructure to take over the implementation of this model from the developers of this model. One important aspect was to outline how this would occur and there is now a matrix titled, "PMTO requirements to ensure sustainable fidelity and quality of the PMTO in our state". This matrix outlines the various roles and requirements of each role (Trainee, Supervisor, PMTO clinician, PMTO coach, PMTO Fimper, PMTO coach, PMTO Trainer, PMTO regional coordinator, PMTO state coordinator and PMTO consultant) and how they contribute toward ensuring a sustainable PMTO model.

Contact People: *Sheri Falvay, (517) 241-5762, or falvay@michigan.gov, or Connie Conklin, (517) 241-5765, or conklinc@michigan.gov*

PRACTICES IMPROVEMENT STEERING COMMITTEE

The Evidence-based Practice Steering Committee was established by the Michigan Department of Community Health (MDCH) in 2004 to address how to implement evidence-based practices (EBPs) in Michigan's public mental health system. This initiative grew out of national mandates (e.g., the President's New Freedom Commission and the resulting Federal Action Agenda, Institute of Medicine's Improving Quality of Health Care for Mental and Substance Use Conditions), federal Mental Health Block Grant (MHBG) funding requirements, and Michigan's Governor's Mental Health Commission that all called for using EBPs where they exist, and improving other practices that are currently being used by the public mental health system.

The Committee, later renamed Practices Improvement Steering Committee, is made up of representatives from universities, Prepaid Inpatient Health Plans (PIHPs), advocacy organizations, consumers and MDCH. It initially focused on identifying a small number of EBPs that would be implemented by PIHPs and supported by the MHBG dollars, and then become contractually required to be available at each PIHP beginning FY 08. The Committee selected two adult practices that already had free "toolkits" developed for the federal Substance Abuse and Mental Health Administration (SAMHSA): family psycho-education and integrated treatment for persons with co-occurring mental health and substance use disorders. One children's practice, Parent Management Training/Oregon model, was chosen for competitive opportunity to receive block grant funds to support its implementation. Subcommittees of the Steering Committee were established to oversee the implementation process, and an additional subcommittee was charged with identifying common measurements of success across the practices. Each EBP has an evaluation component that involves a university.

The Steering Committee also serves as a clearinghouse of information about, or provides advice on, efforts to adopt and train on other evidence-based, best, or promising practices, and on improving existing or usual practices. Examples of these are: Assertive Community Treatment, Developmental Disabilities services, Peer Specialists, Cognitive Behavioral Therapy, Multi-systemic Therapy, and Medication Algorithms. The Steering Committee has been supported in its efforts to implement EBPs, best practices and promising practices by the Michigan Association of Community Mental Health Boards (MACMHB) which has served as fiduciary and facilitator for the individual practice trainings, and has dedicated its last three spring conferences to providing training and information on improving practices.

For FY08, the Steering Committee advised MDCH to make MHBG funds available to two additional EBPs: supported housing and supported employment.

In January 2009, the MDCH issued the Application for Renewal and Recommitment (ARR) to Michigan PIHPs. In FY10, the Steering Committee will focus on assuring that the transformation framework (separate handout) is supported in Michigan practice improvement efforts.

Steering Committee Co-chairs are:

Irene Kazieczko, (517) 335-0252, or kazieczko@michigan.gov.

Judy Webb, (517) 335-4419, or webb@michigan.gov,

RECOVERY

It is the policy of the Michigan Department of Community Health (MDCH) to support systems transformation efforts to one based on the fundamental principle of recovery for persons with mental illness. The U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), published a National Consensus Statement on Mental Health Recovery. The Consensus Statement defined recovery as "a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential." Michigan has supported a variety of initiatives that coincide with the release of the National Consensus Statement. Some of the major building blocks of recovery have been the active involvement of the Michigan Recovery Council and the growing workforce of Certified Peer Support Specialists.

MDCH appointed the Recovery Council in December of 2005, with funding from a Mental Health Systems Transformation Grant through the federal Centers for Medicare and Medicaid Services. The Council continues to meet every other month to assure rapid movement towards a public system of care based in recovery. To demonstrate the strong MDCH commitment for consumer participation in systems transformation efforts and policy development, the Recovery Council is comprised of over 75% primary consumer representation. Included in this large percentage is one individual from each of the 18 Prepaid Inpatient Health Plans (PIHPs) who also serves on the Improving Practices Leadership Team (IPLT) for the region.

One of the accomplishments of the Recovery Council was the development of the statewide Michigan Recovery Center of Excellence (MRCE). The MRCE has established a website www.mirecovery.org to provide an informational service and platform for linking and supporting a virtual community of statewide change agents to foster and support recovery initiatives.

In partnership with the Advocates for Human Potential, the Recovery Council selected the Recovery Enhancing Environment (REE) Measurement as the system-wide tool to evaluate individual and organizational performance indicators of recovery. As a quality improvement project, all 46 Community Mental Health Services Programs are working with the Recovery Council and MDCH in the implementation efforts of the REE.

Each of the state-level initiatives for practice improvement for adults with mental illness is being implemented in partnership with consumers and is aimed at supporting recovery. Information about each initiative is presented as a choice and option during the development and enhancement of the Individual Plan of Service completed through a person-centered planning process. Recovery Council members that serve on the Improving Practices Leadership Team provide the necessary link to ensure the MDCH vision for a system based in recovery.

Recovery Council Contact Person: Irene Kazieczko, (517) 335-0252, or
kazieczko@michigan.gov
Contact Person for Recovery: Pamela Werner, (517) 335-4078, or
wernerp@michigan.gov

SUPPORTED EMPLOYMENT

Overview: Many people living with serious mental illness want to work. For many, work is becoming an important aspect in their recovery. When people with mental illness find competitive jobs, they also gain many related benefits to finances, self-esteem, and quality of life. Employment is providing a way to be active and productive, a source of self-confidence, and a way to improve quality of life.

The Michigan Department of Community Health (MDCH) believes that employment is an important path not only to gain an income, but also to obtain and enhance community membership for persons with disabilities. MDCH works to improve and expand employment services and supports for persons with mental illness. As part of its transformation to a recovery-oriented system of care, the MDCH has made employment a priority and supports the fundamental principles of recovery for persons with mental illness. In doing so, MDCH has adopted an evidence-based practice approach to employment services and supports that differs from traditional vocational services.

Service providers in the community mental health system are to provide services and supports that are strength-based and promote recovery principles and values. What makes this practice different from traditional vocational services is that the employment specialist is a part of the mental health team. Previously, if someone expresses interest in vocational services, they were referred to a vocational service provider and were required to demonstrate work readiness. Now, mental health professionals and employment specialists work together to assist the individual in finding and keeping employment in an area that the consumer wants to work.

Evidence-Based Supported Employment (EBSE) has been used in various settings by culturally diverse consumers, employment specialists, and practitioners. The critical elements of EBSE include, (1) rapid job search, (2) jobs tailored to individuals, choice, (3) time-unlimited following supports, (4) integration of supported employment and mental health services, and (5) a zero-exclusion policy (i.e., no one is screened out because they are not ready).

In the beginning of fiscal year 2008, non-competitive block grant funds became available for Prepaid Inpatient Health Plans (PIHPs) to implement Evidence-Based Supported Employment, and to expand opportunities for consumer choice and competitive employment. To date, nine PIHPs, out of the state's eighteen PIHPs, have implemented EBSE. Each of them is at a different stage of implementation. In addition, the MDCH has established a statewide committee consisting of a diverse group of stakeholders from throughout the Michigan Mental Health system to coordinate these efforts. In partnership with PIHPs, the MDCH will continue to focus on implementation, fidelity monitoring, and sustainability of Evidence-Based Supported Employment.

For additional information, please visit

***<http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/employment/>
or contact Su Min Oh at (517) 241-2957, or ohs@michigan.gov***

SYSTEM OF CARE FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE AND THEIR FAMILIES

Overview: To improve outcomes for children with serious emotional disturbance (SED) and their families, the development of a community system of care has been encouraged in the past and is part of the PPG and ARR process for FY10. *The system of care is to be comprehensive, family-driven/youth guided, community-based, culturally and linguistically competent.* It is a system that is developed for children/youth and their families that represent the organization of public and private services within the community into a comprehensive and interconnected network in order to accomplish better outcomes for all children. An integral part of the system of care development is the involvement of parents and youth. The process is to be family-driven/youth-guided where the family members (parents and youth) guide the development of the system of care.

Communities were requested to utilize a system of care planning process in preparation for application for funding from the Children's Mental Health Block Grant for the past three years and in implementing the 1915(C) SED Waiver. The Michigan Department of Community Health (MDCH) is particularly interested in increasing access to specialty mental health services and supports for Medicaid eligible children/youth in Child Welfare (i.e., abuse/neglect and/or adopted children/youth) and Juvenile Justice who have SED.

Community Mental Health Services Programs (CMHSPs) were asked to take leadership and join with local stakeholders to identify all of the mental health services for children/youth and their families available in the community, the number of children/youth served, the capacity of the program/agency, total cost and funding source(s) as part of the environmental scan. Stakeholders were asked to determine if the services identified are an evidence-based or promising practice. Parents and youth were required members of the stakeholders group.

Accomplishments:

- ◆ CMHSPs utilized the system of care planning process as they developed their applications for Children's Mental Health Block Grant funding for the past three fiscal years.
- ◆ Children's mental health services planned for through the system of care process and submitted for Children's Block Grant funding were evidence-based (PMTO, Trauma Focused Cognitive Behavioral Therapy, etc), promising practice (Wraparound, Infant Mental Health, etc.) and/or innovative approaches (Baby Court, parent to parent support, etc.)
- ◆ CMHSPs attended training in development of a system of care for children with serious emotional disturbance, and four CMHSPs have been funded to continue working with their partners to develop a comprehensive system of care through the implementation of evidence-based programs, a cross system screening process or the SED Waiver.

- ◆ Several of the CMHSPs applying for Children's Block Grant identified another agency/organization as providing a portion of the match funds for the block grant-funded service.

Plans for FY11:

Continue to utilize the system of care planning process as a precursor for the Children's Block Grant application.

- ▶ FY 08/09 mental health capitation for children was increased and performance measures have been established for the Prepaid Inpatient Health Plans (PIHPs) to increase the number of children served and the expenditures for both children with SED and developmental disabilities with a special focus on children in the Department of Human Services (i.e., abuse/neglect, foster care).
- ▶ Work closely at the state level with the Department of Human Services and other system partners at the state level to address barriers (funding, policy, contract requirements, etc) that impact local communities' ability to create an effective system of care.
- ▶ Provide training and technical assistance to assist CMHSP to build a system of care for children with a Serious Emotional Disturbance as well as Children with a Developmental Disability as part of the PPG and ARR requirements.

Contact People: *Sheri Falvay, (517) 241-5762, or falvay@michigan.gov, or Connie Conklin, (517) 241-5765, or conklinc@michigan.gov*

TRAUMA FOCUSED COGNITIVE BEHAVIORAL THERAPY (TFCBT)

Overview: The Michigan Department of Community Health (MDCH), Mental Health Services to Children and Families, is supporting the training of clinical staff (clinicians and supervisors) in Trauma Focused Cognitive Behavioral Therapy (TFCBT). Training in this evidence-based practice uses the Learning Collaborative Model (Markiewicz, Ebert, Ling, Amaya-Jackson and Kisiel, 2006) which utilizes a specific quality improvement method designed to enable participants to make dramatic improvements in a focused practice topic over a short period of time. There are several critical characteristics of the Learning Collaborative methodology that help agencies learn TFCBT, quickly test, and then fully implement these practices in ways that are appropriate for the individual agency as well as sustainable over time (Markiewicz et al., 2006).

It has been estimated that up to 80% of children served by CMHSPs would benefit from TFCBT. National studies show that 90% of public mental health clients have been exposed to trauma with most having multiple experiences of trauma (*Mueser et al.*, in press, *Mueser et al.*, 1998). 97% of homeless women with SMI have experienced severe physical and sexual abuse with 87% experiencing this abuse both in childhood and adulthood (*Goodman et al.*, 1997). Therefore, the focus of the TFCBT initiative is to provide clinical staff and their supervisors with the skills needed to provide this treatment to children with serious emotional disturbance (SED) and their families within the home-based services to ensure appropriate clinical intervention to a population that has a high probability of trauma.

Community Mental Health Services Programs (CMHSPs) involved in Learning Collaboratives have designated local teams to learn trauma informed assessment practices and methods of identifying children appropriate for TFCBT. Each local CMHSP team includes at least one direct clinical supervisor and a therapist that they supervise.

The TFCBT Learning Collaborative participants:

- attend a 3-4 day training with topics focused on Complex Trauma and Trauma Informed Assessment measures, including assessment to determine child/parent readiness for TFCBT and/or other potential treatment strategies as well as TFCBT principles, practices, implementation.
- participate in coaching conference calls, twice per month for clinicians/supervisors and monthly coaching calls with supervisors to address supervisory issues.
- attend follow-up trainings to review cases, assessments/assessment processes, TFCBT implementation, and evaluation.
- complete monthly evaluation metrics to assure fidelity which will be entered on internet training site.

To ensure implementation of the TFCBT, conference calls with senior leadership (CMHSP Children's Services Directors, Executive Directors) and TFCBT faculty

regarding system implementation and potential agency barriers to implementation will be facilitated by the department.

In addition, the initiative includes providing a training of trainers in the Resource Parent Training curriculum. This curriculum provides parents with information on trauma and how they can be of assistance/support to their child as they receive treatment. The training is provided by a parent/professional team in the community.

Accomplishments to Date:

- Clinical and supervisory staff is being trained to provide TFCBT in 13 CMHSPs (Cohorts 1, 2 and 3) and are participating in coaching calls and the evaluation of the initiative. Cohort 1 and 2 will complete their training in fall, 2009.
- Clinical and supervisory staff from 13 CMHSPs has been trained in assessment of trauma in children.
- Parents and professionals from 13 CMHSPs are being trained in the Resource Parent Training curriculum and are implementing trainings for parents (biological, adoptive, and/or foster) in their local communities.
- Resources for training Cohort 4, 5 and 6 (FY10) have been identified.

Expected Outcomes: The Learning Collaboratives are participating in an evaluation that includes both process and outcome evaluation to measure the impact of this multi-layered trauma informed system. Evaluation includes, but is not limited to, measures of fidelity to TFCBT implementation and adoption, delivery of training services according to the work plan, and identification of and addressing potential barriers to improved implementation and outcomes.

Overall, it is expected that the use of TFCBT will ensure appropriate intervention with children with SED that have experienced trauma and their families and improve their outcomes.

Contact People: *Mary Ludtke, (517)241-5769, or Ludtkem@michigan.gov or Sheri Falvay, (517) 241-5762, or Falvay@michigan.gov*

VIRTUAL TEAM

Purpose of Virtual Team:

The Michigan Department of Community Health (MDCH) has a virtual consultation team composed of MDCH staff and external participants with recognized expertise to assist CMHSPs and PIHPs in identifying support and service options to stabilize individuals with developmental disabilities during crisis situations. The team is aimed at developing the capacity in communities statewide for resolving challenging situations for persons with developmental disabilities with minimal disruption to the individual's life.

Examples of Challenging Situations for Virtual Team:

- Living situation jeopardized by:
 - physical aggression
 - property destruction
 - frequent elopement
 - self-injurious behavior
 - sexual offender issues
 - exacerbation of co-occurring DD/MI
- Overwhelmed/aging families
- Identifying the needed community supports for discharges from Mt Pleasant Center
- Developing clinical expertise at local level, and targeting areas where expertise needs to be expanded

Virtual Team Network:

- Central Office group - 20 individuals with varied experience and backgrounds
- Non-State of MI - experts from CMHSPs/PIHPs
 - Center for Positive Living Supports
 - Private providers - psychologists, therapists, etc.
 - DDI
 - Consumers/families
 - Advocacy groups - those with hands-on experience/expertise

Virtual Team Communication:

- Face-to-face meetings - decisions made for set-up, hypothetical situations, and protocol
- E-mail account - out of office correspondence to MDCH-Virtual Team
- Team Room – in-house discussion to formulate situational response

Plans for FY 10:

- Continue to respond to requests, revise forms as needed and maintain database
- Develop conference call method for problem solving with select VT members, concerned parties from CMHSP/PIHP and community resources

Contact Person: Charlyss Brandon, (517) 373-3678, or brandonc@michigan.gov

Request for Assistance from the DCH Virtual Team

Upon Completion, please email to: DCH-VirtualTeam@michigan.gov

Name of Agency	Date
Agency Contact/Phone/Email 	

Individual's Age and Gender: Age: __ Male Female

Please give a brief description of the individual, including their likes and dislikes, and what they do in a typical day. Cite examples of choices they are able to make throughout their day and what kinds of control they have over decisions involving their daily activities.

Describe an ideal day for this person, how they would like to spend their time:

Date and location of most recent Person-Centered Planning (PCP) meeting: _____

PCP led by: Supports Coordinator Independent Facilitator

Presence of Family/Advocates/Natural Supports (If so, who?):
Review of Strengths, Interests, and Needs that were identified during the PCP. Considering their likes and dislikes, how are the priorities for this person being addressed by their individualized plan of service?

Medications (Current medications/dosages, and reason for each medication; changes in the past year)

Identification of barriers that prevent individual from having an ideal day:

Strategies that have been tried to remove these barriers:

Previous Successes (What worked/helped in the past and why are they not currently working):

Interpersonal Issues that are relevant to the barriers (Relationships with family, friends, peers, staff and co-workers...):

Physical Health issues that are relevant to the barriers and date of most recent physical and health status exams:

Indications of Trauma that may contribute to the barriers (If so, what/when):

Analysis of Environmental Triggers (Antecedent, Response, Time of Day, Alone/Group Setting):

Other:

Review by in-house clinical team

Consultation with other CMHSPs, PIHPs or professionals in the relevant area (with whom did you consult, what were the suggestions, what were the results)

What do you expect from the Virtual Team?

WRAPAROUND MODEL

The Michigan Department of Community Health's (MDCH) Division of Mental Health Services to Children and Families has been supporting Wraparound in the state of Michigan for over 17 years. Wraparound is a promising practice that primarily provides support to youth with Serious Emotional Disturbances and their families. Wraparound is a family-driven, youth-guided planning process. The Wraparound process encourages the involvement of all service systems and natural supports in children and families lives. As a team planning process, Wraparound takes a holistic view of the lives of children, youth and families. The Wraparound model affirms that the best way to assist families is to listen to what they identify as their needs. The planning process provides them with a structure that builds upon their unique strengths and abilities as a means to meet those needs.

Wraparound Facilitators must complete the MDCH and Michigan Department of Human Services (MDHS) co-sponsored a three-day Wraparound Facilitation training. In addition, training and support is provided on an ongoing basis to assist in the further development of skills. Wraparound facilitators and supervisors must attend a minimum number of state-sponsored trainings annually.

MDCH is in the process of developing fidelity tools that will determine the areas where more support and training are needed, as well as finalizing the Wraparound Enrollment Criteria and process.

Summary of Accomplishments

MDCH, in partnership with MDHS, provides initial training to hundreds of facilitators and other child serving systems each year. The Wraparound Technical Assistance Coordinator provides initial training and provides ongoing statewide trainings as well. Training is also available to communities upon request. In addition, MDCH is working with Michigan State University to develop fidelity assessment tools and a thorough evaluation process.

Contact People: Connie Conklin, (517) 241-5765, or conkinc@michigan.gov, or Millie Shepherd at (517) 373-6879, or shepherdm@michigan.gov