Evidence-Based Practice

SAGINAW COUNTY
COMMUNITY MENTAL
HEALTH AUTHORITY

EVIDENCE-BASED PRACTICES

and

SYSTEM TRANSFORMATION

2005 – 2010

Improving Practices at SCCMHA

MARCH 2011

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BACKGROUND & INTRODUCTION

Michigan Department of Community Health & National Transformation

The Michigan Department of Community Health (MDCH), with support from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), initiated a system transformation effort to implement evidence-based practices throughout the Michigan mental health service system in FY 2005, beginning with the establishment of a Practices Improvement Steering Committee. The Michigan Mental Health Commission had issued a report echoing nationally identified needs to disseminate and implement evidence-based practices as one of its recommendations for improvement of the mental health system statewide. The MDCH Steering Committee, comprised of varied representatives, was charged with development of a strategy for disseminating evidence-based practices. The initial focus was to improve the practices used by the public mental health system to assist adults with serious mental illness with recovery. MDCH assigned state staff key roles, and initiated the availability of federal block grant funds on annual basis to the 18 PIHPs through a request for proposal process to support the development and successful implementation of evidence-based practices in local service delivery networks. MDCH also made numerous state and regional trainings available to PIHPs and CMHSPs, including topics covered in Michigan Association of Community Mental Health Board (MACMHB) sessions, to support the knowledge base of practitioners necessary for this system transformation effort.

MDCH prioritized certain adult and children's practices for implementation, and eventually required that each PIHP successfully implement at least one evidence-based practice at the local level; some of the MDCH block grants were noncompetitive to help promote this expectation which later became a contractual obligation. MDCH included two specific practice attachments on IDDT and FPE in the FY 2011 MDCH/PIHP contract. MDCH requires that all PIHPs now have an improving practice process and implement at least several key practices as part of the overall, required PIHP Quality Assessment and Performance Improvement Program. MDCH and the Michigan Association of Community Mental Health Boards (MACMHB) offered support for state level workgroups and committees on specific practice areas to provide guidance and assistance as PIHPs and CMHSPs moved forward with their EBP implementation efforts. MDCH later incorporated existing models of service within the scope of the system transformation to ensure fidelity to practice requirements in current service areas. EBP models were also incorporated into the Michigan Medicaid Manual for providers, as MDCH sought to ensure sustainability of evidence-based practices throughout the public mental health system.

A key requirement of MDCH was that each PIHP develop a local Improving Practices Leadership Team. The role of the IPLT was: 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. The MDCH leader for improving practices was Irene Kazieczko.

Nationally, system transformation was spurred on not only by SAMHSA, but also the Surgeon General's 1999 report on mental health, the President's New Freedom Commission Mental

Health, *Achieving the Promise: Transforming Mental Health Care in America* in 2003, the National Institute of Mental Health's *Bridging Science and Service,* as well as other publications, all of which stimulated a national movement to disseminate and implement various evidence-based practices in routine mental health settings.

Saginaw County Community Mental Health Authority

In 2004, Sandra Lindsey, SCCMHA CEO, initiated support of local review of the literature and research to assist staff and providers through the planned publication of evidence-based practice guides. As part of this transformation process, SCCMHA obtained core relevant materials from SAMHSA, including key practice toolkits and other resources available in the public domain (i.e., free of charge) relevant to implementation plans. These materials were shared with key system clinical supervisors and other partners where appropriate. SAMHSA's vision,"Shaping Mental Health Services Towards Recovery" was used in numerous ways throughout the SCCMHA network in early efforts to educate staff and providers about the new initiative. SAMHSA now uses the tagline of "A Life in the Community for Everyone" on such publications.

The Saginaw County Community Mental Health Authority (SCCMHA) officially kicked off its system transformation in 2005. The CEO appointed an Improving Practices Leadership Team in June, and the first meeting of this group was held in October of that year. An IPLT leader, Ginny Reed, was also appointed by the CEO, and contractual resources to support this effort were secured. Part of that contractual effort was to continue to research and issue various evidence-based practice guides by population in order to ensure a broad understanding of evidence-based models in existence and to support and ensure staff, provider, consumer and stakeholder education in evidence practices. This was a singularly unique decision made by SCCMHA in order to provide for commitment and visibility of this system change. These evidence-based practice guides were completed for SCCMHA by Barbara Glassheim.

The IPLT was expected by MDCH to: align relevant persons, organizations, and systems to participate in transformation process; support membership of a consumer/Certified Peer Support Specialist 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; demonstrate progress in system transformation by implementing evidence-based, promising, new and emerging practices; and communicate statewide information in a feedback loop to representative agencies including the board of directors, executive director, agency staff, consumers, advocates and community stakeholders. MDCH was also prescriptive on the membership of the IPLT, and SCCMHA built its IPLT based on this model. The SCCMHA representative on the MDCH Recovery Council is Amelia Johnson.

SCCMHA utilized a number of methods to help promote a broad understanding and develop champions of specific evidence-based practices. Staff, provider, and community newsletters included progressive content on evidence-based practices and SCCMHA's improving practice implementation efforts and successes, including the personal stories of consumers' recovery experiences. SCCMHA issued policies related to the provision of evidence-based practices and specific practices to support and embed the sustainability of practice models throughout the network. Workgroups specific to certain practices were initiated and champions were identified. Consumers and family member stakeholders were engaged at all levels of SCCMHA implementation for participation in leadership planning and service receipt. SCCMHA also sought funding on an annual basis to support its efforts with the submission of MDCH block grant requests, many of which were funded from 2005 – 2011. Progress would not have been possible without these additional federal and state grant resources in the SCCMHA network to

cover significant training and other initial implementation costs. SCCMHA has tracked key milestones of the evidence-based practice accomplishments, incorporated goals within its corporate strategic plan, integrated evidence-based training as part of its continuing education program, included key milestones in provider and community communications, and continues to report on evidence-based practices as part of the overall quality improvement program through various network and community venues. In 2007 SCCMHA initiated inclusion of an improving practices award as part of its annual Every Day Heroes event celebration which provides added community visibility as well as key champion recognition. Recipients to date have been: Steve Gonzalez, 2007; Barbara Glassheim, 2008; Diana Fernandez, 2009; and Chris Bauman, 2010. Other SCCMHA personnel who were honored with everyday hero awards in part for their EBP work were Heidi Wale and Tim Howard.

For SCCMHA, this transformation process was embraced for several key reasons, all of which are associated with SCCMHA's organizational mission, key values, and principles:

1) Use of evidence-based practices are known to lead to optimal consumer outcomes and functioning, promoting community independence;
2) Consumers and their families have the right to be educated about optimal treatments and supports and to make informed decisions regarding receipt of such; and,
3) The erosion of resources as well as rising demand in the public system and local communities, including, and perhaps especially Saginaw County, makes investment in practices proven effective sound if not necessary fiscal sense.

SCCMHA was quite ambitious in seeking to implement a number of practices simultaneously, and in a number of areas of its service delivery system, rather than having a practice limited to a single team. The number of practices implemented as well as the extent of the practice reach, while requiring a significant amount of energy and attention, has served both consumers and practitioners well. More consumers have benefited from this broader approach, and the depth and breadth of SCCMHA efforts has**,** in some ways**,** supported sustainability. SCCMHA is proud of the many accomplishments related to evidence-based practices, most notably the reported positive outcomes expressed by consumers/service recipients of the difference that evidence-based service has had in their lives and their recovery experience.

This report is intended to record the highlights of SCCMHA's five years – from 2005 to 2010 – in true system transformation through the shift to evidence-based practices. And, while there is more to be done, including the ongoing and critical effort needed to ensure sustainability, it is time to celebrate and note for posterity the depth and breadth of our efforts, resulting system change, as well as positive outcomes, accomplishments, challenges, and recommendations for future efforts.

KEY CONCEPTS

Developing a basic and systemic understanding of what evidence-based practices entail with staff and providers was necessary for SCCMHA to move forward with various practice implementations. Early and continued efforts have focused on network education and demonstration of key concepts. For purposes of this summary report the following brief definitions of key concepts are relevant:

Anti-Stigma efforts are those directed at mitigating, reducing, preventing or eliminating the societal stigma often associated with the experiences of persons who have a mental health condition.

Cultural Competency is defined as the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population.

Evidence-Based Practice is a clinical intervention that has a strongly rooted scientific foundation and produces consistent results in assisting consumers to achieve their desired goals or outcomes. Evidence-based practices include skills, techniques, strategies, and principles that have been shown by research or current scientific evidence to be effective in assessment, treatment, prevention or other human services settings. Such practices generally have a defined model, protocol or manual and fidelity scale to facilitate adherence to the practice.

Fidelity is the extent to which the principles and components of a given practice are adhered to. Research has shown that fidelity is critical to achieving beneficial outcomes. Many evidence-based practices have fidelity review tools that may be used to periodically review adherence to the model. Fidelity reviews may be conducted by external entities to provide for a more neutral review.

Person or Family Centered Practice recognizes the uniqueness of individuals and family systems, the right to express preferences and make choices, and seeks to build empowerment and strengthen resiliency and develop mutual partnerships between consumers and supporters.

Qualified Staff refers to the need for individual practitioners or interventionists to have specific training and ongoing supervision in the specific practice principles, including review of any updates to the evidence-based practice model.

Recovery is the process in which people are able to live, work, learn and fully participate in their communities, either despite a disability or with a reduction or complete remission of symptoms of an illness.

Stages of Change refers to a model showing that, for most persons, a change in behavior occurs gradually, with the person moving from being uninterested, unaware, or unwilling to make a change (precontemplation), to considering a change (contemplation), to deciding and preparing to make a change (determination). Genuine, determined action is then taken and, over time, attempts to maintain the new behavior occur. Relapses are almost inevitable and become part of the process of working toward life-long change. The Stages of Change model is useful for selecting appropriate interventions. By identifying a person's position in the change process, practitioners can tailor interventions to enhance success. During the precontemplation stage, people do not even consider changing. During the contemplation stage, people are ambivalent about changing. During the preparation stage, people prepare to make a specific change. During the action stage the person is taking a definitive action to change. Maintenance and relapse prevention involve incorporating the new behavior permanently. Discouragement

over occasional slips (lapses) may halt the change process and result in the person giving up. However, most people find themselves recycling through the stages of change several times before the change becomes truly established.

Trauma-Informed Practice means providing services and supports with a recognition of potential or actual psychologically distressing events experienced by persons served, and the role such experiences may play in lasting damage to their lives, growth, functioning and response to others.

Welcoming is a concept often applied to 'no wrong door' entry into treatment for co-occurring psychiatric and substance use disorders; it refers to the need for the system – both staff and settings – to convey a warm, empathic and hopeful attitude in order to engage persons who seek services, especially those who may be unwilling to accept or participate in recommended services**,** or who do not easily fit into available program service models.

PRACTICE SUMMARIES

Assertive Community Treatment (ACT)

Like all PIHPs in Michigan, SCCMHA has had an operational ACT team for a number of years. Michigan was an early adopter of the ACT model, originated in Wisconsin in the 1970's as a hospital without walls for adults with serious mental illness in need of maximum supports in order to maintain community tenure. ACT is a Michigan Medicaid required service and is reviewed for compliance by MDCH as a part of the annual Medicaid Site Review process, sometimes known as the Michigan ACT Model. The ACT team in Saginaw was initiated in 1989; the program is provided contractually by Training & Treatment Innovations, Inc. SCCMHA purchases ACT services through a single, large ACT team historically serving 75-90 consumers. The SCCMHA ACT team was included in the IDDT (Integrated Dual Disorders Treatment) implementation, similar to most PIHPs/CMHSPs statewide, and the ACT program was the first Saginaw IDDT program to be reviewed by MIFAST in September 2008. SCCMHA elected to conduct its own ACT fidelity reviews through a PIHP workgroup starting January 2006 using the DACTS, Dartmouth Assertive Community Treatment Scale. Scores on the 140 point scale in 27 dimension areas ranged from 104 to 112. Points of discussion during those reviews included the role of the employment specialist vis-à-vis employment specialists working in the Supported Employment (SE) practice model as well as ACT dedicated physician program time and timeliness of core ACT training for physicians and staff. In addition, SCCMHA participated in the MDCH directed and developed ACT Field Guide review in November 2008. Improvements were seen in the follow up MiFAST reviews of ACT from September 2008 to June 2010. Tommie Orange is the current supervisor of the SCCMHA ACT program.

During the first five years of initial EBP implementation, 123 persons participated in ACT for some length of time. During the most recent (2010) MDCH Site Review, the ACT program received 30 out of 32 points, with partial score citations in the standard areas of team composition (the psychiatrist job description assigns one physician to ACT team) and staff compliance with initial ACT training (again for the psychiatrist). Prior scores in 2006 and 2008 were 29 out of 34 and 30 of 32 possible points. Psychiatry changes and levels of service have been areas of challenge for the ACT program. Also, over the course of the first five years of EBP implementation at SCCMHA there were some changes to the Michigan Medicaid standards for ACT programs.

Cognitive Behavior Therapy (CBT)

Cognitive behavior therapy has a strong evidence base for a number of mental health disorders and various CBTs are part of SAMHSA's evidence-based practice toolkits, including motivational interviewing. CBT can be provided in either individual or group settings. Over 100 practitioners within the SCCMHA network have had some formal training in CBT concepts and it is assumed that consumers are benefiting from CBT provided in various forms throughout the network; however, the delivery of CBT is not easily currently measured inside the current SCCMHA data capture structure. SCCMHA has also supported Trauma-Focused CBT (TF-CBT) training and treatment; for children with serious emotional disturbances.

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

This practice is defined in a SAMHSA toolkit intended for adults with both mental illnesses and substance use disorders, and was one of several key adult practices endorsed by MDCH for implementation as part of the statewide system transformation effort. SCCMHA elected to work

to implement this practice early and was unique in targeting all adult case management teams for this practice, not just ACT as did many of other PIHPs. The model calls for congruent and integrated services, with mental health practitioners becoming knowledgeable about substance use disorders. The primary targeted service recipients are those with both high mental health and high substance use disorder treatment needs, although those with any level of both disorders benefit from the practice. This model, as with other EBP practices, required a shift in thinking and treatment approaches; in the past persons with acute substance use disorders were deemed inappropriate for immediate mental health treatment. In the substance use disorder treatment community, persons with acute mental health disorders were often likewise determined untreatable, even with an accompanying unmet substance use disorder treatment need.

SCCMHA convened a Co-Occurring workgroup in November 2005, with Natividad (Steve) Gonzalez as the lead facilitator. Representatives of the workgroup included clinical supervisors and other program staff as well as consumers, substance abuse treatment system representatives and other key stakeholders. Amy Murawski of the Saginaw County Substance Abuse Treatment and Prevention Services (TAPS), the local substance abuse coordinating agency (CA), served on both the SCCMHA co-occurring workgroup as well as the IPLT. Amy Murawski and representatives of SCCMHA also participated in Recovery Oriented System of Care trainings sponsored by the state for CAs, as well as ongoing change agent training programs hosted by MDCH, and state COD/IDDT and ITC (Integrated Treatment Committee) workgroups and subcommittees.

This practice involved extensive training over a long period of time and it was expected that the practice would take an extended amount of time to fully implement. SCCMHA took advantage of state provided training, often led by Drs. Kenneth Minkoff and Christine Cline to promote the development of dual diagnosis capable (DDC) programming throughout of system, not just dual diagnosis enhanced (DDE) services for consumers with serious dual disorders. SCCMHA also arranged for a series of local training and regional programs in Saginaw, including several visits by Drs. Minkoff and Cline. Other related trainings included motivational interviewing, recovery, and trauma as underpinnings to this practice. Dr. Minkoff was instrumental in providing physician and general leadership to this practice implementation statewide and at SCCMHA. His reminders that the absence of either substance use disorder or mental health disorder treatment for persons with identified dual disorders was akin to failure to treat, and would be unthinkable in the medical community for any other disorders or diseases. The principles of CCISC (comprehensive, continuous, integrated system of care) were promoted throughout the Minkoff and Cline training programs and technical assistance was provided to assist with focusing on improvements within entire systems of care for persons with a level of co-occurring disorders.

The SCCMHA ACT team and the four SCCMHA adult case management teams were included in this practice development. Measurement tools, including SAMHSA's General Organization Index (GOI) and others endorsed by Drs. Minkoff and Cline were utilized during the initial phases. MDCH supported and provided leadership for development of fidelity review teams, known as MiFAST, (Michigan Fidelity Assessment and Support Team) which would visit local programs sites and review the local IDDT team practices against the model. SCCMHA was represented on the MiFAST team by Heidi Wale.

Some of the expectations of IDDT teams serving persons with co-occurring disorders from the SAMHSA fidelity scale include: multidisciplinary team, integrated substance abuse specialist, stage-wise interventions, access to comprehensive dual disorder services, time unlimited services, outreach, motivational interventions, substance abuse counseling, group dual disorder treatment, family education on dual disorders, participation in community self help groups,

pharmacological treatment, interventions to promote health, and secondary interventions for substance abuse treatment non-responders.

To date, three of the five Saginaw teams have participated in one to several MiFAST reviews, with progressive improvements in practices, and sustainability efforts when staff changes occurred. SCCMHA included in policy statements model expectations for all service areas, since dual disorders are often prominent. All service providers were expected to become dual disorder capable (DDC), with the specific adult IDDT teams achieving IDDT certification status as dual disorder enhanced (DDE) teams. Late in FY 2010, the Improving Practices structure separated the COD workgroup into two groups, a general COD workgroup to maintain knowledge and focus on service to persons with dual disorders throughout the network, and a specific IDDT team, to provide targeted support for the enhanced teams with specific IDDT certifications issued by MDCH. This provided for better definition and focus on DDC vs. DDE expectations in the SCCMHA system. As with other practices, SCCMHA's administration supported progression but allowed individual teams to work at their own pace to implement practices successfully. Beginning in 2008, the MDCH Medicaid Site Review Protocols included Co-Occurring Disorders, and SCCMHA scored 100% at this initial review.

SCCMHA has enjoyed a high level of collaboration with the local substance abuse coordinating agency in implementation of services to co-occurring populations. Data taken from FY 2009 Saginaw County Substance Abuse TAPS CA demographics shows that nearly 50% of the persons admitted for substance abuse services display some indication of mental health issues. For the IDDT certification, the direct operated Community Support Services adult case management team was required to obtain substance abuse program licensure, completed in October 2008.

SCCMHA data on consumers of mental health services shows that of the 9,608 adults and children served, 894, or about 10%, received some level of integrated mental health and substance use disorder treatment. Diagnosis data extracted by SCCMHA to indicate the prevalence of dual disorders for persons with serious mental illness, has indicated approximately 50% of those persons with a serious mental illness being served have some level of co-morbid substance use disorder. This would indicate that additional persons would benefit from integrated treatment.

The model includes expectations of integrated screening, assessment and intervention for both the mental health and substance use disorders, on a concurrent basis rather than sequentially. The practice requires not only extensive training but also a cultural shift to concurrent treatment, including concepts related to prescribing medications if an individual is known or suspected of using substances.

The four quadrant model includes recognition of high or low substance use and high or low mental illness impairment. Persons with high mental illness indicators are those most likely to be served by the mental health system in adult case management programs, regardless of their level of substance use.

Due to the prevalence of co-occurring disorders, as part of policy SCCMHA delineated expectations or providers throughout the service array. Adult case management and ACT programs were expected to become dually enhanced providers and programs, and all other service providers were expected to strive towards dually disorder capable status. Members of the substance abuse services panel were expected to be dual disorder capable to ensure mental health needs were addressed.

Dialectical Behavior Therapy (DBT)

Similar to ACT, SCCMHA had already initiated DBT as a practice within the scope of services for adults with serious mental illness. One of the adult programs operated by SCCMHA, under the leadership of the clinical supervisor and director, offered the first DBT group experience. DBT graduations have been held in August 2006, February 2008, April 2009, and September 2010. Since that time, DBT services have been offered in another adult team as well as to older adolescents (DBT-A) through a child and family team.

Recently, as MDCH has issued DBT certification requirements, the SCCMHA team obtained this status in 2010. Coincidentally, the lead supervisor for DBT has also been the practice champion for IDDT efforts, so the implementation of multiple EBP within the same program occurred.

DBT provides structured team-based treatment and support activities and includes key concepts of core mindfulness skills, interpersonal effectiveness skills, emotion regulation/modulation skills and distress tolerance skills. Both individual psychotherapy and group therapy are utilized in the practice. The core strategies taught are validation and problem-solving and behaviors are addressed in a targeted hierarchy based on level of serious risk. Persons served are those who have borderline personality disorder, especially those who engage in parasuicidal behavior. The model is effective for both adults and adolescents. Goals of the program include decreases in: suicidal, parasuicidal and self harm activities; therapy interfering behaviors; quality of life interfering behaviors; and increases in interpersonal effectiveness, ability to tolerate stress and manage strong emotions as well as core mindfulness skills.

DBT leadership has been provided by Steve Gonzalez, as well as Lori Denter for adolescents. The SCCMHA DBT team received the new MDCH certification for this practice in 2009. MDCH required components include: individual therapy, acuity, group skills training, 24/7 on-call response, staff training, staff consultation and peer supervision, and peer support specialist inclusion. Over the course of the five year period, a total of 19 persons completed the treatment program.

Family Psychoeducation (FPE)

As SCCMHA sought to strengthen the existing adult practices of ACT and DBT, and had initiated the implementation of IDDT, the second new adult practice was determined to be Family Psychoeducation (FPE), as directed by MDCH priorities as well as SCCMHA researched priorities. Robert Thrash was identified as the new workgroup facilitator which was first convened in October 2006 although core training was not accessible to the SCCMHA network until January 2007. SCCMHA used block grant funds to support this training. SCCMHA also experienced a delay in the provision of external supervision for the teams as funded by the MDCH block grant for this practice; Doris Joy provided this supervision in 2009-2010. Several case management teams serving adults with serious mental illness pursued this practice implementation, and staff took advantage of all statewide training programs whenever available to gain the required skills and expertise to implement joining and ongoing family groups.

SCCMHA now has three adult teams who have offered at least several groups over the past five years, with several groups spinning off on their own continuation efforts after 3 years with professional consultation and support as needed. Stakeholders and consumer advocates have been quite vocal about the need for and very positive impact of this practice, and while some feel that the practice would have been most helpful to both the consumer and the natural support system closer to the onset of the illness, overall the practice has found to be valuable for both newly diagnosed and longer term service recipients.

This practice has flourished with the vocal support of those who have benefited directly from it; champions include program staff as well as consumers and their families and friends. In several cases, consumers with few or no natural family supports have been able to develop meaningful friendships through the group sessions, thereby developing strong natural supports they did not previously have available to them. The model includes an initial joining session as well as ongoing multifamily groups, focusing on education about mental illnesses and coping strategies and supports. Over the five year period 2005 – 2010, 81 consumers have benefited from family psychoeducation.

Mobile Urgent Treatment Team (MUTT)

SCCMHA applied for a MDCH block grant to support the development of a mobile, crisis response team for children and adolescents and their families. Key persons from Saginaw involved in the development visited the Milwaukee program and its Wraparound service delivery program in May and August 2009. The SCCMHA MUTT services began on a limited basis in March 2010. This initial pilot phase of the implementation made the service available daily from 5 to 10 pm. The SAMHSA grant awarded to SCCMHA for Children's Mental Health Initiative/System of Care will help further advance the development of the MUTT team and services. The MUTT program design currently available has been presented to key SOC partners including schools and law enforcement.

This model of practice involves the team traveling to the site of any occurring crisis, on site assessment, and determination of interventions in the home, other emergency setting or if hospitalization is indicated. The MUTT response includes case management and linking to community services. The service is available to families with a child currently being served by SCCMHA who is experiencing a mental health crisis and whose behavior places them at risk for removal from home, school, community etc. SCCMHA intends to expand the MUTT program in the future.

Motivational Interviewing (MI)

MI is a collaborative, person-centered set of techniques designed to elicit and strengthen a person's intrinsic motivation for change by helping them explore and resolve ambivalence. It is especially effective when working with consumers who are reluctant to change their behavior or are ambivalent about changing by helping them to marshal their own resources and intrinsic motivation so they can move forward in a positive direction. Motivational interviewing techniques have been found to be most effective for people in the pre-contemplative and contemplative stages. SCCMHA now requires MI training for all practitioners.

Motivational interviewing is founded on four main principles to effect behavior change: (1) expressing empathy (or creating a sense of shared understanding), (2) developing discrepancy (or helping consumers recognize how their values are or are not reflected in their behavior), (3) rolling with resistance (or avoiding challenging a consumer's hesitation to change), and (4) supporting self-efficacy (or encouraging the belief that consumers can change their behavior).

Parenting Wisely (PW)

SCCMHA elected to pursue several children's practices during this first five years of intensive evidence-based practice implementation efforts. Parenting Wisely is a practice that offers support for families and children who display aggressive and disruptive behaviors. The model is based on the evidence-based practice of Functional Family Therapy, a multisystemic prevention and intervention model.

Parenting Wisely was initiated at SCCMHA in 2007. Parenting Wisely classes for teens were initiated in April 2008 with the first class graduation held in July 2008. The second class was initiated in August 2008 with the graduation in November 2008. In January 2009 the third teen class convened and a class for young children began, both were completed in April 2009. The service capacity of this practice at the time of the SAMHSA grant submission in 2009 was 90 families. Of note is not only the System of Care momentum for this practice, but also the community penetration: for example, a local Saginaw church announcement recently included a notice on Parenting Wisely training.

Parent Management Training-Oregon (PMTO)

Perhaps one of the most creative forms of evidence-based practice expertise building for SCCMHA occurred in the area of PMTO, or Parent Management Training-Oregon model. This practice was the recommended practice for children and families by MDCH as part of the system transformation efforts in Michigan. PMTO is an evidence-based 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, and may be applied to families with complex needs and challenges. Parents are encouraged and supported as they learn new skills they can utilize to provide appropriate care, instruction, and supervision for their children. Clinicians use role-playing and problem-solving to promote the development of effective parenting skills. The five core components of the model are: encouragement, limit setting, problem solving, monitoring, and positive involvement.

SCCMHA found many challenges in initial discussions and planning for implementation of PMTO, including the cost per practitioner to be trained, and the risk of staff turnover in the children's area. A creative arrangement was made with another PIHP to barter PMTO training and development oversight in exchange for child and adolescent assessment training provided by SCCMHA for their system. SCCMHA focused training efforts with two children's practitioners, which began in September 2007. The PMTO model requires extensive role play demonstrations and ongoing supervision, focused on the model's aspects of encouragement, limit setting, monitoring and supervision, family problem-solving and positive parental involvement. By September 2010, two staff members were receiving training and one key SCCMHA professional obtained certification. The SCCMHA service capacity for PMTO is 16 families.

Peer Support Specialists (PSS)

SCCMHA was an early adopter of the implementation of peer support services, hiring peer staff in the positions which were then called case manager assistants beginning in FY 2004. SCCMHA committed to the development of a vibrant peer culture and peer support throughout the SCCMHA system. With some early support from MDCH block grants, SCCMHA had 14 peer positions throughout the adult service array by 2010, including not just in primary case management teams with peer support specialists as a required, defined service, but also in crisis, jail, housing supports and psychosocial rehabilitation programs.

Peer support services are provided with an emphasis on the key principles of recovery. Persons working in peer support roles are current or past recipients of mental health services who are assigned to participate as full-fledged members of multidisciplinary teams and/or work directly with consumers in other service settings. Peer services are offered to all consumers of mental health services. In February 2009, as part of a case management training program, SCCMHA included recovery and a peer panel discussion as part of the agenda to educate staff and providers on the role of peer support specialists. While current budget funds have not allowed for the further expansion of these positions, the expansion of the volume of these services, as well as the growth of the number of consumers who receive these services has continued. This

is a current 2011 performance measure for SCCMHA and has been a part of the SCCMHA strategic plan in the "A Life Like Everyone Else" section from its inception in 2006.

Peer support services are embedded in SCCMHA's policy and practices, and peers meet with the Directors of Clinical & and Network Services on a regular basis to provide system consultation on peer service issues and needs. Peers working as Peer Support Specialists must obtain certification based on MDCH requirements. SCCMHA also drafted a Peer Support Services Fidelity Scale in 2010. In the five year period of 2005 – 2010, 577 adults with serious mental illness received some level of peer support services. It is anticipated in FY 2011 that a peer role will be incorporated into planning for system access improvements. MDCH has also established a performance improvement project for FY 2011 for all PIHPs to expand their peer support services.

Picture Exchange Communication System (PECS)

PECS is an augmentative/alternative communication (AAC) technique and modified applied behavior analysis program that teaches communication using picture cards. It is designed for individuals with limited or no verbal skills and is provided during typical activities within natural settings. This functional communication system, which consists of a series of phrases which teaches the use of pictures to express concepts, has been used in the Community Ties skill build programs of SCCMHA 2008. Four staff members have received PECS training to date.

Psychosocial Rehabilitation (PSR)

The clubhouse program has been a long standing part of the Michigan Medicaid program for adults with serious mental illness. The SCCMHA program, Bayside Lodge, has been in place since 1994 and has been provided on a contractual basis since 2002. Bayside Lodge is one of 44 Michigan clubhouses which provide services through a work ordered day structure, including transitional employment opportunities. Many programs like Bayside Lodge were developed using the components of the International Association of Psycho-Social Rehabilitation Services (IAPSRS) model. Members direct the program structure, schedule, standards and operational policies.

As part of the improving practices mission, SCCMHA included some routine review of clubhouse requirements and issues as part of its fidelity monitoring activities. The first workgroup review occurred in April 2008. MDCH provided several block grants to SCCMHA during this period to support clubhouse programming and quality improvements. During the MDCH Medicaid Site Visit reviews, the SCCMHA PSR program received scores 2006, 2008 and 2010 of 23 out of 24, 26 of 26 and 26 of 26 respectively. Recently the clubhouse program developed special programs and activities for younger members, as well as offering an option for alumni participation. Approximately 190 persons have been served in the clubhouse program over the past five years. Jim Nesbitt is the current supervisor of the SCCMHA clubhouse.

Supported Employment (SE)

SCCMHA was an early proponent of the supported employment evidence-based practice model, and sought and obtained MDCH block grant funds for training and start up position funding for dedicated employment specialist roles. Over the five year period, 245 consumers have received services through the supported employment unit. Richard Thiemkey and Heather Beson provided past supervision for this practice, the current supervisor is Greg Carter.

SCCMHA used the SAMHSA Supported Employment Fidelity Scale to periodically review progression of this practice area. Aspects of the scale include: availability of dedicated, generalist employment specialists and assigned unit; lower case load sizes; service integration;

zero exclusion criteria; ongoing work-based assessment and rapid, competitive and individualized job search; job development diversity and permanence; use of jobs as positive transitions. The first Supported Employment fidelity review took place in January 2006. Out of the 75 total points possible on the SE SAMHSA fidelity scale, measures ranged from 57 to 70, with steady progressive improvement closer to full fidelity.

The practice has been used with all interested adult consumers, regardless of their disability status. SCCMHA has also supported the development of micro-enterprises for persons served, including free advertising and availability of a loan program. As of 2010, 20 consumer microenterprises existed.

SCCMHA recognizes that the movement of consumers into competitive employment roles will continue to be a challenge, including but not limited to the weak economic climate as well as disincentive impact earned income may have on stability of benefits for many persons with serious disabilities.

For FY 2011, MDCH has developed a statewide employment plan, in addition to PIHP employment performance measures, in an effort designed to increase the number of consumers who are competitively employed.

System of Care (SOC)

SCCMHA began system of care discussions and planning with key juvenile justice system and Saginaw Department of Human Services partners in 2007. A community wide kick-off meeting announced the concept and planning for various community representatives serving children in Saginaw. Pennie Foster Fishman of MSU was hired as a consultant and SCCMHA was able to obtain multiple year block grants from MDCH to support initial planning and structure development.

System of Care is framework for fostering and developing a structure of community services and supports for children with serious emotional disturbances and their families, with a focus on children who have needs of multiple community resources, including but not limited to public partners in mental health, courts, education and human services. The overall goal is to address issues to keep children in their communities with their families whenever possible. After some initial efforts, SCCMHA, on behalf of the Saginaw community, applied for and obtained a highly competitive, multi-year, multi-million dollar grant from SAMHSA to build the SOC infrastructure for a children's mental health and system of care. This grant began in October 2010.

SCCMHA has provided family-centered services to children and their families on an ongoing basis. Strong partnerships with the court, human services, and to some extent schools and law enforcement, have been assets to SCCMHA in the advancement of all specific children's evidence based practices as well as progression with system of care planning. A key part of the Saginaw SOC has been strong family and youth participation, as well as various private and not-for-profit community stakeholder groups and individuals.

System of Care goals include: expanding capacity to serve children and adolescents with serious emotional disturbances and their families; provide a broad array of accessible, clinically effective and fiscally-accountable services, treatments and supports; serve as a catalyst for broad-based, sustainable systemic change inclusive of policy reform and infrastructure development; create a care management team with an individualized service plan for each child; deliver culturally and linguistically competent services with special emphasis on racial, ethnic, linguistically diverse and other underrepresented, underserved or emergency cultural groups; implement full participation of families and youth in service planning, in the

development, evaluation and sustainability of local services and supports and in overall system transformation activities.

Trauma

As part of evidence-based practice development at SCCMHA, there was recognition of the trauma experienced by those served. Saginaw County in recent years has experienced some of the highest levels of violence, unemployment, and poverty in the country.

Specific MDCH block grants were obtained by SCCMHA to offer community-wide training in the area of trauma and its impact on persons receiving services in the mental health and human service system. In addition to training and education on trauma-informed principles and practices as well as trauma-focused treatment, SCCMHA revised assessment tools to provide improved identification of incidents of trauma in order to ensure integration with treatment planning and provision of supports.

The development of gender-specific trauma support groups became a goal for both adult and children's service teams as well. At the end of this report period active groups were providing support to girls, women and men in targeted trauma support groups throughout the SCCMHA network using the TREM model, Trauma Recovery and Empowerment, for the trauma training and practice area, which is a group based intervention for men (M-TREM), women (W-TREM), and adolescents girls (G-TREM), who are survivors of trauma and addresses issue of physical, sexual or emotional abuse. SCCMHA has been funded for FY 2011 for a MDCH block grant to develop a train-the-trainer program for trauma-informed and trauma-focused practice sustainability.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Trauma-Focused Cognitive Behavioral Therapy is an empirically supported intervention designed to help children and adolescents, aged three to eighteen, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. The program can be provided in individual, family, and group sessions. It targets symptoms of posttraumatic stress disorder, which often co-occur with depression and behavior problems. The intervention also addresses issues commonly experienced by children who have been traumatized (e.g., poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior). More than 30 children have received services through the SCCMHA network from staff using this practice model.

Wraparound

Like many PIHPs, SCCMHA has provided some level of wraparound services for children and their families over a number of years. The SCCMHA wraparound team includes representatives from all public sector organizations. Expansion and improvements in the wraparound program are planned as part of the SAMHSA funded system of care grant program. The system of care planning to date, as well as the SAMHSA grant, will serve to revitalize the wraparound program, since it is an integral part of the system of care approach to delivering services and supports for children with serious emotional impairments and their families. SCCMHA currently has one wraparound coordinator and a community team serving 30 children and their families annually.

Core components of wraparound are: community based services and supports; individualized and strength-focused planning; culturally competent; family-driven; team-based; flexible funding; balance between conventional and natural supports; unconditional commitment; collaboration; and accountability of outcomes. Wraparound often involves braiding and/or blending funding

creatively among public and private partners to better serve children and their families. Children served are generally those who are involved in multiple services systems, such as mental health, child welfare, and juvenile justice and who are at risk of out-of-home placement, juvenile justice involvement, or psychiatric hospitalization.

Steps of the wraparound process include engagement; crisis stabilization and safety planning; strengths, needs and culture discovery, child and family team formation and nurturing; creating a child and family team plan; ongoing crisis and safety planning; tracking and adapting the plan; and transition out of formal services. Wraparound in Michigan is part of the statewide Medicaid program. In Saginaw, the key partner in wraparound has been the local Saginaw County Department of Human Services, with shared funding to provide key services and supports.

OTHER RELATED PRACTICES & CONCEPTS

SCCMHA was one of the first PIHPs to incorporate family advocacy and supports in the provision of Medicaid services in 2005. Currently two full time staff provide family advocacy and parent peer supports to parents and families who are receiving family-centered services in the SCCMHA network. In addition, some planning has occurred to date around the concept of delivery of peer supports for persons with developmental disabilities.

Health Care Integration

Health care integration has been an area of concern at SCCMHA. National data indicating persons with serious mental illness dying at much earlier ages for a variety of health reasons has been found to be evident at SCCMHA as noted in sentinel event reviews. SCCMHA has hosted wellness fairs and other health and wellness supports for consumers and staff, and in 2010 a health and wellness publication for consumers was drafted. In addition, SCCMHA is co-locating services with the local Federally Qualified Health Center, Health Delivery, Inc., in an effort to increase access to mental health services for patients of the health clinic and increase health care access for consumers.

Home-Based Services

Home based services are available for children and adolescents with serious emotional disturbances and their families. Services include family therapy and other evidence-based practices delivered in consumer's homes. This is a required Medicaid service and is offered by SCCMHA when indicated.

Justice System Collaboration

Jail Diversion is an area of SCCMHA involvement for a number of years. While recent budgetary constraints have limited the extent of SCCMHA direct involvement in the jail setting for jail based service delivery, SCCMHA has been very active in the provision of services to consumers who are involved with the justice system. SCCMHA has been involved with Michigan Prisoner Reentry Initiatives in several ways. In 2009, SCCMHA became the fiduciary for the Tri-county MPRI program for Saginaw, Midland and Bay. In addition, SCCMHA has provided mental health services for persons who have been involved in the criminal justice system.

Pharmacy Quality Improvement Project (PQIP)

SCCMHA participated in the Michigan PQIP, Pharmacy Quality Improvement Project. Dr. Renee' Thomas Clark, the Medical Director, served on this MDCH sponsored statewide psychiatry PIHP and health plan group for several years, which reviewed medication prescribing practices and documented outliers, and sought to obtain feedback from practicing physicians.

Respite

Respite provides temporary relief to primary caregivers in order to reduce stress, support family stability, prevent abuse and neglect and minimize the need for out-of-home placements. SCCMHA has provided respite services for families in need of temporary relief from the care giving duties of those consumers with disabilities with severe emotional disturbance and developmental disabilities for a number of years. Respite is an evidence-based practice which recognizes that adult family members need occasional relief from stressors or a change of pace in order to maintain their own physical and mental health.

Supported Housing

SCCMHA's Housing Resource Center, named for Johnnie Salter and opened in 2009, links people with housing that is subsidized by federal and state funds for affordability. Consumers are able access services and supports for treatment as well as housing related assistance. There are several relevant, evidence-based housing models and some components are offered by SCCMHA at this time.

Wellness Recovery Action Plan (WRAP)

Although not implemented at SCCMHA, several staff members, including peer support specialists, were trained in WRAP. WRAP is a consumer-driven, self-help, recovery-oriented program in which consumers develop their own system for monitoring and responding to symptoms to attain wellness. In this program consumers and providers train and are trained together to encourage empowerment. The program helps professionals understand mental illness from the consumer's perspective. WRAP uses case vignettes to exemplify the approach using the development of a wellness toolbox, changing the title of the case manager to recovery specialist, and having the consumer complete a recovery plan instead of a treatment plan.

SIGNIFICANT SYSTEM STRENGTHS

In hindsight, it is clear that SCCMHA did a number of things right in approaching the implementation of evidence-based practices, which has in turn created a receptive environment for sustainability. A number of the strengths or accomplishments of the SCCMHA system transformation effort are particularly noteworthy.

Administrative & Clinical Leadership
From the beginning of evidence-based practice planning at SCCMHA, administrative leadership has been evident. The CEO appointed a Director to oversee Evidence-Based Practice implementation and facilitate the Improving Practices Leadership Team. The Clinical Director has been a key leader in assigning key supervisors as practice champions. Other Directors have created pathways for data and quality and financial tracking systems for EBP. The CEO's vision to support the development of evidence-based practice guides to instill a broad system framework to education and understanding for all members of the network and key staff members was a crucial step in the beginning of SCCMHA efforts.

System Wide Implementation
Practices were implemented at a scope that was designed to benefit the largest group of consumers, not just those served by a single team per practice. At the same time, teams and their supervisors were given the flexibility to pursue practice development at a pace that was reasonable to meet their unique team needs. Supervisors were able to consult with and support each other with typical implementation challenges within the same service structure of the SCCMHA network and Saginaw community.

Effective Consultant Support & Integration
Two key contracted consultants have supported the system transformation process at SCCMHA. Barbara Glassheim has been the author of the series of evidence-based practice guides, and has served to support the broad education on evidence-based practice concepts and implementation, not just with staff and provider programs, but also in board member and citizen advisory committee and other community partner venues. Heidi Wale has been involved in SCCMHA overall quality program leadership, and her role in the review of data, outcomes as well as her statewide participation in MiFAST and measurement groups has been invaluable to SCCMHA. Both consultants have provided for the necessary oversight coverage to support participation in statewide trainings, meetings and planning. Their ongoing advice, problem-solving and troubleshooting, as well as periodic review and key consultation has effectively served SCCMHA in all aspects of the needed EBP implementation and sustainability efforts. The CAFAS children's assessment and outcome tool, developed by Kay Hodges (Eastern Michigan University) is used by SCCMHA with the training program is under the oversight of Heidi Wale. During this period the CAFAS as well as other children's assessment tools were piloted with a key community public partner, Saginaw DHS (Department of Human Services). This pilot, as well as connectivity to statewide assessment and fidelity review information, was facilitated for SCCMHA by Heidi Wale. In addition, Heidi Wale also served as a member of the MDCH Measurement Workgroup for Evidence-Based Practices. SCCMHA was able to obtain the consultant services of Pennie Foster-Fishman in the early system of care planning, also funded by a MDCH block grant, as well as Peter Selby for required national evaluation support at the time of the SAMHSA grant submission in 2010.

Practice Champion Development

SCCMHA endorsed and developed individual staff and provider champions for specific practices. These champions are knowledgeable about 'on the ground' issues for teams and clinicians, and yet have the 'big picture' of articulated system goals and necessary cultural shifts. SCCMHA included an improving practices award category in its annual recognition event beginning in 2008, Specific champions have been an important part of building enthusiasm and staff support and engagement in changes needed to successfully implement practices.

System Integration & Visibility

From the inception, evidence-based practice goals were included, measured and reported through the SCCMHA strategic planning, policies and procedures, job descriptions, quality systems and continuing education program efforts. This visibility and integration of evidence-based practices into the fabric of service throughout the SCCMHA administration and service delivery network helped to shift the culture and embed knowledge and understanding as part of the service structure of SCCMHA. Some of the SCCMHA training programs for practices have had a wider impact in the Saginaw region. Key public and private partners were included and have benefited from the offerings made available to them by SCCMHA. SCCMHA has not only brought the knowledge of EBP to its PIHP network, it has supported inculcation within the wider Saginaw community, including with other human service agencies, school systems, law enforcement, and advocacy groups. For example, recently it was noted that the marquee of a local community organization included an announcement of available Parenting Wisely classes.

Stakeholder Voice

Over the course of five years SCCMHA has been able to engage a number of individuals who are either service recipients or family members of service recipients in the evidence-based practice implementation effort. Family members and consumers have served and continue to serve on implementation work groups as well as members of the Improving Practices Leadership Team. While there has been some natural turnover of specific consumer representation, similar to staff and provider involvement turnover, there continues to be consumer input as standing agenda items in all EBP related venues. Direct consumer feedback and leadership has contributed to ongoing specific practice implementation as well as overall system sustainability.

Electronic Medical Record Installation

During the same period as the first five years of the SCCMHA system transformation to evidence-based practices, SCCMHA was also engaged in the installation of an electronic medical record (EMR). While this simultaneous effort created some additional challenges, including a system start and stop with one information system vendor, the value of the electronic medical record has, in many ways, supported the strengths of the EBP practices at SCCMHA. For example, the electronic medical record supports the staging of co-occurring disorders in the assessment and treatment plans, and requires that all persons receiving mental health identified as having a co-occurring disorder have a plan that addresses both conditions. SCCMHA has been able to modify the EMR to meet EBP practice needs, including future outcome measurement planning.

Aggressive & Creative Resource Pursuit

SCCMHA elected to seek maximum block grant dollars for the implementation of evidence-based practices over the five year period, and took advantage of nearly every training opportunity or resource made available to the PIHP from MDCH and MACMHB. Numerous block grants were awarded to SCCMHA through MDCH to support training and other implementation costs. SCCMHA also utilized creative methods to finance evidence-based

practice implementation where possible. For example, for one practice, funds could not be secured or easily made available for the needed costly per individual training; SCCMHA was able to arrange a barter situation with another PIHP, and receive staff specific training in exchange for consultation from one of the SCCMHA contractors in a specific children's area of expertise. Of note is SCCMHA's successful procurement of a multi-year SAMHSA grant beginning in FY 2011, to support system of care efforts for children and families in the Saginaw community. In recent years, SCCMHA programs have also obtained community resource supports in many ways for practices, such as the use of food bank resources for consumer groups.

Continuing Education Program Alignment
At the onset, SCCMHA had an established, competency‑based, in-house training and continuing education program, with effective policies, training tracking and continuing education planning leadership oversight. Simultaneous with system transformation planning, SCCMHA also obtained Social Work CEU status, and also has the ability to award substance abuse counseling credential credits, both of which have allowed SCCMHA to use grant funds to implement system wide and community based training programs which included CEU credits for licensed social workers as well as professionals with substance use disorder credentials, to benefit staff, providers and community partners. SCCMHA was able to modify the training tracking parameters to specific EBPs as needed, and the mandatory training program has begun to include key evidence-based expectations of service and supports staff and providers. The continuing education unit of SCCMHA also significantly supported the expanded education of EBP concepts, knowledge and education, including community partner training events, home manager training programs, and consumer education supports. No less than 40 evidence-based practice related training events have been delivered directly by the SCCMHA Continuing Education Unit during the five year period.

CRITICAL SUSTAINABILITY CHALLENGES

In spite of the number of accomplishments and strengths of the SCCMHA system transformation effort of evidence-based practice implementation and sustainability, SCCMHA has and will continue to face challenges and barriers. It is important to recognize, define, and have a plan to address these as well as any new future obstacles in order to ensure and maintain long term sustainability.

Limited Resources
The first five years of EBP transformation at SCCMHA were also significantly challenging financial resource years for SCCMHA and the Saginaw community. The state of Michigan weathered budget shortfalls and MDCH cuts, and SCCMHA experienced critical, direct reductions in state funds as well as continued erosion of limited reserves, all while service demands escalated. SCCMHA made good use of numerous block grant funds to support EBP efforts, and made careful decisions about the use of limited service and support resources throughout the network and SCCMHA programs to survive this period, while continuing to roll out EBP practices effectively. It is likely that resource challenges will continue well into the future. SCCMHA elected to leverage the use of EBPs as an investment and emphasize the comparative multiple costs of not being an EBP focused system.

Lack of Adult Outcome Measurement Tool(s)
Also during this period of initial EBP history at SCCMHA, MDCH was seeking to select an adult outcome tool to measure consumer gains from provided mental health services. To date, this search continues. SCCMHA has elected to use SAMHSA's NOMS (National Outcome Measures), ORS (Outcome Rating Scale), and soon, the Kennedy Axis V instrument to measure consumer outcomes, including those who have been recipients of evidence-based practices.

General Data Collection Barriers
The simultaneous implementation of a new information system during this period allowed SCCMHA to address the new data needs associated with evidence-based practice monitoring and consumer outcome measurement. However, the ability to readily garner meaningful data has been more challenging than anticipated. Efforts are underway to draft reports that will routinely report progress in all evidence-practice areas, but SCCMHA is not at the level of routine monitoring desired at this time. There have been some starts and stops with efforts to correctly collect EBP service data, given overall coding complexities, as well as specific challenges such as the correct use of and integration of code 'modifiers' in the information system. This is a major continuation goal as part of SCCMHA's current sustainability and strategic plan.

Ongoing System Change
As with any implementation effort in a human service system, constant changes are impacting the EBP sustainability plan. Staff turnover, competing priorities of other initiatives, and shifts in individual consumer needs will continue to impact SCCMHA. SCCMHA has already experienced and had to address some changes in leadership of key champions for specific practices, and it is expected that this type of turnover will continue at some level. Staff must be willing to continue to adapt to program and consumer needs as well as any practice requirement changes which might occur.

Level of Physician Engagement

One of the most challenging groups of practitioners to engage in the implementation of evidence-based practices has been the psychiatrists throughout the SCCMHA network. As with overall staff, there has been some turnover, and physicians have similar if not more significant time challenges for core training. To date, SCCMHA has had very limited success in generating plans to fully engaging doctors involved in primary case management programs, including planning or treatment. Dr. Kenneth Minkoff's presence in Saginaw in November 2005, March 2007, and January 2009, served to provide some key orientation in dual disorder treatment, critical for medication and other medical treatment related practice shifts. However, all physicians who are treating SCCMHA consumers are in need of stronger supports for evidence-based mental health treatment education targeted to meet their specific needs. The former SCCMHA medical director was very involved in the review of medication patterns through the statewide review process. At this time SCCMHA and some of the key provider programs have experienced medical practitioner and leadership changes.

Identification & Discontinuation of Non-Evidence-Based Practices

While many staff and contract network member practitioners have been directly engaged in the development and delivery of services and supports through evidence-based practice models to date, not all have been fully engaged. SCCMHA has not yet taken a systemic approach to reviewing all practices being used by staff and providers in the treatment of SCCMHA consumers for all populations and service delivery areas. It is assumed that there are still some practices being used within the network that are not appropriate and/or where more evidence-based or at least promising practices are available. Practices by SCCMHA service array areas have been recommended, but contractual expectations for all programs are still needed, with clear messages to all practitioners about discontinuation of non evidence-based practices.

RECOMMENDATIONS FOR FUTURE SUCCESS

There are a number of aspects to the current SCCMHA sustainability plan for evidence-based practices. Many of these activities and objectives are included in the SCCMHA strategic plan. In order to protect the current evidence-based practice strengths as well as incorporate new directions indicated by research or system needs, focus on certain areas for the future are recommended.

Review & Refresh Sustainability Plan
SCCMHA should develop an annual, updated sustainability plan that can be generated as part of the SCCMHA quality program. This plan could address new areas of need as well as serve to renew and ensure ongoing maintenance of existing implemented practices. Each practice area needs specific goals related to the components of the practice as well as SCCMHA network issues, strengths and challenges. Part of the updating of the plan should include prior efforts as well as the documented recovery plan for the SCCMHA system. The sustainability plan needs to take into account ongoing and new training needs.

Reconfigure EBP Leadership
As practices were prioritized at SCCMHA, specific practice work groups were convened to provide the direct service level of support necessary to ensure successful implementation, including directing resources, supporting or development training, incorporation with data and documentation, integration with the quality program and fidelity review and oversight. As practices were successfully implemented and integrated into ongoing team service delivery and practices, work groups have adjusted the frequency of meeting schedules and/or faded out ongoing special leadership activities. In addition, at SCCMHA, system of care leadership has developed its own structure, and though linked, is independent of the Improving Practices Leadership Team. Regardless, to date the IPLT has included all practice areas and populations in its review and oversight. Much has changed since 2005 for the SCCMHA system and network in the area of evidence-based practices. SCCMHA needs to develop an updated plan, now that the system has matured, to ensure the active but more limited oversight needed to create sustainable practices. Sustained and enhanced consumer input and leadership, along with other key stakeholders, must be part of this structure.

Establish Practice Research Monitoring Means
Over time, new research produces changes in practices or even new practices in the field of behavioral health and human services. Changes in practices or newly emerging practices with promise or shown to be evidence-based, need to be incorporated into the system's repertoire of appropriate treatments and supports for use by practitioners.

Maintain Visibility of Key Concepts, Outcomes & Champions
One of the key aspects of SCCMHA's sustainability has been the ongoing education about practices and key concepts, including with community partners. Because the high visibility has been instrumental in the sustainability plan and overall success to date, it is recommended that EBP continue to receive attention throughout the SCCMHA structure to reinforce integration.

Ensure Fidelity Monitoring
SCCMHA needs to establish a consistent and comprehensive system for effective and efficient fidelity review and/or other administrative review of all evidence-practice areas, incorporating any external reviews by MDCH or other resources. Fidelity review has been inconsistent.

Feedback from fidelity reviews needs to be incorporated into staff supervision as well as system sustainability monitoring and planning and continuous quality improvement activities. An ongoing fidelity review plan each year is recommended to ensure that all practices receive either internal and/or external attention to fidelity.

Implement Additional & Expand Current Practices
The evidence-based practices at SCCMHA are primarily those for adults with serious mental illness and children with serious emotional impairments. Evidence-based practice impact on persons with developmental disabilities has been limited to date. SCCMHA intends to issue an older adult evidence-based practice guide in the future. SCCMHA priorities to implement practice with existing or new population groups served will need to be determined and included in the ongoing sustainability plan. In addition, some practices may exist but have not yet been implemented with certain groups, such as co-occurring services and supports for adolescents and their families. An additional IDDT team is expected in FY 2011.

Data Capture & Outcome Measurement
Systematic data capture and full reporting associated with the number of consumers served by each practice, as well as data on impact and outcomes is critically needed in SCCMHA's future sustainability plan. SCCMHA needs not only readily available consumer penetration data to note the progression of additional consumers having access to services and supports that are evidence-based, but also, and perhaps most importantly, outcome data that demonstrates positive impact for persons served. Much of the reportable impact or outcome information at this time is disappointedly antidotal or incomplete.

Obtain Comprehensive Commitment
Shifts necessary to maintain EBP can uncover a myriad of barriers at the individual staff level, especially given new or additional training expectations in a climate of rising productivity expectations, transparency of medical record quality review, and limited system funds. Persons who have not yet embraced the values of evidence-based practices or demonstrate a lack of support for such will not serve to support the success of sustainability. Covert resistance may exist, which is more difficult to address when the staff member is not open about their concerns. Education to increase comfort with knowledge of practices, and supervisory support to realign priorities and problem solve will likely be necessary action steps. Targeted efforts may be needed for specific groups, including but not limited to network psychiatrists, to appropriately support their unique needs and role. SCCMHA should initiate an individual practitioner privileging process for specific practice(s) to assist with this goal area.

APPENDIX 1: EVIDENCE-BASED PRACTICE GUIDES LIST

- ❖ A Guide to Evidence-Based Practices for Adults with Mental Illness (2005)

- ❖ A Guide to Evidence-Based Mental Health Practices for Children, Adolescents and their Families (2006)

- ❖ A Guide to Evidence-Based Practices for Individuals with Substance Use Disorders (2007)

- ❖ A Guide to Evidence-Based Practices for Psychiatric Hospitalization (2008)

- ❖ A Guide to Evidence-Based Practices for Child Welfare (2008)

- ❖ A Guide to Evidence-Based Practices for Individuals with Mental Illness, Co-Occurring Substance Use Disorders, and Criminal Justice System Involvement (2008)

- ❖ A Guide to Evidence-Based Practices for Individuals with Development Disabilities (2009)

- ❖ A Guide to Evidence-Based Trauma-Focused Practices Helping Schools Respond to Crises (2009)

- ❖ A Guide to Evidence-Based Practices for Older Adults with Mental Illness (planned)

- ❖ A Guide to Evidence-Based Practices for Prisoner Reentry (planned)

These guides and other EBP policy information are available on the SCCMHA website at www.sccmha.org.

<u>APPENDIX 2: SCCMHA IMPROVING PRACTICES LEADERSHIP TEAM</u>

2005 – 2010 Members

Ginny Reed
Linda Schneider
Barbara Glassheim
Heidi Wale
Amelia Johnson
Amy Murawski
Georgia Reyes
Jennifer Keilitz
Fran Erwin
Dawn Estrada
Greg Carter
Glen Black
Jan Histed
Jennifer Tomaszewski
Jim Nesbit
Joe Dula
Julie McCulloch
Kevin Sackett
Lori Denter
Lula Haynes
Mark Leffler
Matt Linkowski
Nancy Urban
Natividad (Steve) Gonzalez
Robert Thrash
Rocky Archangeli
Sherrhonda Brown
Tommie Orange
Dave Dunham
Dalia Smith
Tyuana Simmons
Monika Rotunno
Lorie Tobin
Pamela Hales
Doris Patrick
Brooke DeBolt
Bedonna Maiberger
Patrick Wranik
Cecilia Thomas
Richard Thiemkey
Heather Beson
Johnnie Salter
Sarina Brown
Ted Gray
Mary Amend

APPENDIX 3: SCCMHA PROGRAM/SERVICE-SPECIFIC EBPs

SERVICE TYPE	PRACTICE	TRAINING REQUIREMENTS	REFERENCES/RESOURCES
ADULT CASE MANAGEMENT	**MI**	MINT training or equiv.	SAMHSA TIP # 35 SAMHSA IDDT Toolkit SCCMHA Website/ Adult & SUD EBP Guides
	DBT	Behavioral Tech, LLC	SCCMHA Website/Adult EBP Guide
	IDDT	Statewide trainings	SAMHSA TIP # 42 SAMHSA IDDT Toolkit SCCMHA Website/Adult EBP Guide
	COD	SCCMHA	SAMHSA TIP # 42 SAMHSA TIP # 35
	FPE	Statewide trainings	SAMHSA FPE Toolkit SCCMHA Website/Adult EBP Guide
	TREM / M-TREM & W-TREM		SCCMHA Website/SUD EBP Report
	IM&R[*]		SAMHSA IM&R Toolkit SCCMHA Website/Adult EBP Guide
	SE	SCCMHA Orientation	SAMHSA SE Toolkit SCCMHA Website/Adult EBP Guide
	PADs	SCCMHA Orientation	MDCH Website National Resource Center on PADs (http://www.nrc-pad.org/)
	PCP	SCCMHA	
	Supportive Housing		SCCMHA Website/Adult & SUD EBP Guides

SERVICE TYPE	PRACTICE	TRAINING REQUIREMENTS	REFERENCES/RESOURCES
	PSS / WRAP	MDCH PSS training	Copeland WRAP materials SCCMHA Website/Adult EBP Guide
ACT TEAM SERVICES	IDDT		SAMHSA IDDT Toolkit SCCMHA Website/Adult EBP Guide
	COD	SCCMHA	SAMHSA TIP # 42 SAMHSA TIP # 35
	SE		SAMHSA SE Toolkit
	ACT Team	ACT 101 (MDCH)	SCCMHA Website/Adult EBP Guide Michigan Medicaid Provider Manual
	MI	Mint training or equiv	SAMHSA TIP # 35 SAMHSA IDDT Toolkit
	PADs	SCCMHA Orientation	MDCH Website National Resource Center on PADs (http://www.nrc-pad.org/)
	FPE		SAMHSA FPE Toolkit
	IM&R*		SAMHSA IM&R Toolkit SCCMHA Website/Adult EBP Toolkit
	PCP	SCCMHA	
CHILDREN'S CASE MANAGEMENT	TF-CBT	MDCH-sponsored training	SAMHSA SCCMHA Website/ Children EBP Guide NCTSN Website
	PW		SCCMHA Website/ Children EBP Guide Family Works, Inc. Website
	PMTO	14 months PMTO approved training	SCCMHA Website/ Children EBP Guide

SERVICE TYPE	PRACTICE	TRAINING REQUIREMENTS	REFERENCES/RESOURCES
	Family-Centered Practice	SCCMHA	SCCMHA Website/ Children EBP Guide
	G-TREM		SCCMHA Website/ SUD EBP Guide
	DBT-A		SCCMHA Website/ Children EBP Guide
	SOC / Wraparound		SCCMHA Website/ Children EBP Guide
	MST	MDCH-sponsored training	SCCMHA Website/ Children EBP Guide
	Respite (DD)		SCCMHA Website/DD EBP Guide
CHILDREN'S MOBILE CRISIS TEAM		MUTT Orientation	MUTT literature SCCMHA Website/ Children EBP Guide
PSYCHIATRIC SERVICES	MIMA*		
CLUBHOUSE	TE		SCCMHA Website/Adult EBP Guide Michigan Medicaid Provider Manual ICCD Website
	Work-Ordered Day		SCCMHA Website/Adult EBP Guide Michigan Medicaid Provider Manual ICCD Website
SUPPORTS COORDINATION	ABA		SCCMHA Website/DD EBP Guide
	PECS		SCCMHA Website/DD EBP Guide
	PCP	SCCMHA	SCCMHA Website/DD EBP Guide

SERVICE TYPE	PRACTICE	TRAINING REQUIREMENTS	REFERENCES/RESOURCES
	PBS		SCCMHA Website/DD EBP Guide
GERIATRIC SERVICES	CBT		SCCMHA Website/Older Adult EBP Guide
	PCP	SCCMHA	
	COD	SCCMHA	SAMHSA TIP # 42 SAMHSA TIP # 35
RESIDENTIAL SERVICES	PCP	SCCMHA	
	PBS		
CRISIS INTERVENTION SERVICES	MI	MINT training or equiv.	SAMHSA TIP # 35 SAMHSA IDDT Toolkit
	PCP	SCCMHA	
	COD	SCCMHA	SAMHSA TIP # 42 SAMHSA TIP # 35
INPATIENT SERVICES	MI	MINT training or equiv.	SAMHSA TIP # 35 SAMHSA IDDT Toolkit
	PCP	SCCMHA	
	IM&R*		SAMHSA IDDT Toolkit SCCMHA Website/Adult EBP Guide
	MIMA*		
CRISIS RESIDENTIAL	COD/DDC		SAMHSA TIP # 42 SAMHSA TIP # 35
	MIMA		
	PCP	SCCMHA	

* Recommended practice not implemented by SCCMHA

KEY:

ABA = Applied Behavior Analysis
ACT = Assertive Community Treatment

M-TREM = Trauma Recovery and Empowerment for Men
NCTSN = National Child Traumatic Stress Network

CBT = Cognitive Behavior Therapy
COD/DDC = Co-occurring Disorders/Dual Disorders Capable
DBT = Dialectical Behavior Therapy
DBT-A = Dialectical Behavior Therapy for Adolescents
EBP = Evidence-Based Practice
FPE = Family Psychoeducation
G-TREM = Trauma Recovery and Empowerment for Adolescent Girls
ICCD = International Center for Clubhouse Development
IDDT/DDE = Integrated Dual Disorders Treatment/Dual Disorders Enhance
IM&R = Illness Management & Recovery
MI = Motivational Interviewing
MIMA = Michigan Implementation of Medication Algorithms
MINT = Motivational Interviewing Network of Trainers
MST = Multisystemic Therapy

PAD = Psychiatric Advance Directive
PBS = Positive Behavior Supports
PCP = Person-Centered Planning
PECS = Picture Exchange Communication System
PMTO = Parent Management Training - Oregon
PW = Parenting Wisely
SE = Supported Employment
SOC = System of Care
SUD = Substance Use Disorder
TE = Temporary Employment
TF-CBT = Trauma-Focused Cognitive Behavior Therapy
TREM = Trauma Recovery and Empowerment
WRAP = Wellness Recovery Action Plan
W-TREM = Trauma Recovery and Empowerment for Women

APPENDIX 4: MDCH AND SAMHSA REFERENCES

MDCH

❖ Michigan Medicaid Provider Manual, Chapter III:
http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html

❖ Mental Health and Substance Abuse Administration:
http://www.michigan.gov/mdch/0,1607,7-132-2941-146590--,00.html

❖ For information go to http://www.michigan.gov/mdch

SAMHSA

❖ Integrated Treatment for Co-Occurring Disorders Toolkit

❖ ACT Toolkit

❖ Family Psychoeducation Toolkit

❖ Illness Management and Recovery Toolkit

❖ Supported Employment Toolkit

❖ Permanent Supportive Housing Toolkit

❖ These and other resources can be found at http://www.samhsa.gov/.

❖ SAMHSA's National Registry of Evidence-Based Practices:
http://www.nrepp.samhsa.gov/Search.aspx

APPENDIX 5: EBP CHRONOLOGICAL REPORT

FY 2005	
CEO appoints Improving Practices Leadership Team	June 2005
EBP Introduction to CAC	July 2005
SCCMHA submits COD/IDDT block grant request	August 2005
Key staff/providers begin initial COD/IDDT training Adults with Mental Illness EBP Guide Published EBP Information Included in MDCH Annual Submission/PPG	September 2005
FY 2006	
Improving Practices Team Convenes SCCMHA Awarded Supported Employment Block Grant (based on SAMHSA model) SCCMHA Awarded COD/IDDT Improving Practices Block Grant Initiation of SCCMHA Website Posted EBP Information Initiation of SCCMHA Provider Newsletter EBP Communications Integration of Improving Practices with SCCMHA Quality Program	October 2005
COD/IDDT Workgroup Commences Ken Minkoff/Chris Cline Training at SCCMHA	November 2005
Continued Training/Attendance at MDCH COD Meetings SCCMHA Representative Appointed to MDCH Recovery Council	December 2005
Recovery Standing Agenda Item for Improving Practices Leadership Team ACT Work Group Commences (102-104/140 baseline measure) Supported Employment Work Group Commences (57/75 baseline measure)	January 2006
SCCMHA Integrated Services Charter Issued	February 2006
Patrick Boyle Team Consultations MI FAST Training/SCCMHA Representative on State COD/IDDT Fidelity Team	March 2006
Internal Fidelity Review Initiated by SCCMHA for ACT (program began in 1990) Supported Employment Fidelity Review (67/75) David Mee Lee Training EBP Information to CAC	April 2006
SCCMHA EBP Policy Issued SCCMHA COD/IDDT Policy Issued	May 2006
SCCMHA Provider Newsletter Recovery Series Commenced EBP Presentation with Consumer Leadership Teams Medical Director COD Letter to Psychiatrists	June 2006
SCCMHA Recovery Policy Issued SCCMHA ACT Policy Issued SCCMHA DBT Policy Issued DBT & Outcome Measurement Workgroup Convenes	July 2006
DBT Group Graduation Event	August 2006
Children/Adolescent/Family EBP Guide Published SE Fidelity Review (69/75) ACT Fidelity Review (105/140) COFIT Baseline Measurement Completed (197-219/500)	September 2006
FY 2007	

SCCMHA Awarded MDCH FPE Grant	October 2006
SCCMHA Awarded MDCH Recovery Training Block Grant	
SCCMHA Awarded MDCH COD Training Block Grant	
FPE Workgroup Commences Planning Meetings	
Children's EBP Guide Presentation to CAC	
Recovery Series Initiated in SCCMHA Provider Newsletters	
EBP Update with Consumer Leadership Teams	November 2006
Medical Director EBP Update Letter to Psychiatrists	
Recovery Principles Posters Disseminated	December 2006
FPE Training with William McFarlane	January 2007
SCCMHA FPE Policy Issued	February 2007
EBP Update to CAC	
Michael Clark Begins Training – Motivational Interviewing, Stage Wise Assessment & Intervention and Substance Abuse Counseling	March 2007
SCCMHA Initiates Baseline System Recovery Assessment	
Kenneth Minkoff Consultation/Training Including Physician Dinner	
Michael Clark Training Continues	April 2007
SCCMHA Initiates Recovery Baseline Consumer Measurement	
Supported Employment Fidelity Review (70/75)	
ACT Fidelity Review (111/140)	
Children's SOC Community Stakeholder Meetings	
Steve Gonzalez Everyday Hero Recognition – Improving Practices Leadership Champion	May 2007
Children's SOC MDCH Block Grant Submission	
Michael Clark Training Continues	June 2007
CSS Teams Receive Fidelity Consultation	
Baseline GOI Scored for CSS Teams (30/60)	
Discussion of COD/IDDT Team Barriers	
SCCMHA Welcoming Policy Issued	July 2007
Residential Provider Communication on EBP Expectations	
Baseline ROSI Report Issued	
Additional Recovery Training Including Peer Support Specialists	
Supported Housing Work Group Convened	August 2007
Saginaw Psychological Team Receive Fidelity Consultation	
TTI ACT Team Receives Fidelity Consultation	
William McFarlane FPE Training for Additional Team Members	September 2007
PMTO Training Initiated	
FY 2008	
SE Fidelity Review (70/75)	October 2007
FPE Family Group Convened – Saginaw Psychological Services	
Wellness/Recovery Community Event (WRAP)	
SCCMHA PMTO Policy Issued	
PMTO Training Continued	
SCCMHA awarded SOC, CAFAS Block Grants	
SCCMHA awarded COD Enhancement, Trauma, Supported Housing, Clubhouse & Peer Support Training Block Grants	
SCCMHA awarded Case Management & FPE renewal Block Grants	
Heather Flynn MI Training	November 2007
Residential COD/IDDT Training	
SCCMHA Supported Housing Policy Issued	

SCCMHA recognized by MDCH/EMU LOF - SED Children Services Severity/Excellence	
Substance Use Disorder EBP Guide Published Interventions in Homelessness Training	December 2007
SCCMHA Participation in MDCH Change Agent Series FPE groups initiated – TTI EBP presentation for SCCMHA Board of Directors	January 2008
FPE groups initiated – CSS DBT (second) group graduation National Center for Children in Poverty Center visit to SCCMHA Ethics for Co-Occurring Disorders Presentation On-Line Co-Occurring Disorders Training Initiated	February 2008
SCCMHA Participation in MDCH Change Agent Series SOC Leadership Group convened Homelessness System Transformation Block Grant Awarded	March 2008
CAC presentation on SUD guide Board Ends presentation on SUD guide FPE Training (Additional) SE Fidelity Review (68/75) ACT Fidelity Review (112/140) Wraparound EBP Review Initiated Psychosocial Rehabilitation (Clubhouse) Best Practice Review Initiated Parenting Wisely (Teen Class) Initiated	April 2008
Trauma Informed Community Training Event Hispanic Mental Health Conference Presentation – Cultural & Stages of Change Assessment SCCMHA Participation in MDCH Change Agent Series	May 2008
Criminal Justice System Involvement EBP Guide Produced (not yet released)	June 2008
SOC Leaders & Implementation Team Groups Continue SCCMHA Participation in MDCH Change Agent Series SE Presentation at Board Ends Committee First Parenting Wisely Teen Class Graduation	July 2008
Encompass Integrated Treatment Note Released Trauma Recovery Education Team Training – TREM (Female Consumers) Second Teen Parenting Wisely Class Initiated	August 2008
ACT first MI FAST Assessment Scheduled Trauma Recovery Education Team Training – TREM (Male Consumers)	September 2008
FY 2009	
SCCMHA obtains provisional SA licensure CSS first MI FAST Assessment Inpatient/Hospital EBP Guide issued Children's mobile crisis block grant approved	October 2008
ACT Field Guide MDCH/MPA Site Visit Change Agent Training Second Teen Parenting Wisely Graduation Family Advocates Initiate Training in TF-CBT	November 2008
Team Leader Training Sessions (one held at SCCMHA) SPS initiates dual disorder groups Suicide Prevention Plan for Saginaw County Issued	December 2008
Dr. Kenneth Minkoff Sessions at SCCMHA (physicians, clinicians, consumers)	January 2009

CSS approved for DBT certification by MDCH First Young Children Parenting Wisely Class Initiated Third Teen Parenting Wisely Initiated	
Understanding Role of Peer Support Specialist Trainings Trauma Training for Saginaw school personnel	February 2009
	March 2009
Culture of Gentleness Training Introduced by MDCH Trauma Training for Children DBT graduation (3rd group) Doris Joy consultation for four FPE teams/groups initiated First Young Children and Third Teen Parenting Wisely Graduations	April 2009
EBP Guide for Persons with Intellectual and Developmental Disabilities published Submission of FY 2010 children's block grants SCCMHA Visit to Milwaukee MUTT Program	May 2009
Train the Trainer FPE participation MI Train the Trainer participation Saginaw Psychological Services MI FAST review SCCMHA Peer Support Specialist EBP panel presentation at 1st Annual Michigan Peer Specialist Conference MRS Consultation	June 2009
Trauma Informed Practice Policy Supported Employment Fidelity Review	July 2009
Suicide Risk Factors Community Training Follow Up Milwaukee Visit to MUTT/Wraparound Programs	August 2009
CBT training Resiliency Training Creating a Trauma Informed Community Training G TREM Training (girls trauma) Measurement of Health Status for Persons with Serious Mental Illness Training Wraparound/MUTT Milwaukee Presentation SOC Leaders Group Project LAUNCH Michigan Federal Grant Awarded to Saginaw County Head Start Contract Awarded to SCCMHA	September 2009
FY 2010	
EBP DD Guide Presentation CAC IDDT Workgroup Initiated MPRI Administrative Services Contract Awarded to SCCMHA Marshcak Assessment Training Preliminary PSS Fidelity Review	October 2009
	November 2009
SOC SAMHSA Grant Submission Second MI Fast Review-CSS Initial REE Survey Completed	December 2009
New FPE groups planned	January 2010
Men's Trauma Group Initiation CSS Addiction Counselor Development Series (Monthly) Start-Up	February 2010
MUTT Implementation Completion of FPE External Supervision MI Training commenced	March 2010
ACT State Work Group Commences SCCMHA Culture of Gentleness Training participation	April 2010

Children & Adult Block Grant Submissions REE report issued EBP overview training Participation in MDCH sustainability review project	May 2010
ACT MI-FAST review	June 2010
	July 2010
	August 2010
SCCMHA presented at state trauma conference (RW & SG) DBT graduation (third) PMTO staff certification (FSU-ML)	September 2010
FY 2011	
SAMHSA SOC grant award commenced Adult block grants – consumer recovery conference, co-location project and trauma train-the-trainer commence Men's Trauma group commences (second) Introduction to EBPs Training	October 2010
	November 2010
SPSI MI-FAST review	December 2010
CSS MI-FAST review	January 2011
MI Training	February 2011
EBP Five (5) Year Report Issued MI Training	March 2011
	April 2011
MPRI EBP Guide SCCMHA Older Adult EBP Guide Recovery Plan Update Trauma Train-the-Trainer Consumer Recovery Conference	TBD (planned or pended)

EBP Acronym Key:

ACT	Assertive Community Treatment	**PMTO**	Parent Management Training – Oregon Model
COD/IDDT	Co-occurring Disorders/Integrated Dual Disorder Treatment	**PSR**	Psychosocial Rehabilitation Services (or Clubhouse)
CBT	Cognitive Behavior Therapy	**PW**	Parenting Wisely
DBT	Dialectical Behavior Therapy	**SE**	Supported Employment
EBP	Evidence-Based Practice(s)	**SOC**	System of Care
FPE	Family Psychoeducation	**SUD**	Substance Use Disorder
MI-FAST	Michigan Fidelity Assessment Service Team(s)	**TF**	Trauma Focused
MUTT	Mobile Urgent Treatment Team (Children)		