

Preliminary Work Group Reports

As approved by the work group chairs

July 26, 2004

WORK GROUP I: EDUCATION, RIGHTS, OUTREACH, AND ADVOCACY

Chair: Guadalupe Lara

Preliminary Report

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
Recommendations: Public Attitudes, Awareness, and Stigma				
<p>1. Public misconceptions about mental illness produce a public stigma that results in fear, discrimination, and mistreatment.</p> <ul style="list-style-type: none"> The stigma of mental illness prevents individuals from seeking treatment for themselves or family members (impeding timely diagnosis and appropriate treatment) and increases the risk of suicide, results in significant economic loss, and harms family relationships. Stigma is rooted in the erroneous historic premise that mental illness is qualitatively different from other physical illnesses. There is no unified, authoritative voice delivering the truth about mental illness. 	<p>A. Form an independent organization consisting of representatives of state and local government, including the Michigan Surgeon General, consumers, advocacy organizations, and advertising and public relations industries to create a continuing campaign to educate the public that mental illness is physical illness.</p> <ul style="list-style-type: none"> Activities should include the creation of a central Internet site containing all the materials and information produced for this effort. The campaign should use people who have experienced mental illness to tell their stories and provide accurate information. It should include the use of video interviews, stories, and short documentaries that can be made available to schools, organizations, businesses, and the website. The campaign should create speakers bureaus in each county utilizing the skills of people who have experienced mental illness. The campaign should include targeted marketing to reach students, educators, news media, health 	<p>A. Increase awareness about mental health and mental illness; alter public perception.</p> <p>B. Make information about mental illness widely available.</p> <p>C. Increase political awareness.</p> <p>D. Increase interest in and funding for brain research.</p> <p>E. Promote acceptance of and increased opportunities for those with mental illness.</p> <p>F. Incorporate mental health issues into early education programming in school curricula.</p> <p>G. Foster more holistic treatment in health care settings.</p> <p>H. Promote better understanding by police and corrections workers.</p> <p>I. Clients, providers, and the public will be better informed by forms and publications that are</p>	<p>Multiple parties:</p> <ul style="list-style-type: none"> Surgeon General Executive branch can launch an independent group (in a similar fashion to the way MPHI was begun) 	<p>Short-term action for launch; long-term implementation</p>

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	<p>workers, police/corrections workers, business and community leaders, and others.</p> <p>B. Review the utility, suitability, and readability of the literature and forms distributed to consumers and families receiving or applying for services.</p>	understandable.		
<p>2. During the last 20 years there has been a systematic erosion of mental health insurance benefits in the private sector. Over this same period there has been an explosion of new knowledge about mental disorders, which has translated into major advances in treatment. Insurance discrimination based upon stigma about mental illness should no longer be tolerated by the people of Michigan; equal reimbursement for recognized medically necessary services by providers that are currently licensed and certified by the state makes sense. The commission should strongly advocate on behalf of state parity legislation.</p>	<p>Support legislation that requires all insurers to offer coverage for the treatment of mental illnesses and addiction disorders that is equivalent to the coverage for all other disorders. That is, the legislation should prohibit the use of higher co-pays and deductibles, lower maximum coverage dollar limits (annual and lifetime) for both inpatient and outpatient treatment, and arbitrary outpatient visit limits and/or hospital stays. The legislation should assure coverage of medically necessary treatment for all disorders listed in the DSM-IV, in the categories of both mental health and addictive disorders.¹</p>	<p>A. Eliminate insurance discrimination against persons with mental illness and addiction disorders.</p> <p>B. Reduce indirect costs to employers caused by reduced productivity, increased absenteeism, and employee turnover.</p> <p>C. Eliminate the economic burden on patients and their families caused by the out-of-pocket burden resulting from insurance discrimination.</p> <p>D. Reduce the number of persons with mental illness that become disabled as a result of their illness.</p> <p>E. Offer small businesses the same access to the same types of mental health insurance coverage that large businesses use to provide protection and security for their employees, improving productivity while reducing health care costs.</p>	<p>Legislature (passing legislation)</p> <p>Governor (signing legislation)</p>	<p>Immediate</p>

¹ "Addictive disorder" is defined as (1) any behavior that an individual recurrently fails to control, and (2) any behavior in which an individual continues to participate, despite significant harmful consequences.

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		<p>absenteeism, disability, and workers' compensation.</p> <p>F. Reduce the cost shifting that results when persons with mental illness lose their mental health coverage and/or job and cannot afford treatment due to insurance discrimination, thus becoming clients of the public mental health and/or Medicaid systems.</p>		
<p>3. Michigan is not utilizing the world-class resources it has for brain research and related business and education opportunities. A primary focus of the "Life Sciences Corridor" should be on diagnosing and treating diseases of the brain, including addictive disorders and co-occurring disorders.</p>	<p>A. Encourage the state's four public medical schools (U of M, WSU, MSU-CHM, MSU-COM) to work cooperatively on research projects:</p> <ul style="list-style-type: none"> • Assist the medical schools in seeking public and private grant funds for research and treatment • Serve as a liaison between the medical schools and private sector corporations • Work with the medical schools to develop pilot projects in the public mental health system <p>B. Enlist the support of the MEDC and local economic development groups to embellish the "life sciences corridor" by attracting to Michigan pharmaceutical and other related private industries that will capitalize on research into the causes and treatments of mental illness.</p> <p>C. Encourage mental health-related organizations located in Michigan to work cooperatively.</p>	<p>A. Michigan will become a recognized center of excellence for research into brain structure and function, the causes of mental illnesses, and successful treatments.</p> <p>B. The public and private mental health systems will benefit from the "local" access to cutting-edge research and best practices.</p> <p>C. State medical schools will have increased access to research funding.</p> <p>D. This positive emphasis on brain research and the treatment of brain disorders will help to eliminate stigma.</p> <p>E. The retention and creation of high-tech jobs will be fostered.</p>	<p>MDCH, a state mental health advocacy organization, or a combination thereof</p>	<p>Long-term</p>

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<p>4. Despite having good information about populations at risk for mental illness, there is no mechanism for reaching out to assist those with mental illness who are not receiving treatment.</p>	<p>A. Increase early identification/screening and prevention efforts to match those of other health conditions, possibly through schools.</p> <p>B. Restore of prevention demonstration services within MDCH.</p> <p>C. Increase screening and outreach through non-health care human service programs for low-income and homeless individuals (i.e., The Servant Center in GR, PORT program in Washtenaw).</p> <p>D. Support parity legislation so those identified through screening have adequate treatment options.</p>	<p>A. Identification of and early interventions for at-risk youth</p> <p>B. Cost savings due to early identification and appropriate treatment</p>	<p>Legislative and executive action</p>	<p>Short- and long-term</p>
Recommendations: Accountability				
<p>5. Compliance with evidence-based practices and client satisfaction are not always taken into account (nor always done properly) in assessing provider and manager fulfillment of contractual obligations.</p> <p>In addition, there is no way of consistently measuring and evaluating contract compliance across the state.</p>	<p>A. The state rights office will develop uniform methodologies and programs for monitoring the use of evidence-based practices; evaluating program outcomes, service quality, and the appropriateness of services delivered; auditing fund management; and client and applicant satisfaction. The rights office (perhaps through an ombudsman section) will work with representatives from CMHSPs across the state, consumers, family members, advocacy groups, providers, and other stakeholders to develop these programs, which will be designed to measure any service and/or outcome disparities by geographic region, race and/or ethnic group, sex, or age.</p> <p>B. The state rights office will contract with an independent party (e.g., a public university, foundation, or nonprofit advocacy group) to assist with these programs, including the</p>	<p>A. Consumers will gain information important to recovery and experience greater empowerment by learning outcomes of contractual compliance issues that they or their representatives have raised.</p> <p>B. Client surveys will yield more reliable information about consumer perspectives on system performance.</p> <p>C. All parties concerned with the public mental health system will have better information for evaluating and improving key aspects of the system.</p>	<p>Legislative and executive action; latter to include involvement of state rights office ombudsman section</p>	<p>Short-term action toward long-term implementation</p>

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	<p>collection and analysis of client surveys and other data, and the preparation of an annual statewide report. Client surveys not be performed by CMHSP staff to avoid the potential for conflict of interest or coercion.</p> <p>C. Methodologies for monitoring funding needs and budgets will be designed to more accurately assess the “true” costs and benefits of public mental health services rather than measuring within individual program “silos.”</p> <p>D. All MDCH-CMHSP contracts, and all contracts within a CMHSP network, will be required to designate both Medicaid and non-Medicaid applicants and recipients as third-party contractual beneficiaries.</p>			
<p>6. Medicaid “Fair Hearings” have no requirement for clinical input and therefore have limited efficacy; non-Medicaid individuals have no effective service appeal mechanism.</p>	<p>A. The state rights office administers Medicaid Fair Hearings and a corresponding hearing process for the non-Medicaid population, assuring clinical consultation for both.</p> <p>B. CMHSPs will maintain a standard database, created by the state rights office, on non-Medicaid applicants that were denied service. The information from it will be provided to the state rights office on a quarterly basis.</p>	<p>A. Hearing outcomes will have a basis in treatment.</p> <p>B. Non-Medicaid individuals (both recipients and applicants) will have better options to appeal service decisions, and those options will be medically/clinically based.</p>	<p>Executive branch and legislature</p>	<p>Immediate action for short-term implementation</p>
Recommendations: Inadequate Protection				
<p>7. Rights protection is currently offered by the same entity responsible for service management and provision, creating a real or perceived conflict of interest.</p>	<p>A. State Recipient Rights Office (possibly with new name) is made a Type I/ autonomous agency within the MDCH or another part of the executive branch (e.g., Department of Management and Budget or Governor’s Office).</p> <p>B. Local recipient rights offices (currently part of CMHSPs) are turned into local or regional</p>	<p>Real or perceived conflict of interest will be eliminated.</p>	<p>Executive branch and legislature</p>	<p>Immediate action for short-term implementation</p>

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	offices that are staffed by and totally responsible to the state office.			
8. The Office of Recipient Rights doesn't have authority to correct case-specific and systemic instances of noncompliance by either CMHSPs or their end providers, including the levying of sanctions.	<p>A. Regarding systemic noncompliance issues, the state rights office and a CMHSP would initially pursue remediation through collaborative dialogue in which the CMHSP is involved in seeking solutions, after which state rights office would determine the success of such steps. Once dialogue is concluded, remedies recommended by the state rights office would be binding.</p> <p>B. The administration of any CMHSP whose network, after a series of graduated steps toward remedy, exceeds prescribed ceiling of noncompliance with rights protocols, requirements, and performance on a systemic level, will be placed under receivership by the state.² Contracts between CMHSPs, middle managers, and end providers must address rights protection and compliance, including financial sanctions for inadequate rights performance.</p>	Sanctions will deter noncompliance. Receivership as a final enforcement measure would allow the services to be provided without interruption and obviates the need for state to de-fund an entire CMHSP and find another entity to replace it.	Legislative action and executive branch policy supplementation	Immediate action for short-term implementation

² The evaluation criteria for CMH compliance would not necessarily be those in place today.

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<p>9. The procedures and mechanisms currently in place to address rights issues are potentially duplicative, confusing, and sometimes conflicting, and do not address all legitimate client complaints.</p>	<p>A. The state rights office becomes a “one-stop-shopping” center for all mental health and substance abuse rights matters, regardless of Medicaid eligibility:</p> <ul style="list-style-type: none"> • All possible violations of rights accorded applicants, recipients, and families under law • All service appeals • All other consumer grievances for which negotiated dispute resolution is a response option (This option is also available, at consumer’s discretion, for previously named matters.) <p>B. The rights agency will examine recipient and applicant fatalities and sentinel events for issues of possible rights violations. On behalf of a deceased recipient or applicant, an executor, administrator, or other person having authority to act should be given legal standing to initiate a grievance of a denial of service. If permitted by federal law, such standing should also be available to the deceased individual’s family members (as presently defined in the MH Code) or agents designated through an advance psychiatric directive.</p>	<p>All complaints and investigative requirements will be addressed and processed in a more simplified, streamlined, and effective manner.</p>	<p>Executive branch and legislature</p>	<p>Immediate action for short-term implementation</p>

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
<p>10. The interpretation and application of rights law, rules, and policy by DCH and CMHSPs are not uniform.</p> <p>Current forms, handouts, brochures, booklets and other materials that are used within the system to inform consumers and families about their rights and available programs are not "user friendly."</p>	<p>A. Local/regional recipient rights offices (staffed by and totally responsible to the state office) would provide regular education and training to all providers and service managers.</p> <p>B. The state rights office (perhaps through an ombudsman function) would engage in education, training, evaluation, and assistance to primary and secondary mental health consumers in navigating this and other human service systems.</p> <p>C. The rights office, perhaps in conjunction with an independent organization, will review current forms, handouts, brochures, booklets, and other materials that are used within the system to inform consumers and families about their rights and available programs and evaluate them for readability, utility, suitability, and cultural sensitivity. As necessary, the rights office will develop new materials in appropriate formats.</p> <p>D. Legal counsel from the state rights office will be available to all regional offices (as is done in New York).</p>	<p>A. Institute uniformity and minimize variation in the handling of rights issues, consistent with the Michigan Administrative Procedures Act and relevant case law.</p> <p>B. Make service and rights information and paperwork easier for consumers and families.</p>	<p>A. Executive branch and legislature</p> <p>B. For analysis and revision of information and forms, the independent organization referenced in key issue #8</p>	<p>Immediate action for short-term implementation</p>

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<p>11. Consumer preferences for treatment and the involvement of family and others are often disregarded, particularly during times of psychiatric crisis.</p> <p>Court-appointed medical guardians may approve (solely) of any medically necessary and recommended health care procedures for their wards, excepting inpatient psychiatric care not desired by a ward. This forces courts to become involved in commitment proceedings, and contributes to the significant phenomenon of persons with severe and persistent mental illness not receiving treatment.</p> <p>Person- and family-centered planning are not conducted well, nor do they follow the person throughout treatment.</p>	<p>A. Adopt legislation to sanction the preeminence of consumers and their families in the development and maintenance of their treatment experience. Such legislation could include (1) promoting and governing use of advance psychiatric directives (APD) for adults, overseen by the state rights office; (2) allowing medical guardians to approve of inpatient psychiatric care; or (3) requiring that family-centered planning be used with adult recipients who desire and request the involvement of willing family members</p> <p>B. Service providers regulated by the MH code must formally offer and strongly encourage the establishment of such directives for those who don't have one in place.</p> <p>C. Increased mandatory training for service managers and providers regarding person- and family-centered planning.</p> <p>D. Requirement that family-centered planning be utilized not just with minors, but for adult recipients who desire and request the involvement of willing family member participants.</p> <p>E. Required documentation in case record of staff name(s) responsible for informing any new providers of a client's existing person- or family-centered plan.</p>	<p>A. Consumer preferences and desires for responses to psychiatric crises and other future circumstances are documented in advance and can be honored.</p> <p>B. Family access to a deceased consumer's records is enhanced without eliminating the consumer's opportunity while still living to proscribe against that.</p> <p>C. Some court time is freed up.</p> <p>D. Mental illness will be further recognized as a physical illness.</p> <p>E. There will be a lesser need for policymakers to explore approaches as controversial and divisive as the currently proposed "Kevin's Law" for assisted outpatient treatment.</p> <p>F. Person- and family-centered plans are better established and implemented; family members of adult recipients are better engaged in situations where both the consumer and family desire such engagement; and existing plans are more likely to follow consumers and families to new service providers.</p>	<p>Legislature</p>	<p>Immediate</p>

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
<p>12. Despite attempts to address the issue, there remain many longstanding systemic barriers to appropriate treatment and support for people with co-occurring disorders, including “separate administrative structures, funding mechanisms . . . and eligibility criteria,” as well as “inadequate resources for both mental health services and substance abuse treatment.”³</p>	<p>a. Combine mental health and substance abuse rights protections under the “one-stop shopping” structure.</p> <p>b. Support legislation that requires all insurers to offer coverage for the treatment of mental illnesses and addiction disorders that is equivalent to the coverage for all other disorders. (See Key Issue #2)</p> <p>c. Work with the medical schools, MEDC, and the state’s mental health- and substance abuse-related foundations to coordinate research, development, and outreach efforts.</p>	<p>Barriers to the diagnosis and treatment of co-occurring disorders will be minimized.</p>	<p>Executive branch, legislature, a state mental health advocacy organization, the independent organization in Key Issue #1, or any combination thereof</p>	<p>Immediate action toward short-term implementation.</p>
<p>13. SECONDARY ISSUE: Some service recipients are subjected to cruel, excessively harsh (and often counterproductive) procedures.</p>	<p>Continue to monitor the use of, need for and possible changes to seclusion, peer restraint, pharmaceutical restraint, and restraint with mechanical or physical equipment.</p> <p>(Refer to groups on children, adults, and criminal justice/human service interface, to examine practices in various mental health and other settings such as schools, nursing homes, and jails.)</p>			
<p>14. SECONDARY ISSUE: There should be assistance to those families where an elderly parent is taking care of an adult child with serious mental illness, to help them plan for the future of the consumer. (See also Key Issue 11 and Secondary</p>	<p>(Refer to group on adults)</p>			

³ Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, “Report To Congress On The Prevention And Treatment Of Co-Occurring Substance Abuse Disorders And Mental Disorders,” 2002.

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Issues 15 and 16.)				
15. SECONDARY ISSUE: Families are often forced to give up custody of a minor child in order to receive mental health treatment for that child.	(Refer to group on children)			
16. SECONDARY ISSUE: Persons with mental illness may lose custody of minor children when seeking treatment. (See also Key Issue #11, on consumer preferences for treatment and the involvement of family.)	(Refer to groups on adults and children)			
17. SECONDARY ISSUE: Confidentiality laws, particularly with the advent of HIPAA, are inconsistently applied by different providers. (See also Key Issue #9 on interpretation of, application of, and confusion surrounding such laws.)	While remaining compliant with federal requirements, state confidentiality laws are analyzed and revised as necessary to provide a better balance for the maintenance of important consumer privacy protections and the liability concerns of providers. (Refer to group on governance & structure.)			
18. SECONDARY ISSUE: With the closure of many public facilities and the lack of private sector facilities, there is no meaningful, cross-system infrastructure for providing quality mental health care treatment in Michigan (e.g., residential inpatient treatment for minors).	(Refer to groups on adults and children, and to the group on governance and structure, which should include fiscal and health projections on need.)			

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19. SECONDARY ISSUE: Need for involuntary commitment in cases of substance abuse (as is done in Florida), which is defined as a psychiatric disorder in DSM-IV.	(Refer to groups on children, adults, and criminal justice/human interface)			
20. SECONDARY ISSUE: There is no mechanism for reaching out to assist those with mental illness who are not receiving treatment (see Key Issue #4).	(Refer to group on criminal justice/human interface.)			
21. SECONDARY ISSUE: Barriers to appropriate treatment and support for people with co-occurring disorders (see Key Issue #12).	(Refer to groups on children, adults, and governance/structure.)			

WORK GROUP II: SERVICES AND SUPPORTS FOR CHILDREN AND FAMILIES

Chair: Joan Jackson-Johnson

Preliminary Report

Key Issue A

The children’s mental health system is significantly underfunded. Consequently, children (aged 0–18) with emotional and mental health issues are underserved due to the level and structure of funding for mental health services. (Ranking: 19 high, 7 moderate, 1 low)

Efforts to contain cost result in state and local policies and procedures that encourage inappropriate cost- and service-shifting among systems, including, but not limited to, mental health, juvenile justice, child welfare, substance abuse, and education.

The needs of many children with emotional and mental health issues are not being met, nor are we acting upon the increasing knowledge of the mental health field to identify the early antecedents of mental illness. The level and structure of the funding of mental health services is the most significant factor limiting the promotion of mental health in children, screening and assessment, and provision of services and supports.

Children who do not meet income or severity criteria for Medicaid have reduced access to the public mental health system. For those children who are covered by Medicaid, current funding levels are inadequate to meet their mental health needs. There is also uneven geographic access to services for children due to variations in funding among community mental health service programs.

Question: **Would the work group provide further explanation of what is meant by “inappropriate handoffs?”**

Answer: **Inappropriate cost- and service-shifting**

Question: **Would the work group consider the issue of accurate screening and diagnosis to set the stage for the issue regarding the lack of a continuum of services?**

Answer: **Yes. This would be the basis for data for key issues B and C.**

Supporting information for the above statements comes from the Bazelon Center’s “Making Sense of Medicaid for Children with Serious Emotional Disturbance.”

Proposed Option	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
1. Maximize use of Medicaid funding by identifying all bona fide sources for matching and identifying and removing legal and other barriers to Medicaid waivers.	Increased availability of funds to support children’s mental health services	MDCH, FIA, local courts, counties, ISDs, federal government	FY 05

Proposed Option	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
2. Pilot the creation of joint purchasing and alignment of mental health services among local CMHSPs, family courts, and local FIA offices that results in the development of a common provider network in three counties	Improved collaboration with opportunities for blended/braided funding	MDCH, CMHSPs, family courts, FIA, schools, ISDs	1 year
3. Increase the amount of state general fund dollars appropriated for mental health so that CMHSPs can serve children who need services but do not meet current income or severity criteria.	Increased availability of funds to support children's mental health services	MDCH, FIA, JJ, CMHSPs	Lobby the legislature for increased GF for mental health services in FY05
4. Eliminate disparities in allocation of funding (Medicaid and general fund) among and within CMHSPs to provide and fund a comparable array of services in each region.	Creates equal access to services throughout the state.	MDCH and the legislature	FY 05
5. Support mental health parity legislation.	Mental health parity increases access to services for many individuals who currently have trouble affording mental health services.	MDCH, FIA, JJ, CMHSPs	Lobby the legislature in 2005
6. Establish a single entity responsible for assessing and forecasting mental health treatment needs for Michigan children and families across departments and publicly funded programs. This would assist the state of Michigan in developing a target for adequate funding for children's services and a plan for reaching this target.	Flexible and fiscally responsive mechanism for ongoing accountability, targeted funding more closely aligned with changing demographics, age/stage and regional needs	Independent research entity	6 months to establish the group. Feasibility analysis and administrative strategic plan—6 months; data partnership and first run and analysis—6 to 9 months; full operation and first annual review/ dissemination—18 months

Key Issue B

Michigan lacks a comprehensive system of care for children’s mental health services: Stroul and Friedman define a system of care as “a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families.” (Ranking: 19 high, 7 moderate, 1 low)

There are many barriers to accessing children’s mental health services that must be eliminated in order to close the gap between the number of children who receive services and the number of children in need of services.

- The current service system lacks a uniform strategy for screening and early intervention.
- The current mental health system operates to limit access to services by virtue of its fragmentation.
- Many professionals who work with children lack the necessary knowledge and tools to screen and refer children for mental health services.
- Current mental illness diagnoses for children are inadequate contributing to an inability to plan well for their service needs.
- Families are not consistently involved in planning the system of care for children.
- Limited capacity exists to treat and follow up with children who have been determined to need services.
- Services provided are often inappropriate to the needs of the child and family.
- Families become caught between systems when involved with mental health as well as child welfare, juvenile justice, education, or substance abuse. Fragmented funding can make it difficult or impossible to coordinate services and funding to address dual or multiple needs.
- Serious gaps exist in the current array of available services; for instance, prevention and early intervention, respite and crisis care, and residential treatment. Outpatient treatment restrictions force many children into higher levels of care than are necessary.

Creating a system of care involves the organization of public and private service components within the community into a comprehensive and interconnected network in order to accomplish better outcomes for children and families. It involves joint planning and shared funding to accomplish such interconnections as proactive screening, smoothly functioning access to assessment and appropriate service, coordinated service planning across systems, and shared information.

Comment: Consider adding the barrier of inadequate diagnosis of disorders in children, noting that better diagnosis of children is needed before we determine what kind of services they need.

See barriers above and the issue is addressed in the proposed options.

Supporting information for the above statements comes from the Bazelon Center’s “Relinquishing Custody: The Tragic Result of Failure to Meet Children’s Mental Health Needs”; the National Health Policy Forum’s “Children with Mental Disorders: Making Sense of Their Needs and the Systems That Help Them”; Many Youths Reported Held Awaiting Mental Help” from the July 8 *New York Times*; and NAMI’s “Stop Putting Sick Kids in Jail.”

Proposed Option	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
7. Establish and fund a system of care (see attached "Components of the System of Care") and make available a comprehensive array of services at a distance within 60 minutes (one way) of every Michigan citizen.	Greater level of service availability statewide	MDCH	2–5 years
8. Select and implement a specific mental health screening instrument for EPSDT. Screen and refer for assessment at school entry, middle and high school transitions, first suspensions, removal from home by FIA, first court appearance. Coordinate with EPSDT.	This may require a policy analysis and review of EPSDT mandate, developing program integration, rollout, and cost.	MDCH, MCCAP, Michigan AAP	Analysis and planning—one year; roll out—1 year; evaluation and reporting—6 months
9. Explore more appropriate diagnostic tools such as the Zero to Three Diagnostic Classification tool for young children.	Children will be more appropriately diagnosed and the ability to plan for services will be improved.	MDCH, CMHSPs	Immediately
10. Develop a comprehensive coordinated system of care for children aged 0–5 incorporating all state funded services. See attached "Components of Education, Prevention, and Early Intervention."	Aggregate data for study of effectiveness, elimination of program redundancies.	MDCH, Infant mental health, Early On, FIA, Head Start, ISDs, EPSDT	1 year
11. Provide easy, consumer-friendly, timely access to public mental health services at multiple entry points (no wrong door). Establish and monitor a reporting system to track those who attempt to receive services but are denied treatment.	Access to mental health services will be greatly improved.	MDCH, FIA, juvenile justice, CMHSPs	6 months to 1 year

Proposed Option	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
12. Create an education campaign to inform stakeholders of the existence of information and disseminate information through state offices, professional associations, universities, and all organizations that have contact with child- and family-serving professionals.	Greater availability of information necessary to address the mental health needs of children and families	??	1 to 2 years
13. Increase the number of child and adolescent psychiatrists, social workers, psychologists and infant mental health specialists across the state by providing incentive programs to locate in Michigan, provide services to clients of the public system, and receive training and continuing education programs. Support the AACAP and APA at state/national levels on workforce issues.	Increased child and adolescent psychiatry access across the state. Retain quality practitioner participation in public sector mental health. Increase early detection and intervention.	MDCH, universities, professional organizations	Immediately upon identifying appropriate incentive programs
14. Review alternatives to the 20 outpatient visit benefit within the MHPs and promote Medical Health Plans contracting with CMHSPs or consolidate the outpatient benefit within CMHSPs to provide appropriate services for mildly and moderately emotionally disturbed Medicaid children. The capitation amount per child should be increased.	Improved/expanded services for children with mental health issues.	MDCH	Immediately

Proposed Option	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
15. Implement an interagency process to review prior interventions for appropriateness and effectiveness before considering out-of-home placement or change in placement.	Ensures that juvenile justice children get appropriate services		
16. Explore court funding for treatment if a child referred to a CMHSP does not meet mental health criteria for services.		State court administrative office, county commissioners, family division circuit court	??
17. Establish and disseminate fiscal and administrative policy and guidelines that provide for blended funding, screening, assessment, access, services, and sharing of information.	Coordinated service system with improved access to appropriate services for children and families	MDCH, FIA, substance abuse, courts	1 to 2 years
18. Address issues of confidentiality in ways that respect a family's right to privacy but encourage coordination among providers in different systems.	Coordinated service system with improved access to appropriate services for children and families	MDCH, FIA, substance abuse, courts	1 to 2 years
19. Strengthen the resource capacity of schools to serve as a key link to a comprehensive, seamless system of school- and community-based identification, assessment, and treatment services.	SED will be recognized by teachers and appropriate referrals made.	MDCH, ISDs	Begin in 6 months to 1 year and expand over time statewide
20. Mandate in-service training for teachers throughout Michigan to help them recognize mental health issues and provide them with the information they need to make the necessary referrals for care.	SED will be recognized by teachers and appropriate referrals made.	MDCH, ISDs	Begin in 6 months to 1 year and expand over time statewide

Key Issue C

Children and families receiving public mental health services encounter inconsistent use of standards of care and best practices. (Ranking: 14 high, 13 moderate)

There is variation across the state in the use of best practices by agencies (MH, FIA, schools, juvenile justice) providing mental health services to children and families. Barriers to addressing the variation in the consistent use of best practices include:

- Limited capacity to identify, disseminate, and apply increasing knowledge about the nature of emotional disorders in children to public and private screening, diagnostic, and treatment efforts, e.g., inadequate training programs to standardize care and assure the use of evidence-based practices
- Lack of consistent standards of care for children’s mental health services, e.g., lack of a clear definition of “family centered practice,” which makes it difficult to require all public and private providers to include the child and family in all decisions about their care
- Insufficient efforts to offer culturally competent services that assure individualized care with regard to race, ethnicity, disability, gender, sexual orientation, socio-economic status, geography, and the culture of families of children with serious emotional disorders
- Lack of strong connections between the mental health system and entities that could support the use of best practices, e.g., higher education
- Little public recognition of the connection between symptoms in childhood and adult mental illness

Question: What data supports the issue statements?

Answer: Information supporting the above statements can be found in the Surgeon General's report on Children’s Mental Health.

Proposed Option	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
21. Specify use of evidence-based best practices, when available, in contracts (cf. Dr. Robert Friedman and Dr. Kay Hodges) and experiential based practices already proven and implemented in Michigan (e.g., Intensive home-based services and wraparound services). Require adherence to values and principles of system of care (Stroul and Friedman, 1994).	Increased use of evidence- and experiential-based practices	MDCH	Immediately

Proposed Option	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
<p>22. Convene a representative work group to explore use of evidence based and experiential based best practices for children involved in child welfare and juvenile justice leading to requiring feedback evaluation of experiential-based best practices as the first step in evaluating the impact of promising policies and programs.</p>	<p>Collaborative effort at policy and practice levels Documentation of expected statewide standard of care for children and adolescents with mental health needs</p>	<p>MDCH, FIA, with representation from courts, CMHSPs, professional organizations, and local child and family serving agencies</p>	<p>6 months to complete document.; 1 year from documentation to implementation</p>
<p>23. Enhance graduate training within colleges and universities regarding best practice methods for children and families.</p>	<p>Consistent practice standards will be disseminated throughout the state through a variety of outlets</p>	<p>MDCH, FIA, universities, colleges, department administrators, professional associations</p>	<p>Begin immediately and integrate into the system over time</p>
<p>24. Assess current training options and determine the need for implementing a training institute for the state to provide training on best practices to a broad audience, including but not limited, to staff of CMHSPs, FIA, and private child- and family-serving agencies. Link training institutions to be sure that information provided is consistent.</p>		<p>MDCH, FIA, universities, colleges, department administrators, professional associations</p>	<p>Begin immediately and integrate into the system over time</p>

Proposed Option	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
25. Develop a clear consensus-based definition of, and guidelines for, "family-centered practice," outlining implications and action items and revise MDCH policies on person-centered planning to specify <i>family-centered</i> practice when children are the identified consumer so that the child and family are included in any/all decisions about their care Include children in treatment planning by offering them direct information in developmentally appropriate ways about service options.	Clarity of mission and all groups working with children and families will be using same language and participating in development of policies/procedures	MDCH, CMHSPs	Immediately
26. Specify in MDCH contracts that representatives of families of children receiving services be included in governance bodies.	Involving families in system governance will assure increased use of family centered practice	MDCH	Immediately
27. Use family advocates, such as family members with prior experience, to assist families in interacting effectively with complicated service systems.	Family advocates will lessen the confusion of new families entering the system.	MDCH, CMHSPs	Immediately
28. Develop and require implementation of a formal mechanism to utilize service recipient and family feedback in an ongoing quality assurance process.	Assures family/child input into system development	MDCH, CMHSPs	1 year
29. Increase efforts to recruit and train minority providers.	Enables culturally competent care with regard to race	MDCH, CMHSPs, public and private agencies providing mental health services, universities, other training institutions	Immediately

Proposed Option	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
30. Review recipient rights policies for sensitivity to cultural competence issues.	Assures culturally competent care	MDCH	Immediately
31. Licensing agencies and state agencies should require documentation of: policies/procedures, training, quality improvement, grievance process for individuals who have not had their rights respected.	All child/family serving agencies will follow the law	Governor's office through state agencies	3 months to inform applicable agencies and establish working plan for review with implementation to follow
32. Adopt common community and individual indicators as measures of outcome.	Common measures provide direction for improving services.	MDCH, FIA, substance abuse, courts, education	1 year

COMPONENTS OF THE SYSTEM OF CARE

Mental Health Services

Prevention services
Early identification and intervention
Infant mental health services, including
infant-parent assessment and
intervention
Comprehensive assessment of care and
treatment needs
Medication assessment, review and
management
Outpatient services
Home-based services
Day treatment
Emergency services
Therapeutic foster care
Therapeutic group care
Therapeutic camp services
Independent living services
Residential treatment
Crisis residential services
Acute care hospital inpatient treatment

Social Services

Protective services
Financial assistance
Home aid services
Respite care
Shelter services
Adoption services

Educational Services

Assessment and planning
Resource rooms
Self-contained special education
Special schools
Home-bound instruction
Residential schools
Alternative Programs

Health Services

Health education and prevention services
Screening and assessment services
Primary care
Acute care
Long-term care

Substance Abuse Services

Prevention
Early intervention
Assessment
Outpatient services
Day treatment
Ambulatory detoxification
Relapse prevention
Residential detoxification
Community residential treatment and
recovery services
Inpatient hospitalization

Vocational Services

Career education
Vocational assessment
Job survival skills training
Work experience
Job finding, placement, and retention
services
Supported employment

Recreational Services

After-school programs
Special recreational projects

Operational Services

Wraparound services (including systems
and services coordination mechanisms
for multiple needs children and
adolescents)
Transition services for older adolescents
and young adults
Case management
Juvenile justice services
Family support and self-help groups
Advocacy
Transportation
Legal services
Volunteer services

COMPONENTS OF EDUCATION, PREVENTION, AND EARLY INTERVENTION

- Infant mental health services with an emphasis on enrollment during pregnancy or first months of infancy
- Parent education
- Social emotional component within child care and schools
- School curriculum (Michigan Model)
- Proactive intervention in child care (MH services in Head Start); schools (bullying and other violence prevention); and CMHSPs (integrated services making children part of the service plan)
- Mental health services through school health clinics

WORK GROUP III: SERVICES AND SUPPORTS FOR ADULTS

Chair: Michelle Reid, MD

Preliminary Report

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
ARRAY OF SERVICES				
1. MDCH will assure an array and continuum of acute, intermediate and long-term services that are standardized statewide in quantity and quality with a goal of recovery (to be defined). These services will be determined by an appointed, on-going committee representing all stakeholders. It will provide continuous assessment and accountability for services based on both process and outcomes.	Governor will appoint a Mental Health Committee to address the services to be delivered and provide the oversight for quality.	Mental Health services will be provided with geographic and population equity across the state. There will be accountability for the delivery and outcomes of services.	MDCH and Mental Health Committee	Short-term: 1 year Long-term: continuous
2. There will be a quality component for all services. This will include clinical accountability, peer review, an appeals process, and customer satisfaction. The overarching goal is uniform access to a core set of high-quality services.	A. MDCH and the Mental Health Committee will develop the standards and methods to attain a quality improvement plan for the state. B. Communities will implement and provide input for ongoing improvement through the Mental Health Committee.	There will be continuous quality improvement for mental health services to citizens in Michigan.	MDCH, Mental Health Committee and CMH entities	Short-term: 1-2 years Long-term: continuous

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
EQUITABLE				
3. Services must be equitable. The public needs to be informed of mental health benefits and eligibility and "safety net" services.	Develop a communication plan and tools that clearly describe the benefits and resources available.	Community partners will be aware of services and work more effectively and collaboratively on behalf of the client. May increase access to services. Public will be better informed and more supportive of needs in the community.	MDCH with input from local entities	Short-term: 6–8 months
PATIENT SAFETY				
4. Treatment, community and residential services must be provided safely.	Guidelines for medication for specific diagnosis must be developed, selected, implemented, and monitored. Information and education must be provided on a statewide basis for all providers and caregivers.	Consistent and safe treatment and living conditions; decreased variations in care and services	State, CMH, Pharmacy Board, Flinn Steering Group, DUR	Short-term (process): 1 year and Long-term (statewide implementation): 5 years
PERSON-CENTERED CARE				
5. Person -centered care must be the hallmark guiding treatment, services, and supports in the system	A. Increase availability of a safe, supported housing and treatment continuum for adults and older adults. B. Adopt a "recovery vision" as the overriding vision for system planning, services, and support.	Improved quality of life for clients, decreased hospitalizations, increased access to care, and more equitable distribution of resources	MDCH/CMH (policies, practices and education of providers)	Long-term 3-5 years

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
CONTINUITY				
6. Continuity of care: Integration and continuity of primary care services, mental health and substance abuse services.	Use information technology systems with widespread secure access to gain integration of services and continuity of care.	Reduce redundancy, reduce relapse, reduce cost, increase quality of life, achieve appropriate treatment and services, and improve patient safety.	MDCH/CMH	Long-term: 3–5 years
EQUITABLE & CONTINUUM OF CARE				
7. *Continuum of safe and affordable housing options that support the recovery model must be available.	<p>A. Design housing policy to move people to higher-level housing independence, as they are capable.</p> <p>B. Create incentives for group homes to participate in new housing policies.</p> <p>C. Create monitoring and oversight of the complete housing continuum (including unlicensed housing).</p> <p>This new design for monitoring must be carried out in collaboration with other state and local agencies.</p>	Improved health and safety for individuals with mental illness	MDCH, FIA, CMH, legislature	Long term: 3–5 years

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
CONTINUUM OF CARE				
8. *A continuous support for the continuum of services must be in place at the state and local levels.	A. Review admission criteria for entry for the most severe levels of care. B. Assure adequate number of facilities and their locations.	Improved outcomes of care for the individual	MDCH, CMH	Proposed for Action A: Short-term: 6 months Proposed for Action B: Long-term: 3–5 years
9. *Supportive employment and supportive education must be components of the recovery model.	A. Same issues as continuity of care and continuous supports above. B. Criteria for participation in these programs must be reviewed and revised. Staff in these agencies and programs must receive education about the unique needs of the MH population.	A. Better coordination with other funded groups (vocational, education); education about issues of quality and stigma, in particular B. Emergence of a seamless system of services	MDCH, CMH, State and local vocational and education agencies	Long-term 3-5 years for statewide impact
PREVENTION				
10. *Prevention A. Integration of MH treatment with primary care for early detection and intervention B. Smooth transition for services from childhood and adulthood for both screening and treatment C. Prevention of relapse/re-hospitalization	A. Expand models currently used in the Federally Qualified Health Centers. B. Basic health care should be available at CMH sites where appropriate. C. Assure continuous communication between agencies and programs serving children and adult programs in the community.	Outreach for early identification and intervention for persons with mental illness (ex: schools, PSAs, primary care physicians) Columbia Model is one example.	MDCH, Medicaid, CMH, schools; qualified health plans, local public health	Short-term: 1–2 years

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
INFORMATION AND INFRASTRUCTURE				
11. A statewide infrastructure is needed to operationalize data and information related to mental health services, projects, best practices sharing, etc.	Design and implement a statewide, state-of-the-art information system that is coordinated across state and local agencies, transparent, accessible to all CMHs and ties together access to standards, services, education/training; a partnership through which to readily exchange data, information, ideas, best practices.	Information for increased quality, efficiency, improved access, and seamless service transfer	MDCH	Short-term: 6–9 months
EDUCATION AND TRAINING				
12. There is an overall lack of consistency in education and training statewide across providers, consumers, family members, and staff.	Develop a uniform infrastructure that is standardized using a Web-based curriculum for training and education on a statewide basis (but accessed at the local level, including work sites.	A. Improved quality of services; potential improved recruitment and retention of providers, staff. B. Increased support for family and caregivers.	MDCH, FIA, CMH	Short-term: 1–2 years
DEFINITIONS OF SERIOUS MENTAL ILLNESS				
13. A consistent, well-articulated definition of “serious mental illness” is needed, along with application of that definition in determining eligibility and services.	A definition will be developed that addresses the idea that there is “no wrong door” for any adult with mental illness. There will be uniform access to PMH services for adults with mental illness on a statewide basis.	Uniform access to services	MDCH with advice from governor-appointed committee	Short-term: 3–6 months

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
SERVICES FOR OLDER ADULTS				
<p>14. Services for older adults</p> <p>A. There are unique treatment implications for older adults with mental illness related to their treatment and relationship to the incidence of multiple chronic diseases and their simultaneous treatment.</p> <p>B. Older adults reside in various facilities in the community that impact their eligibility for mental health services.</p> <p>C. There is a lack of providers appropriately trained, as well as in supply, for mentally ill older adults (long-term care/nursing home, geropsych prepared providers; special needs related to depression and dementia are not addressed.</p> <p>D. Older adults in nursing homes have difficulty accessing mental health services.</p>	<p>A state plan will be developed to assess and address the needed workforce for the mentally ill older adult regardless of residence in the community; areas of assessment will include workforce development, payment standards, scope of practice, enhancement of the primary care and advanced practice nurse workforce.</p>	<p>Increased number and distribution of appropriate providers and improved access to care and services for older adults in MI</p>	<p>MDCH</p>	<p>Short-term: 6–12 months</p>

WORK GROUP IV: CRIMINAL JUSTICE AND HUMAN SERVICES INTERFACE

Chair: Nick Ciaramitaro

Preliminary Report

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
Area One: Pre-Entry (Prevention and Early Intervention)			
<p>1. We do not adequately assess or utilize early risk factors or symptoms of mental illness, or protective factors (strengths) in order to address problems before they become more serious. Access to those who are not seriously mentally ill is limited, because private sector mental health is prohibited from interacting optimally with public sector mental health.</p> <p>(Access to Medicaid type 10 and type 11 providers (and/or QHP provider panel) is limited due to availability; services are limited to persons with the most severe levels of disability); private practitioners are contacted with requests to provide services, but are not</p>	<p>1. Line item funding, with maintenance of effort, to provide for primary prevention and early intervention; in order to impact, through diversion, upon the juvenile and criminal justice systems.</p>	<p>1. Legislature; Governor's Office</p>	<p>1. Immediate</p>
	<p>2. Identify appropriate screening and assessment tools and processes, and identify at-risk individuals.</p>	<p>2. DCH; New Best Practices Entity</p>	<p>2. Short -term</p>
	<p>3. Ensure training for first responders in recognizing risk factors, and in the use of the screening and assessment tools and processes.</p>	<p>3. Legislature; DCH/CMH/MHP; FIA; MSP; MSA; Medical Control Authority; MFFTC; MCOLES; ISD</p>	<p>3. Short -term</p>
	<p>4. Provide appropriate services in accordance with Evidenced-Based Practices (EBP).</p>	<p>4. DCH/CMH/MH; Private Providers; Public School System</p>	<p>4. Short-term</p>

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
on the provider panel or cannot be reimbursed for services provided.)	5. DCH should expand the definition of Rule 10 & 11 providers.	5. DCH/MSA	5. Immediate
Area Two: Pre-Entry (Diversion)			
2. There are too many children in the juvenile justice system who ought to be served and supported in the mental health system.	1. There needs to be a full array of services available and accessible 24/7, including publicly run secure facilities other than jail and those operated by the juvenile justice system, in order to prevent use of the juvenile justice system as 'provider of last resort'.	1. Legislature; DOC/OCC; FIA; DCH/CMH/MHP/ODCP/SA; Schools; Private Health Plans	1. Short-term
	2. Require real and measurable pre- and post-booking diversion programs, and identify potential decision points for diversion, that can be based on the screening and assessment; including statewide expansion of the availability of mental health courts.	2. Legislature; DCH/CMH/SA; DOC/OCC; MSA; Local Law Enforcement; Counties and Courts	2. Immediate
	3. Ensure joint training efforts between CMH and other appropriate parties (first responders, service providers, law enforcement, defense attorneys, prosecutors, judiciary, and corrections and probation) for implementing established and required pre- and post-booking diversion programs throughout the state.	3. DCH/SA; Counties; Representatives of the Listed Parties.	3. Immediate
	4. Establish a formal mechanism for the evaluation and monitoring of diversion programs, and for enforcing program sanctions where expectations are not met.	4. Legislature; DCH/SA	4. Short-term
	5. Eligible governmental units should be more aggressive, and work collaboratively, in seeking funding grants for diversion programs.	5. Governmental Units	5. Immediate

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
	6. Direct DCH to modify administrative rules and Medicaid agreements to re-evaluate their policy on seclusion and restraint, in order to allow children with mental health needs to be served in Child Caring Institutions (CCI), with appropriate safeguards; and to provide additional resources for training, monitoring and services.	6. Legislature; DCH/SA; CMS; Congressional Delegation	6. Short-term
3. There are too many adults in the jail and prison system who ought to be served and supported in the mental health system.	1. There needs to be a full array of services available and accessible 24/7, including publicly run secure facilities other than jail and those operated by the criminal justice system, in order to prevent use of the criminal justice system as 'provider of last resort'.	1. Legislature; DOC/OCC; FIA; DCH/CMH/MHP/ODCP/SA; Schools; Private Health Plans; Sheriffs; Counties	3. Short-term
	2. Support continued efforts by the MDOC in reforming its Mentally Ill and Developmentally Disabled offender policies, and the its collaborative efforts with DCH. Examine the impact of, and responses to, the high number of offenders who are detained/sentenced in local jails and sentenced to prison who are Mentally Ill or Developmentally Disabled; focusing on more effective assessment and service delivery (<i>MDOC Five Year Plan to Control Prison Growth</i>).	2. DCH; DOC	2. Immediate
	3. Require real and measurable pre- and post-booking diversion programs, and identify potential decision points for diversion, that can be based on the screening and assessment; including statewide expansion of the availability of mental health courts.	3. Legislature; DCH/CMH/SA; DOC/OCC; MSA; Local Law Enforcement; Courts; Sheriffs; Counties	3. Immediate

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
	4. Ensure joint training efforts between CMH and other appropriate parties (first responders, service providers, law enforcement, defense attorneys, prosecutors, judiciary, and corrections and probation) for implementing established and required pre- and post-booking diversion programs throughout the state.	4. DCH/SA; DOC/OCC; Counties; Representatives of the Listed Parties; Sheriffs; Counties	4. Immediate
	5. Establish a formal mechanism for the evaluation and monitoring of diversion programs, and for enforcing program sanctions where expectations are not met.	5. Legislature; DCH/SA; DOC/OCC; Sheriffs; Counties	5. Short-term
	6. Eligible governmental units should be more aggressive, and work collaboratively, in seeking funding grants for diversion programs.	6. Governmental Units; DOC/OCC; Sheriffs; Counties	6. Immediate
Area Three: During Detention or Incarceration (Pre- and Post-Adjudication)			
4. There are problems with timely and accurate clinical screening and assessment (and therefore, treatment) within the jails, prisons, and juvenile detention facilities. A. Adults B. Children	<u>Adults:</u> A1. Develop best practices for screening and assessment of adults at entry into incarceration, in collaboration with agencies such as the: National Institute of Corrections (NIC); American Corrections Association (ACA); Department of Community Health (DCH); Community Mental Health (CMH); and, the American Psychological and Psychiatric Associations (APA). A2. Implement screening at booking, and assessment, based on the best practice models. A3. Formalize legal responsibility placed on CMH (Section 207) and jails, for citizens who are placed in jails.	A1. DCH/CMH; New Best Practices Entity A2. DCH/CMH/SA; DOC/OCC; Jails A3. Legislature	A1. Short-term A2. Short-term A3. Immediate

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
	A4. Develop a state monitoring mechanism to assure timeliness.	A4. DCH; DOC; Counties; Sheriffs; Jails	A4. Short-term
	<u>Children:</u> B1. Develop best practices for screening and assessment of juveniles at entry into incarceration, in collaboration with agencies such as the: Council on Accreditation (COA); Family Independence Agency (FIA); Commission on Accreditation of Rehabilitation Facilities (CARF); National Center for Mental Health and Juvenile Justice; Public School Systems; and, American Academy of Child and Adolescent Psychiatry.	B1. DCH/CMH; FIA; New Best Practices Entity	B1. Short Term
	B2. Implement early screening and assessment of children when they first come into contact with the juvenile system, based on the best practice models, and by mental health providers in both the public and private sectors.	B2. DCH/CMH; FIA; Counties; Courts	B2. Short-term
	B3. Develop a state monitoring mechanism to assure timeliness.	B3. DCH; FIA; Counties; Courts	B3. Short-term
7. There are problems with the adequacy and appropriateness of treatment for many incarcerated adults & children.	<u>Adults:</u> A1. Develop best practices for treatment to be used in jails and prisons in collaboration with agencies such as the: National Institute of Corrections (NIC); American Corrections Association (ACA); Department of Community Health (DCH); and, Community Mental Health (CMH).	A1. DCH; DOC; New Best Practices Entity	A1. Immediate

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
A. Adults	A2. Provide a full array of evidence-based treatment services, including alternative secure residential treatment, for prisoners in jails and prisons.	A2. Legislature; DCH/CMH/SA; DOC/OCC: Sheriffs and Counties	A2. Short-term
B. Children	<u>Children:</u> B1. Develop best practices for mental health treatment of adolescents in juvenile detention and elsewhere in the juvenile system (e.g., day treatment programs) in collaboration with agencies such as the: Council on Accreditation (COA); Family Independence Agency (FIA); Commission on Accreditation of Rehabilitation Facilities (CARF); National Center for Mental Health and Juvenile Justice; American Academy of Child and Adolescent Psychiatry; and, (1 more from Anne Burns).	B1. DCH; FIA; New Best Practices Entity	B1. Immediate
	B2. Provide a full array of evidence-based treatment services, including alternative secure residential treatment, for children with emotional disorders in juvenile detention facilities and other juvenile treatment programs like day treatment centers.	B2. Legislature; FIA; DCH/CMH; Private Childcare Agencies; Courts	B2. Short-term
Area Four: In Preparation for and Upon Release from Detention or Incarceration			
6. There isn't a unified system of coordinated and collaborative support to ensure a smooth transition for individuals from detention or incarceration to community-based treatment and care.	1. Establish a pre-release planning process that begins at reception in prison or jail, and at intake at juvenile facilities, which creates an offender-specific plan that addresses an offenders' strengths, needs and risks (a prison Transition Accountability Plan (TAP); a jail Community Reintegration Planning (CRP); and, a community reintegration plan for juvenile offenders). Plans should include not just mental health, but other related needs (vocational, educational, etc.).	1. DCH/CMH/SA; DOE; DOC/OCC/TPIC; FIA; MRS; MSHDA; Jails; Private Child Caring Agencies; Courts	1. Short-term

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
	2. Collaborate with the National Institute of Corrections (NIC) and the National Governor's Association (NGA) to reduce recidivism by focusing on three areas (<i>MDOC Transition from Prison to Community Initiative (TPCI)/ Michigan Prisoner Re-Entry Initiative</i>): <ul style="list-style-type: none"> A. Inmate preparation for release thru risk/need reduction; B. Improved parole plans thru collaborative efforts with other state agencies for housing, welfare, education, employment, health and improved parole guidelines; and C. Parole supervision to include more emphasis on relapse prevention. 	2. Governor's Office; DCH; DCH. FIA, DLEG	2. Immediate
	3. Improve training for supervising agents on what to expect from mental health clients, similar to that which is necessary for first responders, service providers, law enforcement officers and others.	3. DCH; DCH. FIA, DLEG	3. Short-term
Area Five: Contributing Factors / Other			
7. The statutory and administrative framework is insufficient to actually yield/achieve real juvenile justice and criminal justice diversion.	1. Make the statutory and administrative changes necessary to comply with the recommendations outlined under Key Issues 1-6 across the effected systems.	1. Legislature	1. Short-term
	2. Identify revenues streams to follow.	2. Legislature; Governor's Office	2. Short-term

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
	3. Develop disincentives for arrest and prosecution, as appropriate, and incentives to move people from the criminal justice system into the service system.	3. DCH/CMH/SA; DOC/OCC; FIA; Counties	3. Short-term
	4. Add 'Diversion from juvenile justice system' to Section 207 of the Michigan mental Health Code.	4. Legislature; Governor's Office	4. Short-term
8. There is an inefficient use of taxpayer dollars as we over utilize an expensive criminal justice system, instead of providing more appropriate and cost-effective mental health assistance/services.	1. Quantify the 'cost v. savings' of diversion as a way to have the resources to implement it: "What we do or don't do" vs. "What if we did it right?" (The cost for jail/prison inmates vs. what we could have done with the same dollars if they had been appropriately diverted?)	1. DCH/CMH/SA; DOC/OCC; DMB; Counties	1. Short-term
	2. Compare the current costs of 'What is', to those of 'That which is desirable' to show savings; include community costs, such as 'lost' costs' if someone one is incarcerated instead of out working, etc.	2. DMB; U of M (or similar) Economic Forecasting Vendor; MI Dept. Treasury	2. Short-term
9. A number of people in the community do not recognize that their own mental illness may result in behaviors which may lead them into the criminal justice system.	1. Ensure an educational-approach model, including education within and of the justice system and law enforcement (first responders, service providers, law enforcement, defense attorneys, prosecutors, judiciary, and corrections and probation).	1. New Best Practices Entity; Representatives of the Listed Parties	1. Immediate
	2. Family, provider and community education.	2. DCH; DOE; Advocacy Groups	2. Immediate

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
<p>10. There is a serious disconnect (lack of integrated treatment) between the dual diagnoses of substance abuse and mental illness (MISA). The access and entry systems of each are not integrated.</p>	<p>1. Identify administrative solutions and opportunities for integrated screening, assessment and treatment.</p>	<p>1. DCH/CMH/SA; DOC; FIA</p>	<p>1. Immediate</p>
	<p>2. Ensure cross training among first providers (cross agency), to identify and direct them to and through the integrated system.</p>	<p>2. Legislature; DCH/CMH/MHP; FIA; DOC; Medical Control Authority; MFFTC; MCOLES; ISDs</p>	<p>2. Immediate</p>
	<p>3. Require that mental health and drug courts be established in a manner so as to address co-occurring disorders, regardless of which 'front door' the person enters; and expand these courts throughout the state.</p>	<p>3. Legislature; DCH/CMH/SA; SCAO; Prosecutors; Law Enforcement</p>	<p>3. Immediate</p>
	<p>4. Develop an array of housing options specifically for persons with mental illness, substance abuse and co-occurring disorders who are being diverted or reintegrated (two separate populations) into the community.</p>	<p>4. Legislature; DCH/CMH; DOC/OCC; FIA; MSHDA/HUD</p>	<p>4. Short-term</p>
<p>11. Outside the criminal justice system, public policy provisions regarding involuntary treatment are not adequate to permit the mental health system to treat many seriously ill people. There is no clear and generally accepted understanding (or agreement) regarding:</p>	<p>1. Direct that all those involved in the involuntary commitment process be trained toward an accurate and consistent understanding and application of the current law.</p>	<p>1. SCAO; DCH/CMH; Law Enforcement; Prosecutors; Courts; MCOLES</p>	<p>1. Immediate</p>
	<p>2. Ask that the Legislature re-evaluate the law, with regard to inpatient and outpatient involuntary commitment.</p>	<p>2. Legislature; Governor's Office; DCH</p>	<p>2. Immediate</p>

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
<ol style="list-style-type: none"> 1. Who has the right to compel treatment; 2. Under what circumstances may treatment be compelled; or, 3. What types of treatment may be compelled? 	<ol style="list-style-type: none"> 3. Consideration shall be given for expanded authority by criminal courts to direct persons to mental health services, as an alternative to criminal penalty, based upon clinical assessment and with appropriate safeguards. 	<ol style="list-style-type: none"> 3. Legislature; Governor's Office; SCAO; DCH; DOC 	<ol style="list-style-type: none"> 3. Short-term
<ol style="list-style-type: none"> 12. There is no effective mechanism to translate established national 'Best Practices' into Michigan operations. 	<ol style="list-style-type: none"> 1. Create a new 'Best Practices Entity' (type to be determined) with the following elements for the identification, collection and dissemination of best practices: 	<ol style="list-style-type: none"> 1. Governor's Office; Legislature 	<ol style="list-style-type: none"> 1. Immediate
	<ol style="list-style-type: none"> A. <u>Information about Current Practice:</u> How are we providing various treatments within our system- to whom, for what, with what effect, etc.? An expert conference and clinician-administrator focus groups will be held to determine what elements of data need to be collected. Data collection instruments will be finalized, process of data entry and storage determined, the infrastructure to support the process developed, and the management structure to coordinate this process organized. 		

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
	<p>B. <u>Formulating and Updating Best-Practices</u>: What is the current evidence-based best practice for the treatment of adults with serious mental illnesses and children with serious emotional disturbances? How is this evidence base operationalized into a defined practice algorithm? How can defined best practices be translated into a disease management plan for each individual? Towards this end, national and international expert consensus panels and colloquia will be held, state and local guideline review panels organized, and national/international and state-level algorithm conferences conducted.</p>		
	<p>C. <u>Quality Assurance</u>: Is current practice consistent with best-practice standards? How are different service plans and individual practitioners providing various treatments? Which practitioners or service programs deviate most significantly from best practice? How can we develop an efficient system of obtaining such information in a timely manner? Methods and principles of outlier analysis will be developed and formal feedback mechanisms will be operationalized.</p>		
	<p>D. <u>Education Function</u>: How can we disseminate information about best practices, efficient and effective treatments, etc? Approaches will include district and state-level conferences, telephone consultations, dissemination of electronic and published materials, etc.</p>		

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
	E. <u>Liaison and Consultation Function</u> : Regular interactions with various stakeholders individually and collectively will be held to obtain necessary input and feedback.		
	F. <u>Statewide Innovative Practice Projects</u> : A mechanism to support innovative projects around the state that are directed towards more effective and efficient treatment will be developed.		
	2. Explore best practices of public/private partnerships, to extend treatment opportunities for individuals who do not meet the priority population requirements of the CMH's, and therefore are ineligible for CMH services.	2. DCH/CMH/MHP; Professional Associations; Private Providers	2. Short-term
13. The County of adjudication (where a crime is committed) may not be the county of residence for the person charged. The county of residence is responsible for the financial piece of providing the mental health services.	1. Direct that the CMH of the county in which a crime is committed, is responsible for the provision of diversion services, including arrangements with the county of residence, where appropriate. Clarify how responsibility for the provision of mental health services is to be settled in these incidences.	1. Legislature	1. Immediate

Key Issue	Proposed Action or Recommendation	Responsible Party	Time Frame (Immediate / Short-term / Long-Term)
14. There must be a state-level capacity for monitoring and evaluating the impact of the Work Group's and MMHC's recommendations.	1. Standardization of data collection and compilation, statewide analysis, and distribution of the results.	1. New Best Practices Entity; DCH/CMH; Jails	1. Short Term

KEY ISSUES FOR REFERRAL TO OTHER WORK GROUPS:

<u>Work Group II:</u> Services and Supports for Children	Direct DCH to modify administrative rules and Medicaid agreements to loosen their policy on seclusion and restraint, in order to allow children to be served in Child Caring Institutions (CCI), with appropriate safeguards; and to provide additional resources for training, monitoring and services.
<u>Work Group V:</u> Governance, Finance, Structure and Accountability of the Publicly Supported Mental Health System	Offenders lose Medicaid coverage while incarcerated, which creates a major barrier to successful re-entry.

WORK GROUP V: GOVERNANCE, STRUCTURE, FINANCE, AND ACCOUNTABILITY

Chair: Milton Mack

Preliminary Report

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
<p>1. Structure and governance: State, regional, and local roles and responsibilities in the public mental health system should be driven by need and function. In other words, who is best suited to performing or overseeing which functions to assure effective and efficient treatment and supports for persons with mental illness?</p> <p>Michigan’s public mental health system is not structured to deliver care effectively, efficiently, and in a timely fashion to people with mental illness. The current structure—that is, the relationships and responsibilities shared among the state, PIHPs, CMHSPs, providers, and consumers—has fostered the following problems:</p>	<p>A. Consolidate CMHs into at most 18 regional authorities/PIHPs. These 18 authorities will integrate mental health and substance abuse services and collaborate with physical health, public health, FIA, corrections, and education to deliver services effectively and efficiently to persons with mental illness.</p> <p>Alternatives to consolidation:</p> <ul style="list-style-type: none"> • Create a true mental health <i>system</i> through a shared governance structure that better coordinates state, regional, and local roles and responsibilities for services to persons with mental illness. 	<p>Allows one entity in each of the 18 regions to manage both Medicaid and general fund monies for public mental health services.</p> <p>Standardize administrative functions, which will reduce administration layers and lower administrative costs.</p> <p>Eliminate county match and county government control.</p> <p>Address the wide variation in funding and access across counties and regions.</p> <p>Address the large population with co-occurring mental illness and substance abuse.</p>	<p>Legislature and MDCH, with input from consumers, CMHSPs, PIHPs, and providers on composition of regions, standardization, and simplification.</p>	<p>Immediate to short-term. A Section 1115 waiver from the federal government could accomplish this change in structure. In the absence of such a waiver, state law would have to be changed.</p>

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
<ul style="list-style-type: none"> Huge variation in funding and therefore service provision and access. Inefficiency because of variation in regulation between the two major funding sources. PIHPs struggle to manage two dramatically different major sources of funding for public mental health services: Medicaid and general fund. These sources have very different requirements, which confuse and frustrate people needing services and drive unnecessary duplication of effort in PIHPs that must conform to these regulations. 	<p>Such a structure depends on (a) improving and enforcing statewide standards for administration and performance (see below); (b) coordinating these functions regionally; and (c) preserving CMHSP local assessment and delivery.</p> <ol style="list-style-type: none"> 1. Establish a task force or work group to examine the delivery and financing of mental health services in rural areas. This group should address the inequitable funding for mental health in rural Michigan and recommend changes to the current structure (PIHPs, CMHSPs) to assure that rural residents' needs are met. 			

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
<ul style="list-style-type: none"> While there has been some progress recently with clinical uniformity and data submission, there is inefficiency from an overabundance of uniform statewide administrative requirements and the absence of a standard method of collecting information from PIHPs, CMHSPs, and providers to meet administrative requirements. The state lacks the staffing and resources to monitor and enforce statewide standards when doing so will reduce administrative costs and improve quality. 	<ol style="list-style-type: none"> Restore the locus of responsibility for public mental health services to MDCH and have an MDCH contract management unit—with monitoring and compliance authority—directly administer contracts with core providers at the local level. 			
<ul style="list-style-type: none"> Too much variance in the quality of mental health care. In addition, federal and state regulations have been the basis of an accountability 	<ol style="list-style-type: none"> Develop demonstration projects that link public mental health services and physical health services through FQHCs. 	<p>Links mental and physical health care at one site for the uninsured and Medicaid beneficiaries. FQHCs receive enhanced reimbursement for services delivered to the uninsured.</p>	<p>MDCH working with the Michigan Primary Care Association</p>	<p>Short-term: 3–5 years</p>

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
<p>system that does not measure the things that matter most to consumers and reflect the commission's values. A quality management system must integrate accountability with quality measures that should be set by MDCH with input from consumers, PIHPs, CMHSPs, and providers. (The early work of MDCH's quality improvement council is promising in this regard.)</p> <p>An optimal structure should preserve consumer involvement in governance and address <i>local control</i> [Mental Health Code, section 204(b)] and guaranteed access to treatments and supports in communities.</p>	<p>C. Make the regional mental health authorities responsible for the 20 outpatient mental health visits now delivered through Medicaid health plans.</p> <p>D. Support for legislation (SBs 591, 1076, and 1079) establishing a Detroit-Wayne County Community Mental Health Agency</p>	<p>Makes more sense for regional MH authorities to coordinate mental health services.</p>	<p>State legislature; MDCH working with consumers, regional mental health authorities, providers, and Medicaid health plans</p> <p>State legislature/ governor</p>	<p>Legislature must change the Insurance Code. Once consolidation has occurred, this can be accomplished immediately.</p> <p>Immediate</p>

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
<p>2. The role of PIHPs and managed care: Does the PIHP model need maturing to function optimally or is the PIHP model itself the issue?</p>				
<p>3. Funding: Michigan's long tradition of progressive public policy for mental health services has been undermined by inadequate funding. State policy decisions to (a) maximize federal revenue through Medicaid and (b) diminish general fund appropriations to public mental health services have resulted in a two-tiered system of coverage and services, with people eligible for Medicaid much more likely to receive public mental health services than those without coverage who must rely on the general fund. Even so, Medicaid does not cover many people (approximately 45 percent) with serious mental illness because eligibility requires meeting a restrictive definition of</p>	<p>Investigate waiver options, with the goal of giving the State the greatest flexibility in benefits and covered populations and the least risk of losing current and future funding, including federal matching dollars. For details on these options, see Morna Miller's May 19 memo on Medicaid expansion options, which appears at the end of this document.</p> <p>THE WORK GROUP REPLACED THIS RECOMMENDATION WITH THE ONE ABOVE, BUT IT REMAINS IN HERE FOR REFERENCE. Secure a Section 1115 from the federal government (HHS) that allows consolidation of all federal funding into one benefit package.</p>	<p>Gives the State maximum flexibility in benefits and covered populations and the least risk of losing current and future funding, including federal matching dollars.</p> <p>Allows consolidation of Medicaid, GF, ABW, and other benefits packages so that there is a single benefit for all who receive public mental health services.</p> <p>Gives the state maximum flexibility in the use of federal and state dollars to fund mental health services.</p> <p>Extends the benefit to more people with mental illness.</p> <p>Standardization and simplification leads to greater consumer understanding of what is covered and easier, less costly administration, leaving more funds for direct treatment and supports.</p>	<p>MDCH, working with all mental health stakeholders</p>	

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
<p>disability and restrictive income requirements. The effect of this two-tier system is exacerbated by the dramatic differences in general fund support for mental health services per capita among Michigan's counties. These inequities mark a crisis in the delivery of appropriate and effective services and supports throughout the state.</p>	<p>Pursue additional general fund appropriations for mental health services to rectify the absence of COLA increases.</p> <p>Investigate new, dedicated funds through special fees and assessments.</p>		<p>State legislature and MDCH</p> <p>State legislature and MDCH</p>	
<p>4. Accountability: Who should be held accountable for what? Which measures should be used for evaluation? Should there be financial incentives for performance? There is too much unproductive variance in quality of care, payer reporting requirements (Medicaid vs. GF), and</p>	<p>A. Invest more resources for the state to set standards for regional accountability; standardize payment, performance, and other administrative functions (e.g., computer systems) so that accountability is achieved without micromanagement.</p>	<p>Standardization and simplification will reduce the burden on regional mental health agencies and providers.</p>	<p>MDCH working with stakeholders.</p>	<p>Short term (1-3 years)</p>

Key Issue	Proposed Action	Anticipated		Time Frame (Short-term or Long-term)
		High-level Impact	Responsible Party	
other administrative requirements				
	B. Reduce regional variations in clinical care through the identification, adoption, and measurement of evidence-based practices and centers of excellence. Move to financial incentives for high performance according to widely accepted, evidence-based measures of quality care.	Improve quality of care across regions.	MDCH working with Michigan leaders in the field of quality improvement and performance measurement.	Short-term (1-3 years)
5. Longer term psychiatric care: More longer term (two weeks to six months) psychiatric care—how can we best deliver it? The future of state hospitals: aging infrastructure, lack of geographic balance Licensure changes needed to create new kinds of facilities to meet longer-term needs of persons with mental illness.	A. Forge partnerships between CMHs and private psychiatric hospitals and psychiatric units of general hospitals to coordinate care of persons with mental illness needing longer term care (and emergency care, step-down, follow-up, etc., as these consumers need an array of services).	Closer partnerships will allow for better coordination of care. CMHs may be able to redirect some public monies to gain access to Medicaid matching dollars.	MDCH, in cooperation with the legislature to make changes to existing law, and other stakeholders (CMHs, providers, consumers).	Short-term

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
<p>Private psychiatric beds: units are closing; many beds are occupied only because patients are waiting for community care</p> <p>Medicaid does not pay for IMDs</p>	<p>B. The state should specially license beds in private psychiatric hospitals, psychiatric units of general hospitals, and other facilities to provide longer term care where and when they are needed, recognizing that 2-3 levels of care may be necessary. No person should have to travel more than one hour from his/her home to receive this care.</p> <p>C. Pursue a Section 1915b waiver, as Hawaii and Iowa have worked around the IMD exclusion through this waiver.</p>	<p>Special licensure (possibly intensive secure residential facilities) will allow the state to meet unmet need for longer-term care in the community. State hospitals are aging and available only in a few communities. Eventually, the state facilities—except for the Forensic Center—would not be necessary.</p> <p>Gives the state more flexibility with persons needing longer-term care.</p>	<p>MDCH applies for waiver.</p>	<p>Short-term</p>
<p>6. Involuntary treatment: The current process for involuntary commitment poorly serves consumers and the public interest. Involuntary treatment should be used only as a last resort. An alternative is needed that preserves self-determination while creating a sensible, effective, clinically driven process to provide care to persons who do require involuntary treatment because they are a</p>	<p>Consistent with person-centered planning, develop a process with several steps—including advanced psychiatric directives—that make every effort to avoid involuntary treatment unless the consumer is a danger to herself/himself or others.</p>	<p>Preserves self-determination while streamlining process for care for persons who are a danger to themselves and others. Allows clinicians, not judges, to make decisions about appropriate treatment.</p>	<p>MDCH, consumers, CMHSPs/PIHPs, and the courts should work together to develop the process.</p>	<p>Immediate</p>

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
danger to themselves or others.				
<p>7. Prevention and early intervention: Prevention and early intervention are essential and have been underfunded. Moreover, the Mental Health Code is a barrier to early intervention. Now, you have to be in crisis to get into the system. Helping people early on can prevent the onset of more serious mental illness later on.</p>	<p>Principle: Prevention and early intervention must be part of the continuum of care. Community mental health is not only for the care of the severely mentally ill.</p> <p>A. The Ticket to Work and Work Incentives Act of 1999 established two new optional eligibility groups to help states cover the working disabled. The TWWIA provisions directly address some of the problems with covering people with mental illness under Medicaid, and Michigan is not currently utilizing any of the options or funds available.</p>	<p>There is ample evidence that people with chronic illness in general—and mental illness in particular—benefit from early intervention; it may, in fact, fundamentally alter the course of the illness.</p>		

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
	<p>The <i>medical improvement option</i> was created explicitly to help states cover people with severe and persistent mental illness that responds to psychotropic drugs, among other things. The federal law limits eligibility to those with a “severe medically determinable impairment,” but the impairment does not have to meet the disability test. Federal law also limits eligibility to those between 16 and 64 who are either working 40 hours a month or meet some alternate definition of employment approved by HHS. The state sets income and resource standards.</p>	<p>Allows the State to cover more people with mental illness under Medicaid. The State must also cover their physical health needs as well.</p>	<p>MDCH applies to federal government.</p>	<p>Immediate</p>
	<p>B. Fully implement EPSDT</p>	<p>Alerts children, families, and professionals to early signs of severe emotional disturbances.</p>		<p>Immediate</p>
	<p>C. Direct the State Board of Education and the Department of Education to enforce IDEA, which requires schools to arrange for and fund</p>	<p>Improves identification of and treatment for children with emerging mental illness.</p>	<p>State Board of Education and the Department of Education</p>	<p>Immediate</p>

Key Issue	Proposed Action	Anticipated High-level Impact	Responsible Party	Time Frame (Short-term or Long-term)
	<p>services to children with severe emotional disturbances.</p> <p>D. Establish Schizophrenics Anonymous and dual diagnosis support groups in every CMH.</p>	Prevents relapse.	Consumers and CMHs	1-2 years
8. Parity: Parity laws' effect on the resources and demands made on public mental health: To what extent does parity lead to private health insurance coverage of services that would otherwise be the responsibility of the public system?	Support SBs 4-5.	Reduce demands on the public mental health system because more people with private health insurance will have their mental health care covered.	State legislature/governor	Immediate

(Work Group V, Continued)

MEMORANDUM

To: Pat Babcock
From: Morna Miller
Office of Congressman Sander M. Levin
Date: May 19, 2004
Subject: Medicaid expansion options

Based on preliminary research, Michigan has a number of options that would potentially increase the number of people in need of mental health services that we could cover under Medicaid. None of the options alone is a silver bullet that solves all our problems, since most are limited to expanding coverage to certain groups, and most have some financial downsides, either requiring/generating an increase in state Medicaid costs or reducing future federal Medicaid contributions.

TWWIIA Basic Coverage/Medical Improvement Groups

The Ticket to Work and Work Incentives Act of 1999 established two new optional eligibility groups to help states cover the working disabled. The TWWIIA provisions directly address some of the problems with covering people with mental illness under Medicaid, and Michigan is not currently utilizing any of the options or funds available.

The *basic eligibility option* allows states to set their own income and resource standards for Medicaid eligibility for anyone who otherwise meets the SSI standard of disability and is not under 16 or older than 65. To qualify, the beneficiaries must be ostensibly be working, but the state can't establish a minimum earnings or hours threshold. Essentially, this would allow us to qualify anyone whose mental illness was severe enough to qualify for SSI on non-income grounds. Of course, if they qualified for Medicaid coverage, the state would be obligated to provide physical, as well as mental health coverage.

The *medical improvement option* was created explicitly to help states cover people with severe and persistent mental illness that responds to psychotropic drugs, among other things. The federal law limits eligibility to those with a "severe medically determinable impairment," but the impairment does not have to meet the disability test. Federal law also limits eligibility to those between 16 and 64 who are either working 40 hours a month or meet some alternate definition of employment approved by HHS. The state sets income and resource standards. As with the other Medicaid expansions, if the state elects the option, the state is required to provide full Medicaid benefits to people who qualify under this option.

To date, Michigan has not taken up either option. 25 states have elected one or both of these eligibility categories.

It seems likely that Michigan could qualify a significant number of the adults currently ineligible for Medicaid for federal reimbursement under one or both of these options. The state can also apply for a federal **Medicaid Infrastructure Grant**, which would provide federal funds for manpower and other administrative costs of implementing the new eligibility groups. Medicaid Infrastructure Grants are competitive grants awarded only to states that apply. Michigan is one of only 13 states that do not currently have a Medicaid Infrastructure Grant. The solicitations for Medicaid infrastructure grants are issued each spring, and a minimum of \$40 million total is available. The grants remain available until 2010.

Early, Periodic Screening, Diagnosis and Treatment for Children (EPSDT)

The poorly enforced EPSDT requirement has always been part of Medicaid regulations and was codified into law in 1989. It requires states to provide periodic health assessments (physical and mental health) for all **Medicaid eligible** (not Medicaid enrolled – in Michigan and in other states, there are large numbers of low-income children who are eligible for but not enrolled in Medicaid) children. The state is then required to provide all health services the screening identifies a need for **even if they are not normally Medicaid-covered**. Essentially, EPSDT provides a mechanism for providing (and collecting a Medicaid match on) children’s health care services (including mental health) that states can’t normally provide through Medicaid.

On the other hand, EPSDT also creates a requirement that the state provide (and pay the state share of) a number of other, non-mental health (although needed) health care services. Aggressive use of EPSDT is almost sure to lead to an increase in state Medicaid spending for needed services to children, which will have a state budget impact.

An EPSDT strategy is also only useful with children in families below 150% of the federal poverty level (about \$28,000 for a family of four). It doesn’t provide avenues of coverage for adults or higher-income children. It also doesn’t pay for population-based interventions, only individual health services. It would, however, expand the number of mental health services Michigan could provide for children using Medicaid funds.

Section 1115 waivers (called HIFA waivers for Medicaid/S-CHIP)

Section 1115 (enacted in 1962) gives the Secretary of HHS broad authority to authorize any demonstration project likely to “assist in promoting the objectives” of state grant programs under the Social Security Act (and thus covers a range of programs in addition to Medicaid and the Children’s Health Insurance Program (S-CHIP)) In practice, the “demonstration” component is loosely enforced, and HHS has frequently approved identical “demonstrations” in multiple states for long periods of time.

The advantage of an 1115 waiver is that it often allows states to use Medicaid or Children’s Health Insurance program funds to provide services not normally covered by Medicaid or to serve populations that are not eligible for Medicaid or S-CHIP and to waive various other program rules that make it difficult to blend the funds with other funding sources. The waivers also allow states to circumvent Medicaid rules that require states to provide the same level of benefits to all Medicaid beneficiaries (normally, states can choose to exclude an optional population or service from Medicaid entirely, but if they include a service, they have to offer to all populations, and if they include a population, they have to offer complete services.)

Because the executive branch has such broad authority to modify existing program rules without Congressional consultation or approval, use of Section 1115 waivers tends to reflect that administration’s policy priorities. The current Administration has signaled a preference for testing two things – capping the federal contribution in exchange for flexibility (block grants) and component that allows people to purchase private insurance instead of enrolling in Medicaid or other public programs. (Connecticut and Florida have block grant applications pending, and all HIFA waivers are required to include at least a feasibility study of “premium assistance” for private health insurance.)

Two things, however, are constant across Administrations.

Budget neutrality requirement. Demonstrations operating under Section 1115 waivers cannot generate higher federal Medicaid spending than would occur without the waiver. As a practical matter, this usually means states either agree to a cap on federal contributions or are required to make explicit cuts in benefits or eligibility for current populations. Because total state allocations under S-CHIP are capped (not open-ended like Medicaid), the S-CHIP requirement is usually just that the changes not increase S-CHIP spending beyond the state’s allotment, which sometimes allows an increase over current spending. Prior to the Adult Benefit Waiver and some reversions of S-CHIP funds to Treasury, Michigan had about \$400 million in unspent S-CHIP funds.

Reporting requirements. Nominally, Section 1115 waivers are research projects to test the efficacy of new approaches. As a result, they come with reporting and evaluation requirements.

Because of the strictness of the budget neutrality requirements, I believe a Section 1115 waiver is unlikely to increase the amount of federal funding available for mental health care (although it could allow us to spend it on different populations) and in fact, could well reduce available federal funding in the long term, since Michigan’s “baseline” for federal funding would be based on the system before Commission-recommended reforms that might increase the number of people eligible for or enrolled in Medicaid or their utilization of services. Although an S-CHIP waiver might be able to tap into any remaining funds in Michigan’s allotment, S-CHIP funds are currently declining, and a waiver that merges S-CHIP and Medicaid funds would require Michigan to accept a lower match (about 51% federal instead of 65% federal) for the entire project.

While it would reduce some kinds of accountability and reporting by waiving rules, it would create new reporting requirements, since we would be required to evaluate it as a research project.

Section 1115 waivers also come with a relatively high level of uncertainty when they do expire, since a change in HHS Secretaries often results in changed priorities for the use of such flexible authority (and they're technically demonstration projects), and Congressional watchdogs (including the Senate Aging Committee and the General Accounting Office) have recently singled out the waivers as an inappropriate use of Medicaid and S-CHIP funds.

Section 1931 expansion

Prior to 1996, adults were generally only eligible for Medicaid if they were receiving welfare or Supplemental Security Income (SSI). Waivers were needed to cover other adults. Under the 1996 welfare law, eligibility for Medicaid and welfare were “de-linked.” Although each state’s eligibility level was technically fixed at the 1996 welfare income level, states were given broad latitude to set their own “earnings disregards” and their own asset tests for low-income parents. (Many people who would otherwise be eligible for assistance have some property or personal savings that disqualifies them.) Essentially, states can dramatically raise the income and asset levels for Medicaid eligibility by “disregarding” income and assets, and can do so without special federal permission or waivers.

The advantage of using Section 1931 is that it doesn’t require any kind of federal waiver, and the option is not likely to disappear. The clear disadvantage is that, since it’s a welfare reform provision, it’s targeted at parents with earned income, so it doesn’t help the state expand to cover people with mental illnesses that prevent them from working or childless adults. The other issue is that a 1931 expansion would require additional state investments, since the state would have to put up its share of not only the mental health treatment, but also of the physical health treatment, since without a waiver, if you expand Medicaid eligible, you have to provide the newly Medicaid-eligible population all Medicaid services that they need.

Section 1619(b) eligibility

In order to encourage Supplemental Security Income (SSI, the federal cash assistance to the poor disabled) recipients who can work to attempt to do so, Section 1619(b) of the Social Security Act requires states to provide Medicaid coverage to people who have already qualified for SSI and continue to have the impairment that qualified them for disability benefits but subsequently have more than \$800 a month in earnings (usually the disqualifier for SSI/Medicaid coverage.) These people remain eligible for Medicaid so long as their gross earnings are determined to be less than the value of the sum of SSI, state supplemental disability payments, Medicaid benefits, and publicly-funded attendant care they would be eligible for if they weren’t working. In Michigan, that threshold is \$22,250 a year. While that’s a relatively low threshold, it’s much higher than the general

income threshold for SSI-based Medicaid – 74% of the federal poverty level, or about \$7,000 a year for a household of one.

The use of this section does not require a waiver of any kind, but is relatively limited, since it only applies to people who are currently receiving SSI and return to work.