

MICHIGAN MENTAL HEALTH COMMISSION REPORT

(FY2008 Appropriation Bill - Public Act 123 of 2007)

April 15, 2008

Section 458: By April 15, 2008 the department shall provide each of the following to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director:

(a) An updated plan for implementing recommendations of the Michigan mental health commission made in the commission's report dated October 15, 2004.

(b) A report that evaluates the cost-benefit of establishing secure residential facilities of fewer than 17 beds for adults with serious mental illness, modeled after such programming in Oregon or other states. This report shall examine the potential impact that utilization of secure residential facilities would have upon the state's need for adult mental health facilities.

(c) In conjunction with the state court administrator's office, a report that evaluates the cost-benefit of establishing a specialized mental health court program that diverts adults with serious mental illness alleged to have committed an offense deemed nonserious into treatment prior to the filing of any charges.

*Michigan Department
of Community Health*



**Jennifer M. Granholm, Governor
Janet Olszewski, Director**

FY2008 Section 458 Report
Implementation Status Report

Boilerplate Section (a) Report

(a) An updated plan for implementing recommendations of the Michigan mental health commission made in the commission's report dated October 15, 2004.

In April, 2005, MDCH issued *A Plan for Implementing Recommendations of the Mental Health Commission*. During FY08 implementation of the seven goals outlined in the plan continued as described in the following.

Goal 1: Public Awareness

Public Education Campaign. In collaboration with the Michigan Association of Community Mental Health Boards and other community partners, MDCH developed an anti-stigma initiative modeled on the federal Substance Abuse and Mental Health Administration's (SAMHSA) national anti-stigma campaign. Michigan's campaign was launched at the March 25, 2008 Anti-Stigma Conference in Dearborn. MDCH Director Janet Olszewski revealed a new slogan that will appear on billboards across the state during the course of the year: "Look Closer ... see me for who I am." The conference featured Terry L. Cline, PhD, SAMHSA Administrator and David Satcher, MD, PhD, former US Surgeon General. Over 500 individuals participated. In addition, MDCH included "anti-stigma" as a category in its annual, competitive request for proposals for funding through the State's Federal Mental Health Block Grant. Since 2006, 39 counties in Michigan have developed MDCH-funded anti-stigma programs. The various programs used a variety of methods to reach out and educate the community about mental illness and related stigma. The most commonly used methods include: presentation of educational programs, development and dissemination of DVDs, partnerships with community organizations, theater productions, art events and consumer-run activities.

MDCH is currently engaged in a planning effort that is aimed at using the information and products developed from the activities described above to develop the next steps for a statewide public education campaign.

Suicide Prevention. The Michigan Suicide Prevention Plan was unveiled by the Michigan Surgeon General in September 2005. Since that time, the MDCH Injury and Violence Prevention Section has taken leadership on suicide prevention in the state. MDCH has a major federal youth suicide prevention grant providing funding to six local sites. In addition, there are a number of communities that have developed their local suicide prevention plans or are in the process of developing their plans (per recommendation #2 of the state plan), as well as those beginning to implement activities for our most vulnerable citizens.

MDCH is partnering with the Suicide Prevention Action Network-Michigan, Michigan Association of Community Mental Health Boards, University of Michigan Depression Center, Michigan Chapter of the American Foundation for Suicide Prevention, and the Michigan Association for Suicide Prevention to plan the “Suicide In Michigan: Perspectives in Prevention” Conference on November 19, 20, and 21, 2008, in Lansing.

Goal 2: Priority Populations and Early Intervention

Uniform Screening and Assessment. MDCH worked with The Standards Group to develop a set of Access Standards aimed at making the screening and assessment process more uniform across the CMHSP and PIHP access systems. The Standards will be attached to the FY09 MDCH/PIHP and CMHSP contracts. An accompanying technical guidance has been developed that will be used along with a core training curriculum to be presented to access workers in the Fall of 2008.

Goal 3: Model Service Array

Evidence-based Practices and Promising Practices. MDCH has dedicated Mental Health Block Grant funds to support practice improvement for adults and children. MDCH has completed a three-year effort to assure that each PIHP service area offers the following adult practices: Family Psychoeducation and Integrated Treatment for Persons with Dual Mental Health and Substance Use Disorders. A technical assistance manual for Assertive Community Treatment has been published by the department and will be used by CMHSPs to make program improvements. Two evidence-based practices for children: Parent Management Training Oregon Model and cognitive behavior therapy are being implemented in several PIHPs. Michigan now has 433 certified peer support specialists. During FY09, practice improvement efforts will continue with the addition of a supported employment initiative.

Quality Management System. MDCH has continued to refine the Mental Health Quality Management System through the Mental Health Quality Improvement Council that has representatives from consumer, advocacy and provider organizations and PIHPs and CMHSPs. The Council in particular analyzed all the Mental Health Commission recommendations to determine those that would be relevant to the Council’s work. The Council provided advice and oversight in MDCH’s efforts to develop and publish on its web site a summary of quality measurements of the PIHPs that is more user-friendly to consumers, families and advocates. This “fingertip” report is updated quarterly. The quality management system will also be monitoring the PIHPs’ implementation of a two-year performance improvement project to increase the access of Medicaid-eligible children into the public mental health system.

Web-based Information Infrastructure. In addition to the increased information that has been posted on the MDCH web site in the past two years, MDCH is working with

PIHPs and CMHSPs on developing a web-based reporting system for submitting real-time, individual-level data on criminal justice involvement and sentinel events. While the reporting on these events is expected to begin sometime in FY09, web-based reporting on other events will be added at a later time.

Interagency Approach to Prevention, Early Intervention, and Treatment for Children. The Early Childhood Investment Corporation (ECIC), through the work of its external Board Advisory Committees has established Priority Outcomes and Benchmarks for Social and Emotional Health, Pediatric and Family Health, Family Support and Parenting Education and Early Care and Education. The next steps are to develop strategies for reaching the benchmarks to develop an early childhood system of care.

MDCH (the Administrations of Medical Services, Mental Health and Substance Abuse, and Public Health) in conjunction with the Michigan Chapter of the American Academy of Pediatrics, MDE Early On implemented an ABCD grant to pilot the use of standardized, validated developmental screening tools for young children by physicians during EPSDT well child visits. Effective April 2008, this was incorporated into Medicaid state policy in accordance with the standards/guidelines set by the American Academy of Pediatrics.

The Child Care Expulsion Prevention Project (CCEP), which is funded by the Department of Human Services with federal child care quality funds and administered by MDCH through contracts with CMHSPs, has expanded to 16 projects serving 31 counties. The CCEP is a mental health consultation model, whereby early childhood mental health clinicians provide consultation and support to child care providers and parents for infants, toddlers and pre-school age children experiencing behavioral difficulties in child care settings. Michigan State University is currently conducting an evaluation of the program.

Goal 4 Diversion

Jail Diversion. Jail Diversion programs and services continue to be viewed as an important element of a community-based service array. With MDCH's Jail Diversion Practice Policy Guidelines and the Gains Center Criminal Justice/Mental Health Consensus Report as a resource base, each local CMHSP system searches for ways to better deliver services to individuals who have a mental illness or developmental disability and have contact with the criminal justice system. There will be efforts to address gaps in current system delivery jail diversion programs, provide better customer friendly services via the use of peer support specialists as jail diversion workers and community liaisons for consumers when released from jail.

The use of Mental Health Courts to address the special needs of this population are taking root in our jail diversion system as several CMHSP and criminal justice systems are collaborating to develop and implement mental health courts which cater to a special population with special needs. The legislative budget for FY09 has earmarked financial

resources to support the development of mental health courts modeled after national mental health court principles.

Goal 5: Structure, Funding, and Accountability

Statewide Standards . MDCH has co-sponsored The Standards Group (TSG) with the Michigan Association of Community Mental Health Boards (MACMHB) and has as members consumers and advocates along with MDCH and PIHP representatives. TSG has produced the Access Standards (see item 8); recommendations for standardizing the purchasing of health information technology; and recommendations for improving the self-determination policy. More recently MDCH has identified additional projects for TSG that would address web-based reporting and administrative simplification of provider contracting. MDCH is also working with MACMHB to address more equitable funding of the CMHSPs. Finally, MDCH has issued a concept paper that sets the stage for many system improvements to be worked on in FY09 and FY10, including access to and quality of services and administrative efficiencies.

Standards for Performance. MDCH, through the quality management system that is overseen by the Quality Improvement Council, continually refines standards for performance and provides training to the CMHSPs and PIHPs at least quarterly.

Administrative Costs. MDCH continued work on developing and implementing a new uniform method for CMHSPs and PIHPs to allocate and report administrative costs. The system went into effect October 2006 and reports are received annually. MDCH also is improving the financial reporting templates in order to receive more comprehensive financial information (quarterly) from CMHSPs and PIHPs.

Incentive Payments. MDCH is working with the state's actuary as the capitation rates for Medicaid are developed to identify allowed adjustments that would provide incentives to PIHPs improving the quality of care. For FY08-09, PIHPs were given an enhanced rate for increasing access for children, and for persons with substance use disorders. MDCH will continue to look for ways to carve out funding that can be targeted for improved quality of care.

Sustainable Models of Collaboration. MDCH applied for and was approved for a 1915(c) waiver for children with serious emotional disturbance (SED). The SED Waiver provides children who need a psychiatric hospital level of care with wraparound community based services. The SED Waiver is a collaborative effort of MDCH/CMH, DHS, and Juvenile Justice in that it is jointly funded by county child care funds and Medicaid, and serves children from the various systems.

MDCH has utilized federal mental health block grant funds to support system of care planning across the state. For the fiscal years of FY07, FY08, and FY09, requests for block grant funds by CMHSPs were to be based on local system of care planning processes that included all agency stakeholders, parents, and youth. Increasing mental health services to children in child welfare and juvenile justice was to be a special focus.

Two federal Substance Abuse and Mental Services Administration (SAMHSA) System of Care grants were awarded to two communities in Michigan—Ingham County and Kalamazoo County in 2006. These two communities are leading the way in the development of comprehensive systems of care that are family driven, youth guided, and culturally responsive. Partnerships with the other child-serving systems are critical to supporting and sustaining these efforts.

In FY08, the Medicaid capitation payment for children birth through 17 was adjusted to support increased access for children to mental health specialty services and supports. Additional funding for substance abuse services was also added to the capitation for children and adults. Performance targets for each of the PIHPs are included in the FY09 contracts between MDCH and the PIHPs. One of the performance targets specifically addresses increased access for DHS abused and neglected children.

Office of Recipient Rights (ORR). The ORR Director reports directly and solely to the director of MDCH. To assure clarification and to support the right of the individual to be admitted to a psychiatric hospital voluntarily, DCH-ORR developed an FAQ on the issue and included that in the DCH-ORR web site. The application form, DCH 0086, is used throughout the state in CMHSPs and LPH/Us as well as our own state facilities. The form is now clearer for consumers to understand and sets out for the hospital/prescreening unit the criteria in determining clinical suitability for voluntary hospitalization.

By December 31, 2008, the DCH-ORR Training Division will convene a meeting of statewide rights offices to assess existing education and training activities, and to identify improvements that will better assist primary and secondary consumers in navigating the public mental health system and other related health and human service systems.

Fair Hearings. MDCH Mental Health and Substance Abuse Administration staff meet routinely with the administrative law judges to clarify Medicaid policy. In the course of their work, the law judges regularly review clinical assessments and clinical opinions of cases. MDCH has revised the technical requirement for CMHSPs to implement a local grievance process for individuals who are non-Medicaid recipients. They have the right to submit a complaint to the Mental Health and Substance Abuse Administration if the local process is unsatisfactory.

Goal 6: Service Integration

Collaborative Models to Integrate and Coordinate Mental Health Services with Primary Health Care. MDCH sponsors a Mental Health Advisory Committee consisting of medical directors from PIHPs and Medicaid Health Plans that is aimed at improving the coordination of care for their mutual recipients. One result has been collaborative models of electronic medical record sharing; and another, a clearer definition of the respective responsibilities for the primary and mental health care of mutual recipients. Seven CMHSPs will utilize federal Mental Health Block Grant funds

in FY09 to implement models for integrating mental health services with primary health care in their service areas.

Co-occurring Mental Health and Substance Use Disorders. MDCH has been working with all 18 PIHP and the 16 Substance Abuse Coordinating Agencies (CAs) so that individuals with both mental health and substance use disorders receive services and supports in an integrated manner. In June 2008, MDCH created an Integrated Treatment Committee (ITC) with 21 invited stakeholders to address barriers and develop strategies for individuals with co-occurring mental health and substance abuse disorders, whether they be primarily served in the public mental health, public substance abuse, or Medicaid primary care system.

MDCH is promoting co-occurring disorder system change at the state level and local levels through a group of individuals that includes administrators, supervisors, consumers and front line clinicians called change agents. MDCH brought approximately 350 change agents together four times this year and plans an additional meeting in October 2008. The expectation for these change agents is that they work regionally with their PIHPs and CAs to identify and address system barriers.

To further promote integrated treatment, the Mental Health and Substance Abuse Administration and the Office of Drug Control Policy issued a joint RFP to CAs in June 2008 to develop services and supports for individuals with co-occurring disorders who are being treated primarily in the public substance abuse services system. MDCH received twelve proposals in response to this RFP and selected six for funding. These two-year initiatives will begin October 1, 2008.

MDCH is working with Wayne State University and a group of fifteen trained fidelity reviewers from PIHP regions to monitor the fidelity of the SAMHSA endorsed Evidence-Based Practice, COD: IDDT. At present, approximately 80 teams are in different stages of implementation of the IDDT model. To date, readiness assessments have been completed for approximately 50 teams and initial fidelity assessments for approximately 30 teams. The fidelity assessment team is also providing technical assistance (TA) upon request. MDCH provided approximately 60 days of trainings and TA through national and local experts at the state level and local level. These trainings and TAs are targeted towards system change, program development and consumer advocacy and self help.

As part of its improving practice initiative, MDCH is currently working with a MINT certified trainer to train a group of clinicians to become the trainers for the system. The first group of 16 trainers will get a Michigan specified limited certificate. It is expected that these individuals will train others in Motivational Interviewing.

Homelessness. Every community across the state has developed a ten-year plan to end homelessness. To assist in implementation of their plans, the Michigan State Housing Development Authority (MSHDA) has made \$14,500,000 available to create supportive housing for homeless families with children, homeless youth, chronically homeless, and homeless survivors of domestic violence. In addition, supportive housing developments

in Detroit, Grand Rapids, and Battle Creek are being proposed targeted to homeless veterans. This initiative will create approximately 275 units of supportive housing for homeless veterans and has been effective in bringing new partners, both private and public, to the table.

The MDCH Homeless Programs consist of Housing Opportunities for People Living with AIDS, PATH, Shelter Plus Care, and Supportive Housing Program grant programs in addition to a program of training and technical assistance made available to sub-grantees. Recent innovations include using PATH dollars to create a Housing Resource Center in Detroit and ten other counties in the state. All of these programs provide outreach to people who are homeless with linkages to support to find and sustain housing.

MDCH participates in a home ownership coalition for people with disabilities. Recent innovations have included making MSDHA down payment assistance available to people who are getting a USDA rural development loan to purchase a home.

Several Community Mental Health Block Grant Initiatives address homelessness (each of these projects is required to have a linkage to a local ten-year plan to end homelessness). On January 9, 2008, a separate Community Mental Health Block Grant Request for Proposal was issued to PIHPs and CMHSPs specifically for the development of Housing Resource Centers in communities without them. The centers outreach to people with mental illness who are homeless and assist them in obtaining and maintaining independent living. Several new projects were funded as the result of this process and funds for this purpose were again offered for new projects for FY09.

Goal 7: User Involvement

Psychiatric Advance Directives. An opportunity for individuals to develop an advance directive for mental health care was provided through an amendment of the Estates and Protected Individuals Code—PA386 (1998), as amended by PA 532 (2004). MDCH developed an information guide and model advance directive. The guide and model advance directive is available on the department's website. English, Spanish and Arabic versions are available. Each year the department utilizes Mental Health Block Grant funds to sponsor trainings on advance directives throughout the state.

Boilerplate Section (b) Report

(b) A report that evaluates the cost-benefit of establishing secure residential facilities of fewer than 17 beds for adults with serious mental illness, modeled after such programming in Oregon or other states. This report shall examine the potential impact that utilization of secure residential facilities would have upon the state's need for adult mental health facilities.

Secure Residential Facilities. As indicated in the FY 2006 report for this section, a preliminary analysis and limited feasibility study regarding the establishment of secure

residential facilities (fewer than 16 beds) was conducted. That report indicated that few states utilize “locked” residential facilities and those states that have residential facilities for consumers with certain high-risk characteristics incorporate high staff to consumer ratios, certification requirements and extensive in-facility programming rather than placing a reliance on security. Further, because of the constraints on personal liberty that locked settings entail, such residential programs should be developed and operated through the state, and individuals be assigned to such arrangements only pursuant to a court order (i.e. alternative treatment order) or other legal directive (e.g., parole requirement). Finally, as previously reported, secure residential settings would appear to hold the most promise for certain individuals in state hospitals that have serious or significant past forensic involvement, and/or for seriously mentally ill individuals who are being released or paroled from a state correctional facility. Even in these situations, the establishment of such settings would not necessarily impact state hospital utilization, generate savings or reduce costs.

The department’s 2008 review of secure residential settings concurred with previous analysis and identified four concerns:

- 1) Appropriate placement. For a very small number of individuals, public safety is a legitimate concern and secure residential settings as currently proposed or envisioned may not provide adequate treatment or public safety.
- 2) Community inclusion. The department has worked for decades to gain acceptance of persons with developmental disabilities or mental illness in communities. The perception of “need” for and “locked” facilities undermines those efforts, is stigmatizing and de-values those members of our community.
- 3) Fire safety. In order to meet these standards, construction requirements would be similar to hospitals and likely prohibitive.
- 4) Involuntary commitment applicability. As identified in previous analysis, commitment laws are expected to apply since these would represent a deprivation of liberty.

Boilerplate Section (c) Report

(c) In conjunction with the state court administrator's office, a report that evaluates the cost-benefit of establishing a specialized mental health court program that diverts adults with serious mental illness alleged to have committed an offense deemed nonserious into treatment prior to the filing of any charges.

Mental Health Court Program. A cost benefit report has not been prepared. However, DCH will be working with the State Court Administrative Office to implement a pilot mental health court program in FY09. This project will consider including an evaluation component that addresses pilot project cost benefit.

The existing body of research on mental health courts demonstrates the value that mental health court programs can provide. However, these may represent cost avoidance or may

represent savings over an extended period of time. The costs may not be aligned with the agency receiving the benefit. For example, costs accrue to the mental health treatment system and to court operations while savings are in reductions in jail utilization.

In 2007, the Rand Corporation, sponsored by the Council of State Governments, published “Justice, Treatment, and Cost, An Evaluation of the Allegheny County Mental Health Court”. This report identified that participation in the mental health court program did not immediately lead to savings. In this evaluation, participation in the mental health court program led to increased treatment service participation in the first year, the costs of which were mostly offset by decrease in jail expenditures. But, over a longer time frame, the program may result in actual net savings associated with reductions in criminal recidivism. This report may be found at:

http://www.rand.org/pubs/technical_reports/TR439/