

UPDATED PLAN FOR IMPLEMENTING RECOMMENDATIONS OF THE MICHIGAN MENTAL HEALTH COMMISSION REPORT

(FY2009 Appropriation Bill - Public Act 246 of 2008)

April 15, 2009

Section 458: By April 15 of the current fiscal year, 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 each of the 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**

**Michigan Department of Community Health
Mental Health and Substance Abuse Administration
FY2009 Appropriations Section 458 Boilerplate 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 FY2009 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, the 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 included "anti-stigma" as a category in its 2008 annual, competitive request for proposals for funding through the State's Federal Mental health Block Grant. 16 Community Mental Health Services Programs were funded to develop local initiatives. During FY 2009, the department convened an Anti Stigma Steering Committee to provide leadership to:

- Examine current efforts and activities connected to other parties already engaged in anti-stigma work
- Learn more about efforts and directions in other states and countries
- Gauge the extent of efforts the outcomes achieved

The initial focus of the committee will be to eliminate stigma within the mental health system, The committee is co-chaired by the MDCH Director of the Mental Health and Substance Abuse Administration and the Director Of The Office Of Consumer Relations. The first meeting was held on June 11, 2009.

Additional MDCH initiatives on Anti-Stigma included the MI Recovery Council and MI Recovery Center of Excellence with its Mirecovery.org website

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. 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 partnered 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 in 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 CMHSPs and PIHPs access systems. The Standards have been attached to the FY2009 MDCH/PIHP and CMHSP contracts. An accompanying technical guidance has been developed that will be used along with a core training curriculum that was presented to access workers in the Fall 2008. During May and June 2009 four training programs were presented in various Michigan locations. Approximately 500 individuals participated in these one-day training programs.

Goal 3: Model Service Array

Evidence-based Practices and Promising Practices. The MDCH has dedicated Mental Health Block Grant funds to support practice improvement for adults and children. The 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 620 certified peer support specialists. During FY2009 practice improvement efforts continued with the addition of a supported employment initiative, motivational interviewing, and dialectical behavioral therapy.

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 MH 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 continues to monitor the PIHPs

implementation of a 2-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. The MDCH is working with the standards group, and the PIHP Chief Information Officers forum for developing the web-based infrastructure.

Interagency Approach to Prevention, Early Intervention, and Treatment for Children. The Early Childhood Investment Corporation 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.

The 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 which is funded by the Department of Human Services with federal child care quality funds and administered by the MDCH through contracts with CMHSPs has expanded to 16 projects serving 31 counties. The Child Care Expulsion Prevention Project 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 for ways to better deliver services to individuals who have a mental 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 specialist as jail diversion workers and community liaisons for consumer when released from jail.

Goal 5: Structure, Funding, and Accountability

Statewide Standards . MDCH has co-sponsored The Standards Group (TSG) with the Michigan Association of CMH 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 the 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 FY2009 and FY2010, 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.

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 FY2009, 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, Department of Human Services, and Juvenile Justice in that it is jointly funded by county child care funds and Medicaid, and serves children from the various systems.

The MDCH has utilized federal mental health block grant funds to support system of care planning across the state. For the fiscal years of FY2007, FY2008, and FY2009, 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, culturally responsive. Partnerships with the other child serving systems are critical to supporting and sustaining these efforts.

In FY2008, 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 FY2009 contracts between

the 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.

The DCH-ORR Training Division convened the 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 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 & 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. Ten CMHSPs are utilizing federal Mental Health Block Grant funds in FY2009 to implement models for integrating mental health services with primary health care in their service areas. The department also received a grant from the federal Mental Health and Substance Abuse Administration to support mental health/substance use treatment integration with primary care. This initiative also includes a new program that will train certified pure support specialists to conduct “Whole Health” training/support programs for individuals with mental illness.

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 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 continues to bring approximately 350 change agents together for training and consultation so that these change agents are supported to work regionally with their PIHPs and CAs to identify and address system barriers.

To further promote integrated treatment Mental Health and Substance Abuse Administration and the Office of Drug Control Policy issued a joint request for proposal 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 request for proposal and selected six for funding. These two-year initiatives began 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 70 teams. The fidelity assessment team is also providing technical assistance upon request. MDCH provided approximately 30 days of trainings and technical assistance through national and local experts at the state level and local level. These trainings and technical assistance 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.

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 10 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 10 year plan to end homelessness). On January 9, 2008, a separate Community Mental Health Block Grant Request for Proposal was issued to PIHPs and CMHSPs specifically for the development of Housing Resource Centers in communities without them. The centers outreach to people with mental illness who are homeless and assist them in obtaining and maintaining independent living. Several new projects were

funded as the result of this process and funds for this purpose were again offered for new projects for FY2009.

Goal 7: User Involvement

Psychiatric Advance Directives. 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 2008 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. 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). 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 cost prohibitive.
- 4) Involuntary commitment applicability. As identified in previous analysis, commitment laws are expected to apply since these would represent a deprivation of liberty.

In view of the previous analysis and conclusions reached regarding secure residential settings, no further examination was conducted during FY2009.

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 non-serious into treatment prior to the filing of any charges.

Mental Health Court Program. A mental health court is a specialized court docket that uses a problem solving approach to reduce contacts with the criminal justice system and to facilitate participation in mental health and substance use treatment services for those identified as mentally ill. Cross system collaboration between the criminal justice system and the mental health community is critical to successful programs.

The original FY2009 Appropriations for both the State Court Administrator’s Office and MDCH included funding for implementation of a pilot mental health court program. The MDCH funds are intended to support treatment costs and Judiciary funds are intended to support court operations. Boilerplate for each agency (section 459 of the MDCH appropriations) requires collaboration and joint development of guidelines for the operation and evaluation of these pilot courts. Correspondingly, in collaboration with the State Court Administrator’s Office, a joint application was issued, applicant proposals reviewed and nine pilot mental health court programs project sites were approved and funded for FY2009 implementation. The total number of projected participants was about 300. These courts are required to be based on the Mental Health Court Principles issued by the Department of Justice-Bureau of Justice Assistance. As of June 1, 2009, all nine projects are operational and have enrolled mental health court participants as follows:

- Livingston County CMH Authority-Livingston County-53rd District Court
- Oakland County CMH Authority-6th Circuit Court
- Northern Lakes CMH Authority-Grand Traverse County-86th District Court
- Berrien Mental Health Authority-Berrien County Trial Court
- St Clair County CMH Services-72nd District Court
- North Country CMH-Otsego County-87th District court
- Detroit-Wayne County CMH Agency-Wayne County-3rd Circuit Court
- Lifeways CMH Authority-Jackson County-4th Circuit Court and 12th District Court

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, but 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. This project includes data collection by the participating courts through the State Court Administrator's Office data system which was modified to accommodate mental health court specific information. It is intended that an evaluation component will address the cost benefit of these programs at a future date.