TRANSFORMING MENTAL HEALTH CARE IN MICHIGAN

A PLAN FOR IMPLEMENTING RECOMMENDATIONS OF THE MICHIGAN MENTAL HEALTH COMMISSION

Michigan Department of Community Health
Janet Olszewski, Director

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Common Acronyms

CMHSP	Community Mental Health Services Program
CA	Substance Abuse Coordinating Agency
DCH	Department of Community Health
DMB	Department of Management & Budget
DOC	Department of Corrections
DOE	Department of Education
DLEG	Department of Labor and Economic Growth
EDIT	Encounter Data Integrity Team
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
EBP	Evidence-Based Practice
FIA	Family Independence Agency
FQHC	Federal Qualified Health Center
MACMHB	Michigan Association of Community Mental Health Boards
MHC	Mental Health Commission
MPCA	Michigan Primary Care Association
MSA	Medical Services Administration
ORR	Office of Recipient Rights
PIHP	Prepaid Inpatient Health Plan
QIC	Quality Improvement Council
SAMHSA	Substance Abuse and Mental Health Services Administration
SCAO	State Court Administrative Office
SED	Serious Emotional Disturbance
SSG	Service Selection Guidelines
SMI	Serious Mental Illness

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OVERVIEW

The Final Report of the Mental Health Commission aptly summarized current problems with mental health care in Michigan: stigma and misunderstanding; barriers to access in both the public and private sectors; a paucity of prevention and early intervention programs; gaps in the service array and capacity constraints; insufficient consideration of children and families; slow adoption of best-practices; inadequate collaboration between mental health and law enforcement; system complexity, transaction costs and funding fragmentation; operational variance; inconsistent rights protection; limited cross-system integration and coordination; and lack of opportunities for consumers.

To address these concerns, the Commission Report offered an expansive vision for a transformed mental health system, a vision buttressed by a compelling set of values, and amplified through seven core goals and seventy-one recommendations. The Commission's findings and proposals speak to the present situation in the public mental health system, but also transcend the bounds of the public system to advocate change in federal policies, modifications within other state and local agencies, engagement by the private sector, and alterations in societal attitudes and perceptions.

The Commission Report is extensive and thorough, and the proposals detailed in the Report comprise a sweeping, ambitious, multi-year prescription for change. The breadth and scope of the Commission's findings and suggestions, however, are also the very things that make implementation of the recommendations so challenging. Implementation of many proposals requires a mixture of state efforts, legislative changes, stakeholder participation, funding improvements, capacity expansions, concerted action by other agencies, and private sector involvement, all sustained over an extended duration.

While the Commission prioritized some of its proposals, there was insufficient consensus within the Commission to establish firm precedence among many compelling recommendations. Time constraints also hindered consideration of some prominent items (e.g., state hospitals, etc.), and other matters of operational importance (e.g., growth in the number of patients at state facilities with past forensic involvement, etc.) were similarly overlooked.

SETTING PRIORITIES FOR IMPLEMENTATION

While each of the 71 recommendations of the Commission is worthwhile and instrumental for transforming mental health care in Michigan, not all proposals are of equal weight or immediate importance for system reform. Transformation has to begin with some priority steps, activities and developments. Not everything can be accomplished everywhere, all at once.

Given the limitations in state administrative capacity and projected constraints in available funding, the Department of Community Health (DCH) has developed an implementation plan that is (by necessity) somewhat more modest in its reach and more deliberate in its approach to system transformation. Rather than proceed on all Commission recommendations, the department has analyzed Commission proposals, and has focused upon a subset of recommendations for implementation activities over the next 12 months.

The recommendations selected for initial implementation emphasis are ones that, in the department's estimation, relate directly to critical issues confronting the public mental health system. Most – but not all – of these critical issues were addressed in Commission deliberations and recommendations. These vital items include:

- Reducing stigma and public misperceptions regarding mental illness;
- Instilling ***recovery*** as the organizing principle for adult mental health services delivery, and promoting ***adaptation***, ***resiliency*** and ***development*** as the guiding motif for mental health services to children and families;
- Enhancing the participation, influence, authority and prerogatives of consumers and families within the public mental health system;
- Clarifying system access requirements and reducing variance in eligibility and service determination decisions;
- Encouraging mental health prevention and early intervention services;
- Assuring the availability of a core set of services - throughout the state - for adults with serious mental illness and children with serious emotional disturbances;
- Promoting awareness and ensuring adoption of selected evidence-based practices;
- Supporting and sustaining the expansion of multi-agency, collaborative, and comprehensive systems of care for mental health services to children and families;
- Addressing the absolutely critical need for better collaboration from mental health, law enforcement, prosecutors, criminal/juvenile courts, correctional facilities and parole personnel to divert mentally ill adult and juvenile offenders, to provide appropriate mental health care for those in penal institutions, and to ensure timely aftercare services when the individual is released;
- Clarifying roles among various entities and exploring restructuring possibilities within the public mental health system to reduce role confusion, decrease duplication and transaction costs, and enhance accountability;
- Maintaining existing funding sources that support mental health care;
- Expanding quality improvement strategies and revising performance measures to reflect priority outcomes;
- Improving rights protections and devising new means of redress for service and/or rights complaints;
- Identifying means to expand housing options for persons with disabilities, and exploring development of supported and/or secure residential alternatives;
- Expanding employment opportunities for consumers;
- Determining the role of state hospitals in a primarily community-based system of care, and establishing a financing mechanism to maintain quality care in these facilities;
- Addressing the needs of the growing numbers of individuals in state institutions with past forensic involvement, and establishing suitable options for community placement when appropriate.

The omission of some recommendations from the department's initial implementation plan does not, by any means, diminish the significance or importance of these proposals. Rather, the selective implementation approach is a simple concession to the limitations of capabilities, resources and time, and an acknowledgement that some matters require immediate attention.

Other system stakeholders may disagree with the priorities established by the department. DCH looks forward to a dialogue with interested parties regarding the items selected for inclusion in this initial implementation plan.

STRATEGIES FOR SUSTAINABLE TRANSFORMATION

The concept of transformation implies an intention, process and effort to realize a vision and/or an actuality that is manifestly different from the current state of affairs. While the Commission's Final Report offered a vision of a transformed mental health system, full realization of this vision will take many years and will require enhanced departmental capabilities, augmented funding, expanded service capacity, infrastructure investments, and regulatory developments.

The principal challenge in formulating this first 12-month implementation plan has been identifying methods to *initiate* system transformation *within* the constraints of existing capabilities and funding limitations, and *without* imposing new mandates that would be unrealistic and unattainable, absent additional resources.

To facilitate transformation, the department plans to employ a variety of strategies to establish a culture of cooperation and "co-development", foster a climate of innovation and experimentation, encourage re-engineering and system redesign efforts, promote participation, and stimulate formation of practical partnerships to extend transformational capabilities.

Applying these strategic concepts to the department's implementation plan means that:

- For recommendations related to controlling variance, establishing standards, reducing role confusion, clarifying procedures, implementing recommended practices, ascertaining information infrastructure needs, shaping quality improvement strategies and revising performance measures, the department will convene and direct workgroups (with broad stakeholder participation) to collaboratively perform selected clarification, standard-setting, and criterion development tasks.
- To promote service innovations, enterprise redesign or to pilot complex system change, the department will offer fiscal incentives or seed funding (e.g., federal block grant dollars, etc.) to willing organizations and communities to implement certain practices, formulate models of improved coordination, devise shared service protocols, explore integrated treatment and/or cross-system care approaches (e.g., children's services; joint behavioral healthcare purchasing; mental health/criminal justice interface improvements; primary health/mental health integration; co-occurring disorders; CMHSP regionalization; etc.).
    - These entities or communities, if successful, may then become *"**benchmark**"* or *"**best-practice**"* sites/organizations, recognized by DCH as centers of excellence for certain practices, services, processes or integrative activities. The experience of these communities or entities will be disseminated to other communities and organizations around the state that wish to emulate the benchmark sites.
- For certain recommendations, particularly those that involve enhanced public education efforts, expanded screening and health promotion activities, the application of new approaches (e.g., disease management models) to care, dissemination of certain practices, and establishment of new entities (e.g., mental health institute), the department will pursue participation and financial support from private foundations, philanthropic organizations, and other suitable partners.
- Recommendations that require enhanced collaboration or joint policy development among multiple state agencies will be addressed initially through the Interdepartmental Directors meetings. The Directors, at their discretion, may establish small interagency workgroups to address specific policy and technical issues related to mental health reform.

- Transformation efforts and activities should revolve around the participation, needs, preferences and plans of the person (consumer) and his/her family (essential for children) or circle of support.

SUMMARY

The department's initial implementation plan is meant to be a living document, updated as conditions change and as experience with transformation accumulates. Modifications will be considered in response to stakeholder comments and suggestions.

The department will publish a timeline detailing when specific implementation activities will commence, key milestones in the implementation process and projected completion dates.

Finally, this is an *initial 12-month implementation plan*. DCH intends to revise and reissue an updated implementation plan in subsequent years to retain the momentum for transformation.

PROPOSED IMPLEMENTATION PLAN FOR SELECTED COMMISSION RECOMMENDATIONS

Goal 1: Public Awareness

Recommendations	Implementation Activities
1. Create a continuing public education campaign.	• DCH will work with the Governor's Office to plan and convene the proposed summit, and to solicit financial support from interested groups, organizations and foundations to underwrite the costs of arranging and conducting the initial organizing meeting and partnership planning. • DCH and CMHSPs will collaborate on anti-stigma and public education efforts by developing common promotional and informational materials and articulating common themes in public information messages and media interviews.
4. Michigan's Surgeon General should lead the implementation of the draft Suicide Prevention Plan of the Michigan Suicide Prevention Coalition.	• DCH will request the assistance of the MDCH Advisory Council on Mental Illness to review the draft Suicide Prevention Plan produced by the Coalition, and to work with the Coalition to produce materials for the Surgeon General to use in promoting implementation of the plan. • DCH will require every CMHSP to establish and report on its Suicide Prevention and Response Plan as part of the annual program plan and budget submission cycle.

Goal 2: Priority Populations and Early Intervention

Recommendations	Implementation Activities
6. Hierarchy of choice: The legislature should amend the Michigan Mental Health Code and the Estates and Protected Individuals Code (EPIC), MCL 700.1, to simplify the assessment of persons who may need mental health services and assure care more quickly.	• Recently enacted statutes have already established assisted outpatient treatment and psychiatric advance directive options, and DCH is developing information on the legislation for CMHSPs and the public-at-large. • The Office of Recipient Rights (ORR) will convene a workgroup to determine the advisability of seeking statutory change to allow guardians to petition the court for authority to consent to voluntary inpatient hospitalization without the individual's assent.
7. Clarify assessment for people needing treatment.	• DCH, in conjunction with the State Court Administrative Office, will send out a technical assistance bulletin to CMHSPs, hospitals, physicians, psychologists, psychiatrists and courts calling attention to the fact that any of the three criteria (a, b, or c) in section 401 are sufficient grounds for asserting (or certifying) that the individual is a "person requiring treatment" and in need of involuntary mental health treatment.
8. MDCH should (a) implement uniform screening and assessment for priority populations, as well as all other populations, and uniform operational definitions and service selection guidelines statewide for individuals eligible for public mental health treatment and support service and (b) expand the system's capability for serving individuals with previous mental illness and mild and moderate disorders. a) "Enhanced access" status b) Crisis stabilization c) Coordination assistance	• DCH will develop information for PIHPs, CMHSPs, provider organizations, and consumers and families clarifying system access standards, eligibility considerations, service obligations, coverage determination decisions, and relevant appeal mechanisms. • DCH will work with the MDCH Advisory Council on Mental Illness and other stakeholders to review available methodologies and to select an approach – to be used by all CMHSPs – for assessing, determining and certifying that an applicant seeking services is serious emotional disturbance (SED) or serious mental illness (SMI). Several states already have such certification criteria for both children (SED) and adults (SMI). Such certification will not, however, confer "enhanced access" status as proposed by the Commission, since there is no legal or regulatory basis for such a designation. • DCH will issue a technical assistance letter advising CMHSPs of their crisis and emergency intervention service obligations as specified both in Code and Administrative Rule (R 330.2006). CMHSPs must have a 24-hour telephone line for mental health emergencies, the capacity to conduct face-to-face interventions when necessary, a preadmission screening unit for hospitalization requests, and the ability to arrange a variety of possible dispositions (inpatient hospitalization, respite care, referral to a Domestic Violence Shelter, etc.) for any given crisis situation. The letter will also clarify PIHP crisis and post-stabilization responsibilities. • DCH will review available mental health assessment tools for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and will recommend modifications of MSA's EPSDT policy regarding screening instruments.

	• A provision requiring CMHSP access systems to provide information, referral and coordination services will be proposed for inclusion in the master contract for FY 06. • DCH will convene a meeting with the Michigan Primary Care Association and the Michigan Association of Community Mental Health Boards to identify current coordination efforts between Federally Qualified Health Centers and CMHSPs and identify opportunities for enhancement of existing arrangements. Information and suggestions gleaned from this meeting will be disseminated to the Community Health Centers and CMHSPs. • DCH will collaborate with the MDCH Advisory Council on Mental Illness and other affected parties to update the existing Service Selection Guidelines (SSGs). However, the revision (for regulatory and contractual reasons) will be less extensive than the modifications suggested by the Commission.

Goal 3: Model Service Array

Recommendations	Implementation Activities
10. MDCH, in cooperation with other state departments, should establish a clear policy and timetable to have in place a comprehensive, high-quality statewide service array that will increase the volume of appropriate services and improve quality of care; give consumers and families increased confidence in the system's ability to respond effectively to recipients' requirements; and position Michigan as an exemplary state for national emulation.	• Given current fiscal constraints, the state cannot assure that all elements of the recommended expanded/comprehensive continuum will be available everywhere according to a set timetable. Nor can the state commit to capacity expansion of existing services and programs to ensure greater access to those components for individuals who currently are not receiving these services (or experiencing limitations in services). • DCH will review existing PIHP and CMHSP services, to ensure that minimum statutory service components exist in each CMHSP, and that required Medicaid specialty services are available in every PIHP. • DCH will also undertake an examination of possible means for creating or expanding capacity for certain service components (e.g., independent living, supported housing, secure residential, supported employment, jail diversion services, prisoner re-entry, etc.) that are critically needed and in limited supply. In promoting the creation or expansion of such services, DCH will consider the use of CMHSP carry forward and Medicaid savings.
14. Individuals anywhere in the state should have access to inpatient psychiatric or secure residential treatment when appropriate and as close to their residence as possible.	• The recommendation that needed inpatient care is available close to the recipient's residence is consistent with departmental preferences. All CMHSPs have contracts for inpatient care provided through the psychiatric units of general hospitals, which generally afford access to hospital care close to the recipient's home location (except, perhaps, in the more rural areas of the state). • The development of small regional public psychiatric hospitals is a long-term goal and cannot be achieved in the near term. • DCH has established an internal "State Hospital Improvement Project" (SHIP) to examine the current condition of the facilities, future bed needs, capital and infrastructure improvements, workforce development issues, and the possibility of establishing more regional capacity. DCH will eventually expand membership on SHIP to include CMHSPs and representatives of other stakeholder groups. • Another part of the charge of the SHIP group will be to examine the growing numbers of patients within state facilities with past or present forensic involvement, assess any special issues and needs these patients present, determine necessary community placement settings and arrangements, and evaluate any changes that should be proposed to Chapter 10 of the Mental Health Code. • DCH will ask the MDCH Advisory Council on Mental Illness, in conjunction with ORR and Michigan Protection and Advocacy, to examine the feasibility and advisability of establishing small, secure residential treatment facilities. In pursuing this examination, DCH will request technical assistance from FIA regarding licensing changes necessary for the establishment of such facilities.

17. The state should create a mental health institute to develop evidence-based practices and research at both the community and state level, supporting implementation of the model array of high-quality services.	• DCH will solicit support from foundations and other philanthropic groups for research regarding how such an institute might be formed, chartered, incorporated, capitalized, organized, funded and managed.
18. Strengthen the MDCH quality management system, building on the mission-based performance system and other existing quality management endeavors, so that it better integrates compliance and quality measures, which the department should set with input from consumers, PIHPs, CMHSPs, and providers.	• The department has already begun strengthening the DCH quality management system with the revamping of the Quality Improvement Council (QIC), which has a broad-based membership of consumers, advocates, CMHSPs, providers, and university representatives. The QIC is currently reshaping quality improvement strategies, assessing modifications to existing performance measures and monitoring national efforts to adapt the findings of the landmark study, *Crossing the Quality Chasm*, to behavioral health.
19. Michigan's public mental health system should be supported by a Web-based information infrastructure, beginning with a simple system and slowly improving it using feedback from stakeholders.	• DCH will solicit financial support from private sources to underwrite a review of information-related infrastructure needs. In conducting this review, DCH will consult with the Department of Information Technology and with the Chief Information Officers (CIOs) of CMHSPs, Coordinating Agencies and provider groups.
20. Michigan's interagency approach to prevention, early intervention, and treatment for children should be strengthened.	• DCH, along with FIA and DOE has already undertaken an initial step to reinvigorate early intervention activities and collaboration, through a conference (sponsored by multiple organizations) in January 2005. • DCH is also working with FIA and local agencies on a federal waiver to improve services for certain high-risk youth. The Interdepartmental Directors have endorsed this approach. • DCH will encourage PIHPs to use Medicaid savings for expansion/enhancement of prevention and early intervention services (Medicaid "community reinvestment" plans submitted by PIHPs). • DCH also proposes to award federal block grant funds to selected communities committed to examining and solving obstacles that have hindered the expansion of coordinated systems of care for children (e.g., legal barriers, statutory mandates, funding limitations, cost allocation methodologies, etc.). The department will assist these communities by coordinating their efforts with ongoing national efforts (e.g., Service Integration Network, NGA Center for Best Practices/Cross System Innovation Initiative, etc.). • DCH, in conjunction with FIA, will solicit volunteer counties (CMHSPs and FIA) to pilot joint purchasing of behavioral health care services for children and families. • DCH will solicit assistance from the National Technical Assistance Center (NTAC) to assess what is being spent on mental health services across state departments. This information will serve as a starting point for comprehensive estimates or projections of the mental health needs of Michigan's children and families.

Goal 4: Diversion

Recommendations	Implementation Activities
26. The legislature, the executive branch, the judiciary, and law enforcement should require effective and measurable, evidence-based pre- and post-booking diversion programs, including formalizing the shared legal duty of CMHSPs, law enforcement, and jails for diversion by revising law to include "diversion from the juvenile justice system" and expanding mental health and drug courts throughout the state.	• Instead of utilizing a regulatory regimen (which will be difficult to apply and fund at this time), DCH will approach implementation of this recommendation by encouraging and incentivizing local collaboration and community ownership, and by leveraging and expanding "social capital" (i.e., familiarity, interactions, and trust among local actors) that exists in many communities. o DCH will promote and utilize the *Criminal Justice/Mental Health Consensus Project Report* as a blueprint for local reform. DCH believes that with the adoption and application of this Report, significant changes could be incrementally implemented in mental health programs, law enforcement, the judiciary and corrections. o Collaborative community models for juvenile justice – mental health coordination are also being developed by various groups (e.g., National Policy Forum for Mental Health and Juvenile Justice, etc.) or being tested in other states. • DCH will use its federal block grant allocation to fund several local collaborative pilot projects that agree to employ the Consensus Project Report (or, for juveniles, piloting or replication of a developed/established program model) as the basis for the project effort.
27. Joint training should be ensured across CMHSPs, first responders, service providers, law enforcement, defense attorneys, prosecutors, judiciary, corrections and probation officers on the implementation of established and required pre- and post-booking diversion programs throughout the state.	• DCH will highlight and publicize information about local communities ("benchmark" or best-practice communities) that are already doing an exemplary job in training, and provide them with funding (via the federal block grant or some other source) to act as a "technical assistance center" to disseminate their training methods, curriculum, interagency agreements, etc., to other communities.
28. State and local law enforcement, including police, corrections, and judicial authorities, and the MDOC should ensure screening and assessment for mental health at their point of entry, booking or reception for children and adults, and at first contact with the juvenile and criminal justice systems.	• DCH will determine if relevant professional associations (e.g., Michigan Sheriffs' Association, Juvenile Justice Association, Michigan Juvenile Detention Association, Michigan Association of Community Mental Health Boards, Michigan Association of Substance Abuse Coordinating Agencies, etc.) and/or private philanthropic organizations might be willing to underwrite the cost of a project directed toward surveying current assessment tools used by law enforcement, jails, detention facilities and corrections, and identifying preferred common screening protocols and assessment tools.
29. The legislature should clarify responsibility for the provision of mental health diversion services where the "county of crime" is not the "county of residence" by directing that the CMHSP 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.	• It is not clear that legislation is needed to clarify responsibility for the provision of mental health diversion services where the county of crime is not the county of residence. Attorney General Opinion No. 6365 sufficiently establishes that "…county responsibility to provide access to community mental health services is based on 'location' of the person relative to the service and not on 'payment' for the service from whatever source."

30. The transition from detention or incarceration to community-based treatment and services should be strengthened by initiating pre-release programming at the point of reception or intake, and training for release supervisors on what to expect from mental health clients. Pre-release planning should address the person's mental health and other needs.	• The Department of Corrections (DOC) Prisoner Re-Entry Initiative is addressing multiple aspects of re-entry, including coordination with local agencies for mental health and substance abuse services. The Initiative plans to fund pilot programs for Corrections-CMHSP re-entry collaboration. • The Report of the Re-Entry Policy Council (from the Council of State Governments, 2004) - which has numerous recommendations related to mental health services - will also be disseminated to all CMHSPs.

Goal 5: Structure, Funding, and Accountability

Recommendations	Implementation Activities
31. Create a true mental health system through a structure that better clarifies and coordinates state, regional, and local roles, responsibilities, and accountability for services to persons with mental illness and emotional disturbance. Such a structure should consist of (a) state leadership, with input from all stakeholders, to improve and enforce statewide standards for administration, performance (see below), and eligibility determination; (b) regional coordination of functions that include, but are not limited to, health plan-like administrative and information infrastructure; reporting and quality programs; assurance of equitable access to services; and shared components of some clinical services that would offer economies of scale without sacrificing access; and (c) preservation of local control, including CMHSP application of eligibility criteria and assessment of needs and service delivery. The state should develop a specific plan for regionalization of appropriate mental health system functions in the next two years.	• DCH will convene a meeting, within the next three months, with regional affiliations, CMHSPs, provider network representatives and other stakeholders to identify and discuss various roles, functions, activities and responsibilities among these various levels and participants. • The public mental health system will always be, to a significant degree, a decentralized system. The important structural issue confronting the system currently is determining what level (state, region, local, provider agency) within this decentralized system should perform particular functions and activities. Role confusion is most pronounced in the interface between regional consortiums, local CMHSPs and community provider networks. The primary objective of a DCH-sponsored "summit" on structural issues will be to achieve consensus regarding functions that can best be done through regional consortiums (due to scale and scope considerations), activities (community planning, local service delivery system configuration, community service integration initiatives) that should remain the primacy of local CMHSPs, and what responsibilities might be delegated to provider networks. • This "consensus framework" on the appropriate distribution of roles, functions and responsibilities will serve as the basis for the required plan for regionalization. • DCH will promote greater uniformity in PIHP/CMHSP contracts with providers, particularly those that contract with multiple PIHPs and CMHSPs.
32. The state should offer financial incentives to counties that coordinate and streamline the regional functions described in the previous recommendation.	• Section 308 of the Code provides financial incentives for CMHSPs to merge, but there is currently no basis in statute for financial inducements for CMHSPs to combine or consolidate certain administrative functions outside of a merger. Financial inducements (incentives) could be added to Section 204b of the Code, which deals with the formation of Regional Entities, and DCH will propose legislation amending this section of the Code.
33. Invest more resources for MDCH to (a) continue setting standards for payment, performance, and other administrative functions (billing, computer systems) and (b) provide training in these areas so that accountability is achieved without micromanagement.	• Given the continuing contraction (due to the budget situation) of DCH administrative resources, the intent of this recommendation (standard setting) can only be achieved through a collaborative "work group" process between DCH, PIHPs, CMHSPs and provider organizations. DCH has already commenced such work group activities, addressing standards for various areas (administrative activities, costing methodologies, performance monitoring, etc.). • If satisfied with the results/products of the work groups, DCH will endorse and disseminate the standards, and provide statewide training on their application.

34. The state should set a range for acceptable administrative costs for PIHPs, CMHSPs, and providers. In addition, PIHPs and CMHSPs should be required to report to MDCH all financial information, including employee salaries and fees to contractors such as consultants and attorneys, so that the department can effectively monitor adherence to the established standards.	• DCH is already working with PIHPs and CMHSPs (through the so-called Encounter Data Integrity Team **[EDIT] Group**) to standardize cost allocation methods and to establish a range of acceptable administrative costs. Sorting out administrative activities associated with managing Medicaid services (PIHPs), general CMHSP administrative costs (related to general fund activities and functions required under state law), and program or provider administrative costs have been the most difficult aspects of the endeavor. • DCH will collect additional CMHSP fiscal information for analysis, comparison and publication.
35. Amend the Mental Health Code to strengthen MDCH enforcement. MDCH currently has little recourse when CMHSPs or PIHPs fail to meet statutory and contractual requirements.	• In regard to strengthening enforcement capabilities, DCH has already discussed with the Governor's Legislative Director the need for legislation, amending the Mental Health Code, to give the department the power to take enforcement action against a CMHSP or PIHP while administrative appeals are pending.
36. Strengthen the role of the current MDCH medical director of mental health so that s/he becomes the leader in the development and adoption of evidence-based practice in the mental health system.	• DCH is in the process of revising the job responsibilities and role of the director of the Office of Medical and Psychiatric Affairs (within the Mental Health and Substance Abuse Administration). Staffing shortages hamper the activities of the Office, and this is unlikely to be resolved within the next 12 months • The department has already established an initiative to identify, select and implement evidence-based practices (EBPs) in the public mental health system, consistent with the Commission recommendation in this regard. However, due to personnel constraints, this effort is not currently being led or directed by the DCH Office of Medical and Psychiatric Affairs. Rather, a broad-based steering group – composed of DCH staff, consultants, university researchers, CMHSPs and provider groups has been formed and is meeting on a regular basis to review EBPs and select practices for system-wide dissemination. • DCH has indicated to CMHSPs that it plans to mandate the use of two EBPs (specifically, certain EBPs published by SAMHSA) in FY 06. The department is also working with a project team established by the Flinn Foundation, to select sites to pilot implementation of the Michigan Medication Algorithms. • The Commission's suggestion that all services and programs supported by public funds be assessed to determine whether they comport with scientific/evidentiary standards (which has been mandated in certain states), and that financial rewards be established in the future for use of EBPs may be premature. There is currently a lively professional debate (see Health Affairs, volume 24, number 1) over the wisdom of such proposals. • The Commission has also proposed that Michigan incorporate into its "quality improvement plan" evidence-based and experientially based "best practices" for treating children in the child welfare and juvenile justice system. The EBP steering committee (convened by DCH) will review available best practices for clinical and system interventions for treating children in the child welfare and juvenile justice systems, and recommend practices for implementation in selected sites. • As noted previously, DCH intends to fund pilot agencies/communities to implement best practices in cross-system collaboration and shared service modalities.

	• Due to federal stipulations (Balanced Budget Act of 1997) and earlier state directives, Michigan already has a standardized quality improvement system throughout the CMHSP system. That system, and state monitoring activities, will be adapted to include a review of adherence to established clinical practice guidelines.
37. Expand the charge of the current MDCH Advisory Council on Mental Illness to assist the MDCH director and the governor with implementation of the commission's recommendations. The MDCH director should appoint advisory council members.	• DCH has already met with the DCH Advisory Council on Mental Illness to apprise them of our implementation planning efforts thus far, and Advisory Council involvement is included as a key component for achievement of several recommendations in the DCH implementation plan.
38. By January 2006, MDCH should issue a progress report on outcomes related to recommendations 31–36. For recommendations that have not been achieved, the report should specify a timetable for completion.	• DCH will provide (by January 2006) a progress report on its efforts to promote structural changes, CMHSP consolidation, service delivery models and options, and any needed legislation regarding structure, governance, functions and operations of the CMHSPs.
39. The governor and the legislature should adopt a new funding strategy for services to state residents with mental illness and emotional disturbance. a) Dedicated state funding b) Use of federal funds c) Budget policy d) County matching funds e) Private funds	• This series of recommendations is addressed primarily to the Governor and the Legislature, and entail extended deliberation and incremental change. • DCH will examine feasibility (and costs) associated with the Commission's suggestion that DCH expand Medicaid eligibility (using certain disability-related eligibility pathways), so that some consumers now served solely with general fund appropriations can qualify for Medicaid-supported specialty services. • The Department of Management and Budget has already issued a Request for Proposals (RFP) related to methods for maximizing federal financial participation. • DCH is planning for the renewal of the state's concurrent 1915(b)/1915(c) waivers (both are up for renewal this year) to maintain Medicaid services and funding for specialty care.
42. Payment for mental health services should be driven by incentives for delivering high-quality care, which is the model toward which physical health has been moving in recent years.	• The concept of rewarding quality and high performance is worthy of consideration, and DCH is examining whether a model of performance pay used with Medicaid health plans could be adapted to the mental health system.
43. Develop specific sustainable models of collaboration at the state and local levels. Maximize resources earmarked for providing mental health services across all public agencies.	• The Commission gave recognition to the difficulties of coordinating the efforts of the formal public mental health system with the mental health-related activities, programs and expenditures of other state agencies (OSA). The President's New Freedom Mental Health Commission acknowledged the need for more comprehensive state mental health plans, and the National Association of State Mental Health Program Directors (NASMHPD) has published a position paper describing a framework for comprehensive state mental health systems. New Mexico has implemented a collaborative interdepartmental behavioral health purchasing initiative. • As indicated previously, DCH will solicit assistance from the National Technical Assistance Center (NTAC) to develop models/protocols for assessing/estimating what is being spent on mental health-related services across state departments.

	• DCH will review possible methods for coordinating the mental health-related programs and expenditures of other state agencies with the activities of the public mental health system, and provide recommendations to the DCH director for implementation.
45. The director of the state Office of Recipient Rights should report directly and solely to the director of MDCH (requires a state Mental Health Code revision).	• The basis for having the director of ORR report directly to the DCH director is already established in Code. Section 754 states: "…the department shall establish a state office of recipient rights subordinate only to the director of the department." However, Governor Engler, in Executive Order No. 1997-4, did authorize the DCH director to delegate the "duty" to oversee ORR and supervise the director of ORR. • Since this delegation is permissive (i.e., the director is not required to delegate the duty) the DCH Director will reassume direct supervision of the director of ORR.
47. The designated appeals division within MDCH for Medicaid Fair Hearings should also oversee a corresponding hearing process for non-Medicaid CMHSP recipients and applicants, also including a required clinical consultation component.	• DCH will work with the MDCH Advisory Council on Mental Illness to explore possible discretionary state level appeal mechanisms for certain CMHSP actions (e.g., second opinions for hospitalization or admission to service, etc.).
48. To further strengthen accountability for rights protection, the recipient rights portion of the state's Mental Health Code should be amended.	• This series of recommendations requires legislative action. DCH will convene a meeting of stakeholders (DCH ORR, CMHSPS, advocacy organizations, consumers, families, etc.) to assess possible consensus recommendations for legislative change.
50. The state rights office, in collaboration with local rights offices, should review and revise 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, in order to make these materials more user-friendly, culturally appropriate, and uniform across the state.	• DCH ORR (in conjunction with local CMHSP rights offices) will initiate a review of existing forms, handouts, brochures, booklets and other materials, to improve the quality, cultural appropriateness and uniformity of such materials.
51. The state and local rights offices should engage in education, training, evaluation, and assistance to primary and secondary mental health consumers in navigating the public mental health and other human service systems.	• DCH ORR will convene a meeting with local 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.
52. MDCH should lead a review and revision of recipient rights policies to ensure culturally competent practices sensitive to ethnic, racial, economic, disability, sexual preference, and gender differences.	• DCH ORR (in conjunction with local CMHSP rights offices) will undertake a review of existing rights policies and recommend revisions to improve culturally competent practices that are sensitive to ethnic, racial, economic, disability, sexual preference, and gender differences.

Goal 6: Service Integration

Recommendations	Implementation Activities
57. MDCH should promote and facilitate efforts to create collaborative models to integrate and coordinate mental health services with primary health care and broadly disseminate the results for implementation.	• There are already a number of collaborative/integrative primary health/mental health care projects throughout the state, several of which were highlighted at a recent conference on this topic. DCH will work with the Michigan Primary Care Association, the Michigan Association of Community Mental Health Boards and the Michigan Association of Health Plans to identify and publicize existing initiatives and projects. DCH also proposes to utilize block grant funding in selected sites to explore methods for improving and/or increasing integrated approaches for disabled populations.
58. MDCH should develop a plan to reduce barriers to treatment for people with co-occurring disorders, with a focus on integrating the care provided, perhaps through consolidation of regional and community substance abuse and mental health services and the development of plans to implement model programs.	• DCH has multiple activities (Co-Occurring Disorders Policy Academy; Evidence-Based Practice Initiative) directed toward promoting integrated treatment models. • DCH will require implementation of SAMHSA's Integrated Dual Disorders Treatment approach (an EBP) for FY 06. The department will also explore and report on possible incentives to encourage voluntary coordinating agency and CMHSP consolidation.
60. MSHDA should consider expansion of the Housing Trust Fund to address housing issues of individuals eligible for community mental health services, leveraging additional funding from Community Developmental Financial Institutions of the U.S. Department of Treasury for such strategies as enhancing opportunities for home ownership or to make permanent supportive rental housing more affordable.	• DCH will work with MSHDA to determine the feasibility of this recommendation. • DCH will provide information and technical assistance to CMHSPs regarding "best practices" in establishing and sustaining housing options for persons with mental illnesses and/or developmental disabilities.
61. MDCH should use SAMHSA's Blueprint for Change to work with CMHSPs and other local community agencies to implement appropriate programs and supports to address homelessness among individuals with serious mental illness.	• DCH will inform these agencies of the existence of the publications (available for download from SAMHSA), and will arrange a presentation on the material at the fall conference of the Michigan Association of Community Mental Health Boards. • DCH will pursue federal grant opportunities to support efforts/projects/initiatives that address homelessness among persons with serious mental illness.
62. MDCH should promote compliance with the Americans with Disabilities Act (ADA) to reduce barriers to housing, education, and employment and facilitate recovery. 63. MDCH should promote compliance with the Michigan Persons with Disabilities Civil Rights Act (1990 P.A. 220) and work with the Michigan Department of Civil Rights to assure enforcement of its tenets to assist persons with mental illness to secure housing, education, and employment and facilitate recovery.	• DCH is already involved in promoting compliance with the ADA and Michigan statutes related to the civil rights of persons with disabilities. DCH – through ORR - will strengthen its interface with the Department of Civil Rights, to assure reporting and investigation of complaints and enforcement efforts.

65. All CMHSP programs serving adults diagnosed with a serious mental illness should offer supported employment services.	• Michigan was an early leader in promoting supported employment, but state technical assistance in this area has waned over the past several years, with the loss of personnel dedicated to this program. SAMHSA'a publication of a toolkit for implementing evidence-based supported employment services has reawakened interest in applying this intervention, and CMHSPs will be encouraged to utilize this EBP model. • DCH will publicize existing approaches (e.g., transitional employment, supported employment, job-sharing, Fairweather Lodge, etc.) to increase employment for persons with serious mental illnesses, and require enhanced descriptions from CMHSPs (in the annual plan and budget submission cycle) on methods being used in their service area. • DCH will highlight each CMHSP's accomplishments on employment in the Performance Indicator Report. • Under the state's Medicaid specialty services waiver, supported employment is a covered "additional" service.

Goal 7: User Involvement

Recommendations	Implementation Activities
69. MDCH should develop and require implementation of a formal mechanism to utilize service recipient and family feedback on user satisfaction and outcomes in an ongoing quality assurance process.	• DCH already requires CMHSPs to solicit, evaluate, and utilize recipient and family feedback on services and outcomes, and DCH site reviewers meet with consumers and family members as part of the DCH site reviews. • DCH will propose greater consumer and family participation on local quality improvement teams and councils, and in performance improvement projects. • To promote the concepts of recovery (adults) and resiliency (children and families), DCH will propose modifications to satisfaction/feedback survey and interviews, to include the recipient's (and/or family's) perspective on whether recovery/resiliency has been the core paradigm or framework for service delivery and supports orientation.
70. MDCH should require service providers to formally offer and strongly encourage the establishment of advance psychiatric directives; directives should ideally include consumer preferences regarding release of records to family, domestic partners, or agents named in the directive in the event of death, and in the absence of any preference, records should be available to closest surviving family member(s).	• Now that legislation on advance psychiatric directives (APD) has been enacted, DCH (Mental Health/Substance Abuse Administration) will take the lead in publicizing the legislation, educating consumers and promoting the use of APDs.