

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

(FY2010 Appropriation Bill - Public Act 131 of 2009)

**April 15, 2010**

**Section 458:** By April 15 of the current fiscal year, the department shall provide each of the following to the house 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 non-serious 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  
FY2010 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*.

The Michigan Department of Community Health (MDCH) through the Mental Health and Substance Abuse Administration (MHSA) has focused on the overarching goal of Transforming Michigan's Mental Health System as well as implementing the seven goals outlined in the plan. In order to continue the transformation of the public mental health system, the Application for Renewal and Recommitment (ARR) and the Program Policy Guidelines (PPG) were implemented and continue in FY10.

In August 2008, MDCH issued a concept paper that outlined directions for future specialty services and supports program improvements. The paper addressed improving the culture of systems of care, assuring active engagement, supporting maximum consumer choice and control, expanding opportunity for integrated employment, treatment for people in the criminal justice system, assessing needs and managing care, improving the quality of supports and services, developing and maintaining a competent workforce, and achieving administrative efficiencies. The paper was followed by the issuance to Prepaid Inpatient Health Plans (PIHPs) in February 2009 of an "Application for Renewal and Recommitment" (ARR) that builds on the 2002 Application for Participation (AFP). While the AFP was primarily based on compliance with the Balanced Budget Act and other regulatory requirements, the ARR is based on a quality improvement model for the process of delivering supports and services, the environment in which they are delivered, and their outcomes for Medicaid beneficiaries. In addition, the ARR provides clear direction that PIHPs must increase the volume and quality of stakeholder involvement in all aspects of their organizations. PIHPs submitted responses to the ARR June 1, 2009 that described the results of their local "environment scans" on how well they were achieving each of the eleven areas noted above, as well as plans for improvement with milestones and timeframes. MDCH teams have reviewed the responses and have conducted conference calls with the PIHPs. These teams will follow each PIHP over the next several years as they implement their plans for improvement and provide technical assistance and consultation.

MDCH also issued in February 2009 a set of "program policy guidelines" (PPGs) to the 46 Community Mental Health Services Programs (CMHSP). The PPGs also were

based on the August 2008 concept paper, but focused specifically on building systems of care for children, improving the quality of life for people with developmental disabilities, administering the Recovery Enhancing Environment (REE) instrument with adults with serious mental illness, and increasing access to self-determination and independent facilitation of person-centered planning. CMHSPs submitted requested data on these elements to MDCH where they will serve as baselines from which to measure progress and to PIHPs where they were used in the environmental scans described above.

*During FY2010 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. In addition, 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 a statewide 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 the outcomes achieved

The focus of the committee is 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 June 11, 2009 and meetings have continued monthly since that time. The committee has found that the uniqueness of each community makes it difficult to find one tactic that works for everyone. As a result, they have determined to focus their current efforts on creating a resource guide or toolkit for Community Mental Health Services Providers (CMHSP) to use with staff, contractors, etc., to address stigma within their local systems. This guide will give CMHSPs resources and options on how to:

- Identify stigma in their systems
- Use interventions to address stigma in their systems. It will provide examples of interventions that have been effective elsewhere.
- Measure the effectiveness of these interventions

The resource guide will take a strength based approach and will help CMHSPs embrace recovery, therefore eliminating stigma. The committee is also developing a plan to

insure that CMHSPs are accountable for using the tools provided to eliminate stigma in their local systems.

Additional MDCH initiatives on anti-stigma included the MI Recovery Council and MI Recovery Center of Excellence with its mirecovery.org website

Michigan has trained and certified over 700 Certified Peer Support Specialists (CPSS). The CPSS workforce is instrumental in providing public awareness in support of MDCH anti-stigma efforts. Peer specialists serve on local and regional anti-stigma committees serving as expert resources. A large proportion of CPSSs attends and presents at regional, statewide and national conferences sharing their story of recovery. Several CPSSs have played an important role in developing and presenting perspectives on anti-stigma through recording and publishing several DVDs. Two of the DVDs highlighting peer specialists have received awards by SAMHSA.

**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 received additional federal youth suicide prevention funding to provide grants to eight local sites for implementation of youth suicide prevention activities. Since the state plan was adopted, approximately 2/3 of Michigan communities report that they have convened a suicide prevention group to develop a local suicide prevention plan or are in the process of implementation of their plan (per recommendation #2 of the state plan). Implementation efforts range from promotional activities (public service announcements, billboards to promote awareness of mental health issues) to post-vention activities (Survivor of Suicide Groups) in communities.

The fourth community suicide prevention workshop will be held in May 2010. The workshop brings together community members (parents, professionals) to learn new techniques in planning, programmatic development and evaluation of youth suicide prevention activities.

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 sponsor a second statewide conference in the fall of 2010. The first conference, held in 2008, was attended by mental health professionals, parents, and community representatives from around the state.

## **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 FY'09 MDCH/PIHP and CMHSP contracts. An accompanying technical guidance has been developed and, along with a core training curriculum, 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. In FY10, Eligibility Criteria for Children with Serious Emotional Disturbance were added to the Department of Community Health contract with the CMHSPs and PIHPs. This criteria was contained in a Technical Advisory that was developed and distributed to the field in FY08 and delineates eligibility criteria for children birth through 3 years, 4 through 6 years and 7 through 17 years of age.

### **Goal 3: Model Service Array**

**Evidence-based Practices and Promising Practices.** Consistent with federal transformation goals, the MDCH has dedicated Mental Health Block Grant funds to support practice improvement for adults and children. As of October 1, 2009 all PIHPs are required to offer two of the SAMSHA endorsed evidence-based practices as a choice for adults with serious mental illness: Family Psychoeducation and Integrated Treatment for Persons with Dual Mental Health and Substance Use Disorders. The Field Guide (technical assistance manual) for Assertive Community Treatment (ACT) has been used widely across the state in a quality improvement initiative designed to improve ACT services. Two evidence-based practices for children: Parent Management Training Oregon (PMTO) Model and Trauma Focused Cognitive Behavior Therapy (TFCBT) are being implemented in a number of CMHSPs. Most all of the 46 CMHSPs have clinicians trained or in training for the PMTO and 16 CMHSPs have clinicians trained or in training for the TFCBT. Michigan now has over 700 certified peer support specialists. Training and support for supported employment, motivational interviewing, and dialectical behavior therapy continues.

The Practices Improvement Steering Committee (PISC) is working to update its charter to address its role in relation to the current status of evidence-based practice implementation and other work to improve practices. A primary focus of the group is to address sustainability and fidelity to the model for those practices being implemented across the state. PISC Subcommittees include Measurement, Family Psycho-education, Parent Management Training –Oregon Model, Assertive Community Treatment, Co-occurring Disorders: Integrated Dual Disorder Treatment, and Supported Employment.

At the regional level, each PIHP has an Improving Practices Leadership Team (IPLT) which oversees its system change work to continually improve the type and quality of services which are available to adults and children served in the public mental health system. The IPLTs are also responsible for the implementation of evidence-based practices within the region, including any affiliate CMHSPs.

The Michigan Mental Health Evidence Based Practices (MiMHEBP) initiative has completed phase II of its plan to develop and disseminate psychotropic prescribing algorithms for major psychiatric disorders. Phase III, with continuing funding from the Flinn Foundation, involves development of a software module that can stand alone or operate within an established electronic medical record to guide prescribers through algorithms and to record data essential to the medical record. The Flinn foundation has

issued an RFP for software development of this module, which will be based upon a prototype developed by Michael Fauman, M.D., Ph.D.

**Supports and Services for People with Dementia and their Caregivers.** A model of Wraparound for adults with dementia and their caregivers has been developed through Administration on Aging and Mental Health Block Grant (MHBG) funds, and three MHBG programs are continuing with enhancements. An initiative to identify and procure sustained funding and reimbursement for Wraparound services is continuing, based on elimination of General Fund (GF) and MHBG funding.

MDCH is providing resources (curriculum, competencies guide and other materials), technical assistance, and regional educational forums for mental health, aging, and long-term care professionals, the latter through MHBG funding on dementia care education. The Administration is continuing an initiative to collect information on existing statewide education and training on dementia.

The Michigan Dementia Coalition is a statewide collaboration of academic institutions, community groups and state government units, with Administration representation. The elimination of funding to staff the Coalition has triggered strategic planning for its continuation. Workforce development, primary care education and outreach, and resources for caregiver support are essential elements of the planning, all with Administration involvement. Administration/dementia representation continues on Long Term Care Supports & Services Commission workgroups on workforce development and person-centered planning curriculum for MDCH. Administration/dementia is also represented on the Michigan Alliance for Person-Centered Communities, a statewide collaboration which promotes an array of adult long-term care supports and services focusing on culture change models, education, and self-determination.

**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 Quality Management System includes not only what MDCH does to oversee quality but also the work of the External Quality Review Organization (EQRO) who reviews the PIHPs' compliance with the federal Balanced Budget Act standards. 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. In the past year, the Council updated its membership, focused on improving the site review process, and refined the fingertip report. It also 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. The Data Exchange Workgroup, a subcommittee of the Chief Information Officers forum, is currently developing a system to submit consumer-specific information on suicides, non-suicide deaths, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrests. This system is being designed to replace the current sentinel event and death reporting. The anticipated start date for this project is October 1, 2010.

**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. The Great Start Systems Team (GSST) began meeting in FY 09 to assist with collaboration between the ECIC and the state partner agency children's services managers in the Michigan Department of Education, Department of Human Services, Department of Community Health—Maternal and Child Health and Children's Mental Health Services. In addition, based on a collaborative effort of the above group, the Department of Community Health was awarded a Substance Abuse and Mental Health Services Administration Grant, Project Launch which is focused on developing a system of care for children birth to 8 years of age that focuses on health and wellness including social emotional health. Saginaw County is the community partner in Project Launch.

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 Department of Community Health Medical Services Administration in conjunction with the Michigan Chapter of the American Academy of Pediatrics is engaged in a spread strategy to train pediatric practices about the use of these screening tools and incorporating them in the EPSDT well child visits.

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 the Michigan Department of Community Health (MDCH) through contracts with CMHSPs had been expanded to 16 projects serving 31 counties. In FY10, the project funding was reduced by almost half and the remaining mental health consultants were deployed statewide to serve birth to 3 year olds in the newly named Child Care Enhancement Program. For FY 10, the Executive Budget eliminated funding for the project. 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. Preliminary results of the evaluation are very positive and show that as a result of the CCEP, children's challenging behavior decreased significantly, child care providers are significantly better able to manage the challenging behavior and that parental stress is significantly lower causing less disruption in the parent's school or work.

#### **Goal 4 Diversion**

**Jail Diversion.** Jail Diversion programs are operating in each Community Mental Health Services Program (CMHSP) and Prepaid Inpatient Health Plan (PIHP). While these programs and diversion services vary by location from urban to rural, they all have the same goal in common. Diverting individuals who have a serious mental illness, including those with co-occurring substance use disorder, or who have a developmental disability and have contact with the criminal justice system around misdemeanor or non-violent felony offences is the goal. Screening and assessment for mental health intervention are provided to determine whether appropriate services can be offered in the community as an alternative to serving jail time. Law enforcement and the judiciary make the final determinations.

Each CMHSP is continuing to assess and revise their jail diversion programs and services to meet the growing need of this population by inclusion of peer support specialist in working with these individuals. It has been shown that peer jail diversion delivered services is a good adjunct to assisting peers in avoiding jail when mental health intervention is needed. Peer support specialists are also valuable in promoting positive reintegration in the community for people that do serve jail time.

The Application for Renewal and Recommitment (ARR) process currently under way across each PIHP also promotes the planning and implementation of jail diversion programs and services that each CMHSP/PIHP must address. As part of its ARR plan, each PIHP is addressing how it will continue work in its region to provide alternatives to incarceration. MDCH ARR teams are working with each PIHP (and affiliate CMHSPs) to better develop and implement its jail diversion plan. In addition through the adult block grant process, data on both pre and post booking jail diversions has been gathered and tabulated and shared with PIHPs, CMHSPs, and other interested stakeholders. MDCH will continue to be available to provide technical assistance and consultation via national, regional and local resources, identify training opportunities and keep CMHSPs/PIHPs in touch with each other to offer individual and specific assistance when requested or as a need is identified.

#### **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; recommendations for standardizing the purchasing of health information technology and recommendations for improving the

Self-determination policy. More recently the TSG has developed standards for CMHSP waiting lists and it is continuing its work on developing core competencies for case managers and supports coordinators. Following MDCH's issuance of a concept paper in 2008, an "Application for Renewal and Recommitment (ARR) was sent to PIHPs. In responses due June 1, 2009, PIHPs had to conduct environmental scans and plans for improvement for eleven topic areas that addressed many system improvements, including access to and quality of services and administrative efficiencies. They were required to involve multiple stakeholders, including consumers and their families in these activities. The plans for improvement span a period of five years. MDCH teams have routine conference calls with PIHPs to guide them as they implement their plans for improvement.

MDCH has begun an effort to increase the accountability of PIHPs by introducing contract language that is specific about MDCH expectations of the PIHPs to monitor their provider networks. The effort is complimentary to another activity to examine MDCH's and others site review processes to assure that all aspects of quality are being monitored, but that there are fewer redundancies.

**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. In addition, practice standards for the Medicaid covered services described in the Medicaid Provider Manual are continually updated. In 2009, extensive work was done to update the provider qualifications to assure that the best-qualified practitioners provide the covered services.

**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 FY'08-09, 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, Department of Human Services (DHS), and Juvenile Justice in that it is jointly funded by county child care funds and Medicaid, and serves children from the various systems. In FY 09, a major collaboration between the Department of Human Services and the Department of Community Health to use the SED Waiver to serve children in DHS foster care was initiated as a result of the Children's Right's Settlement. DHS provides the state match to the SED Waiver for services which allows MDCH to draw down federal Medicaid funds to provide the intense mental health services for DHS children at risk of psychiatric hospitalization. It is planned that up to 266 DHS children will be

served on the SED Waiver and assisted in reaching permanency through the provision of effective mental health services that meet the child's needs.

The 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. This focus for mental health block grant funds continues in FY 10 and FY11.

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. In late FY09, a third Michigan community—Kent County was awarded a SAMHSA System of Care grant. These 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 FY 08, 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 were included in the FY09 contracts between the MDCH and the PIHPs and continues in FY 10. One of the performance targets specifically addresses increased access for DHS abused and neglected children.

The MDCH has been working intensively with the Michigan Rehabilitation Services (MRS) and the Michigan Commission on the Blind (MCB) to better coordinate services to assist people who are jointly served by one of those agencies and the community mental health system. Building on an interagency agreement signed in 2009, joint approaches to education, training, and sharing information are in place.

### **Office of Recipient Rights (ORR).**

The ORR Director reports directly and solely to the director of MDCH.

MCL 330.1754 at subsection (4) was amended effective January 3, 2007 to read:

“...the director of the state office of recipient rights shall report directly and solely to the department director. The department director shall not delegate his or her responsibility under this subsection.

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 services.

This recommendation has not been completed, although proposed code amendments would require rights offices to provide education, training and assistance in rights protection processes to consumers and family members.

The state office has established a toll free number for information and referral services for use by consumers and family members as has most, if not all, local CMHSP rights offices.

At the 2009 Annual Recipient Rights Conference, a presentation was made by a number of advocacy organizations to staff of state, CMHSP and licensed private psychiatric hospital rights offices. Each presenter indicated what advocacy services for primary and secondary consumers were available through its organization.

**Fair Hearings.** Medicaid eligible beneficiaries are able to request state administered administrative fair hearings processes if they are not satisfied with the amount, scope, or duration of services; or if services are denied, reduced or eliminated. MDCH Mental Health and Substance Abuse staff meets with the administrative law judges that conduct those fair hearings as necessary to clarify Medicaid policy. In the course of their work, the administrative law judges regularly review clinical assessments and clinical opinions of cases. MDCH also requires CMHSPs to implement a local grievance process for individuals who are non-Medicaid eligible recipients. Those individuals have the right to subsequently submit a request for an Alternative Dispute Resolution Process to the Mental Health and Substance Abuse Administration, if the CMHSP's local dispute resolution 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 (MHP) 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. Guidelines were developed and approved that assist MHPs, the Prepaid Inpatient Health Plans (PIHP), Community Mental Health Services Programs (CMHSP), and Substance Abuse Coordinating Agencies (CA) in determining the responsible entity for authorization and payment of certain kinds of substance abuse services. The committee is also a forum for disseminating information about health care integration initiatives (described below) and for examining use of psychotropic medications, including regular reports from the Pharmacy Quality Improvement Program (PQIP). Ten CMHSPs were awarded federal Mental Health Block Grant funds in FY 09 to implement models for integrating mental health services with primary health care in their service areas. MDCH met with the grantees, primary care physicians, Federally Qualified Health Centers (FQHC) and Community Health Clinic members, MHP representatives and other stakeholders on a quarterly basis. Recently MDCH met with all the PIHP directors and re-emphasized the importance of addressing physical health for individuals with mental illness. The department also received a grant from the

National Association of State Mental Health Program Directors (NASMHPD) Transformation Transfer Initiative grant to support mental health/substance use treatment integration with primary care. Through this grant MDCH trained several Certified Peer Support Specialists on a curriculum that addresses physical health issues. This curriculum, Personal Action Towards Health (PATH), focuses on healthy living and is currently been utilized by hundreds of consumers with interventions from the PATH trained Certified Peer Support Specialists. The Administration has sponsored meetings with PIHP directors and others that showcase successful approaches to integration and that encourage intensification of programs.

**The Michigan State Housing Development Authority (MSHDA)** uses HOME dollars to provide leasing assistance through the Tenant Based Rental Assistance Program (TBRA). TBRA tenants pay 30% of their income towards rents and the landlord is paid the balance by a local non profit sub-grantee agency. TBRA recipients must be homeless. MSHDA has provided TBRA for Domestic Violence Survivors, Chronically Homeless, Homeless Families, and Homeless Youth.

MDCH is part of an interagency team (MSHDA, MDCH, MDHS) that reviews projects that are developed with Low Income Housing Tax Credits and develops the Qualified Allocation Plan (QAP) that determines how these resources are distributed. The current QAP requires that 10% of each development be permanent supportive housing, in addition to other advantages that encourage the creation of permanent supportive housing units.

In addition, MSHDA provides loans using HOME dollars to developers for the new construction or rehabilitation of units that are rented to homeless individuals or families to make permanent supportive housing units more affordable. During the 2008/2009 fiscal year over \$9,800,000 was committed to Supportive Housing units. These developments range from scattered site single family homes to multi-family integrated affordable housing developments.

Also, approximately 200 Housing Choice Vouchers were project based in MSHDA developments to serve homeless or special need populations.

MDCH participated in a Home Ownership coalition for people with disabilities. This program has achieved full integration with MSDHA's down-payment assistance and home ownership counseling program. USDA Rural Development loans were also integrated with MSHDA's down payment assistance through this coalition.

The Housing Trust Fund is a legislative creation that has not been funded by the legislature.

**Co-occurring Mental Health and Substance Use Disorders.** MDCH has been working with all 18 PIHPs and the 16 Substance Abuse Coordinating Agencies (CA) 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 use

disorders, whether they are primarily served in the public mental health, public substance abuse, or Medicaid primary care system. The ITC developed a strategic plan for the system and is currently focusing on a work plan to address the challenges and barriers that were identified.

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. In 2009, MDCH sponsored a statewide Co-occurring Disorder Conference which was attended by more than 320 people. The conference highlighted the importance of developing a Co-occurring capable system of care.

MDCH is currently utilizing the federal Community Mental Health Block Grant and the federal Substance Abuse Prevention and Treatment Block Grant to fund 6 Substance Abuse Coordinating Agencies (CA) to work collaboratively with the Community Mental Health Services Programs (CMHSP) to enhance and develop sustainable models of co-occurring disorder services for people accessing services through these CAs.

MDCH is working with the Michigan Association of Community Mental Health Boards (MACMHB) and a group of more than 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 and all the PIHPs are in various stages of implementation of the IDDT model. Readiness assessments have been completed for approximately 70 IDDT teams. The fidelity assessment team is also providing technical assistance (TA) upon request. MDCH provided several 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 the 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. At present, approximately 50 staff from PIHPs and CAs are trained and have received the MINT Trained Trainer (MTT) status. 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 leverage other resources to establish a Housing Resource Center in Detroit and throughout the state. All of these programs provide outreach to people who are homeless to find and sustain housing.

MDCH participated in a Home Ownership coalition for people with disabilities. This program has achieved full integration with MSDHA's down-payment assistance and

home ownership counseling program. USDA Rural Development loans were also integrated with MSHDA's down payment assistance through this coalition.

### **Goal 7: User Involvement**

Involvement of consumers is a critical and powerful movement that is integral to all aspects of the Michigan public mental health system. From the moment a consumer presents his/her self at the access center, the goal is to involve that individual in the system of care not only as a participant but more importantly as the center of their own care. In Michigan, Person-Centered Planning places the individual as the focus of care and promotes self-determination. Consumers are directly involved in all functions of the public mental health system in order to create a system that meets the needs of the consumer. The public mental health system can only be most effective when the consumer of services assists in creating services that truly meet their needs. At the core of the system of care is a focus on recovery.

The following is a listing of some of the activities that include consumer involvement. This listing is not conclusive, and Michigan's system of care is striving to foster even more consumer active participation.

Peer Specialists

Community Mental Health Boards of Directors

51 Consumer-Run Drop-in Centers

Psychosocial Rehabilitation Centers

Federal Block Grants

Drop-In Statewide Award

Committees Internal to the Michigan Department of Community Health

Office of Consumer Relations

Anti-Stigma Committees

Person Centered Planning

Trauma Training Care

Successful Recognition Awards

Leadership Areas

Plans of Service

**Psychiatric Advance Directives.** In 2004, the Governor of Michigan, signed into law the Advance Directives for Psychiatric Care. It is the responsibility of the Michigan Department of Community Health to train, inform, and publish information for individuals and staff in all counties of Michigan on the availability and meaning of the Advance Directives law.

Mental health consumers participated in the development of the legal language of the law. In addition, consumers were involved with attorneys in the creation of the formal legal document and also in the trainings for people potentially affected by the law.

Over a three year process, 16 in-depth trainings were held in both metropolitan and rural areas of the state. The attorneys involved were the same individuals who wrote

the law and formal document. Consumers were part of the trainings, creating and responding to the questions from an experiential knowledge base.

Over 20,000 Advance Directives documents were distributed and further trainings were held at the county level. The long term effectiveness of the Advance Directives law is not yet realized and it has not fully impacted the system due to various dynamics. However, the barriers to creating one's own Advance Directive are decreasing and it is historic that the Advance Directives law gives rights to consumers when they are unable to advocate for themselves.

**Family Centered Practice Academy.** In FY 2009, Michigan was selected to participate in a national Policy Academy on Family-Driven, Youth Guided Services. Michigan received support to send a team of 12 state and local leaders and parents to the Policy Academy to develop a plan for how Michigan could implement family-driven, youth-guided services across all the child serving systems at both the individual child and family level and the systems level. The Department of Community Health has developed a draft policy guideline on family-driven, youth-guided services that will be distributed to the field for review and feedback with the goal to ultimately incorporate this as an attachment to the MDCH contract with CMHSPs/PIHPs.

### **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 in previous reports 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 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 a 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 FY10.

### **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.** Beginning in FY09, appropriations for both the State Court Administrator's Office (SCAO) and MDCH included funding for implementation of a pilot mental health court program. MDCH funds supported treatment costs and Judiciary funds supported court operations. Boilerplate for each agency (FY09 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 SCAO, a joint application was issued, applicant proposals reviewed and nine pilot mental health court programs project sites were approved and funded for FY09 implementation. This collaboration continues.

When state GF appropriations for these pilot projects were reduced in FY09 and eliminated in FY10, funding to continue these projects was made available through Byrne/JAG American Recovery and Reinvestment Act of 2009 federal grant funds; these will support the pilot projects through FY 2012. Funded mental health courts are operational in Wayne, Oakland, Berrien, Livingston, Jackson, St. Clair, Grand Traverse and Genesee counties. Otsego County, one of the original nine selected sites dropped out in FY10.

This project includes data collection by the participating courts through the SCAO data system which was modified to accommodate mental health court specific information.

SCAO released results of their process evaluation for FY2009 in March 2010. Of the 180 participants accepted into the program during this period, 77 were felons, 77 were misdemeanants, 24 were charged with city ordinance violations and 2 charged with a civil offense. About 37% of those had no previous felonies 9% had no previous misdemeanors; 158 of the 180 cases came to the program due to new criminal offenses and 14 cases were probation violations resulting in a new criminal offense. The clinical characteristics of participants indicate that 91.1% of those admitted into the programs had a history of mental illness. Nearly 80% of the participants were diagnosed with bipolar disorder, depression and schizophrenia with a variation of bipolar as the most common diagnosis. Of the 180 cases admitted in FY 2009, 63% were male.