

# MICHIGAN MENTAL HEALTH COMMISSION REPORT

(FY2007 Appropriation Bill - Public Act 330 of 2006)

**April 15, 2007**

**Section 458:** By April 15, 2007, the department shall provide each of the following to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director: (a) An updated plan for implementing recommendations of the Michigan mental health commission made in the commission's report dated October 15, 2004. (b) A report that evaluates the cost-benefit of establishing secure residential facilities of fewer than 17 beds for adults with serious mental illness, modeled after such programming in Oregon or other states. (c) In conjunction with the state court administrator's office, a report that evaluates the cost-benefit of establishing a specialized mental health court program that diverts adults with serious mental illness alleged to have committed an offense deemed nonserious into treatment prior to the filing of any charges.

*Michigan Department  
of Community Health*



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



STATE OF MICHIGAN

JENNIFER GRANHOLM  
GOVERNOR

DEPARTMENT OF COMMUNITY HEALTH

JANET OLSZEWSKI  
DIRECTOR

## A REPORT TO COMPLY WITH THE REQUIREMENTS IN SECTION 458 OF PUBLIC ACT 330

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### UPDATED PLAN FOR IMPLEMENTING RECOMMENDATIONS OF THE MMHC

The Final Report of the Michigan Mental Health Commission (MMHC) identified seven principal goals for the mental health system and listed 71 specific recommendations to address these prime objectives. Since the publication of the Commission's Final Report, there have been ongoing projects, activities, and initiatives directed toward improving and enhancing the state's public mental health system, consistent with both the general direction and specific recommendations of the MMHC Final Report. A summary of these various endeavors (legislation, fiscal enhancements, practice improvements, integrated dual disorder treatment, anti-stigma efforts, recovery-oriented services, jail diversion measures, outreach to homeless populations, quality and performance indicator enhancements, standards development, and interagency collaboration) was provided in the department's previous Section 458 Report for FY 06 (required by Act 154 of the Public Acts of 2005).

The following is an updated listing of both ongoing and anticipated future activities directed toward advancing the recommendations of the MMHC.

#### *Public Education and Anti-Stigma*

The MMHC Report recommended improved efforts to inform and educate the public regarding mental illness, and to combat misperceptions and stereotypes regarding these disorders. As noted in the previous Section 458 Report, MDCH has been working with CMHSPs over the last year to develop a consistent anti-stigma message, and MDCH has also provided grants to local agencies for public information and education initiatives.

In the next year, MDCH plans to extend its anti-stigma efforts by:

- Publicizing the information available through the federal Substance Abuse and Mental Health Administration's (SAMHSA) "Resource Center to Address Discrimination and Stigma" (ADS Center).
- Working with interested parties to plan, finance and schedule a major conference or "summit" on stigma, utilizing nationally recognized experts or spokespersons to generate interest and awareness.
- Continue to promote, support and train "certified peer specialists" to assist other consumers in their recovery from mental illness. MDCH will also explore developing a collaborative relationship with higher education (community college) to examine the feasibility of developing a curriculum and awarding elective credits for peer training and certification.

### *Development of Eligibility, Access and Customer Services Standards*

Michigan's public mental health system is supported through multiple funding sources that confer differential access rights and service benefits. The complexity inherent in these arrangements demands more uniform interpretation of eligibility and service obligations, and enhanced "customer service" to assist consumers and families to navigate the system.

To address the need for more consistent and uniform standards, MDCH will:

- Complete an ongoing collaborative project with the Michigan Association of Community Mental Health Boards (MACMHB) to develop standard interpretations of the eligibility, access and benefit requirements under various statutes and funding arrangements.
- Publish draft standards (developed in collaboration with CMHSP representatives) regarding expected customer services practices.

### *Special Populations*

The MMHC expressed concerns regarding "early intervention" services for children, as well as effective service strategies for older adults. MDCH has been engaged in several initiatives related to these concerns, and to maintain these efforts, the department will:

- Continue with both a department-sponsored workgroup examining promising practices and interventions for children with autism-spectrum disorders, and the Interdepartmental Directors' Group focusing on a multi-agency approach to the needs of this population. MDCH will publish the findings and recommendations of the department-sponsored workgroup.
- Enhance current efforts/initiatives to improve the recognition, identification and interventions for older adults in all settings who exhibit significant changes and/or disturbances in mood, cognition, or behavior. MDCH will build upon and expand existing activities related to education, interagency integrated services, pilot site collaborative models, training and consultation.
- Fund demonstrations to develop capabilities and to implement cognitive behavioral therapy for older adults.

### *Mental Health – Justice System Interface*

MDCH has supported and provided seed-funding (under the federal mental health block grant) for development of jail diversion programs – for both adults and juveniles – throughout the state. The department has also published, disseminated and included contractual provisions on practice guidelines for jail diversion.

MDCH will continue its emphasis on jail diversion, as well as promote the transition of former inmates (with a mental illness) who are being released from incarceration by:

- Funding new jail diversion service programs over the next two fiscal years, using federal block grant funds.
- Sponsoring a jail diversion "mini-conference" – with representatives from program staff, law enforcement, and the courts – to review successful diversion programs from around the state.
- Collaborating with the Michigan Association of Community Mental Health Boards (in partnership with the Oakland County Community Mental Health Authority) in a "train-the-

trainer” workshop on successful mental health – police diversion training and implementation.

- Continue participation on the Michigan Department of Corrections’ prisoner re-entry initiative.

### *Structure, Funding, and Accountability*

The Final Report of the MMHC called for clarification of roles and responsibilities between various components of the public mental health system. The MMHC Report also contained recommendations related to funding, administrative costs, performance incentives, psychiatric direction, and the use of evidence-based practices.

There has been extensive discussion and activity on many of these topics, prompted by either statutory change or via specific boilerplate provisions within the MDCH appropriations bill. Building upon, and consistent with, both legislative direction and MMHC suggestions, MDCH will:

- Continue to examine approaches for distribution of general funds among CMHSPs, and to refine methodologies for rate-setting under the Medicaid specialty services waiver. Certain proposed federal regulations may negatively impact current departmental arrangements that maximize federal financial participation.
- Implement “Phase Two” of the ongoing (legislatively directed) project to standardizing classification and reporting of administrative costs by CMHSPs, PIHPs, and large provider organizations.
- Examine the applicability and appropriateness of so-called “pay-for-performance” arrangements within the public mental health system. MDCH has been investigating the use of such incentive mechanisms (and their impact on quality) in physical health care, and within the Medicare program.
- Recruit, select and appoint a psychiatric “medical director” to advise the MDCH Director, consistent with the provisions of PA 586 of 2006. The department has completed a substantial revision of the job description and selection criteria for the Psychiatric/Medical Director, and will move forward to fill the permanent position (MDCH currently has an acting psychiatric/medical director).
- Maintain and expand the now well established “improving practices” initiative, steering committee, and leadership teams; the extensive training and dissemination of evidence-based practices for children and adults; and evolving efforts to measure practice fidelity, facilitation of recovery and clinical outcomes.

### *Service Integration and Coordination*

Michigan has made strides in addressing physical health coordination, integrated care needs, housing issues, and employment supports for individuals with serious mental illness. The department will continue these efforts to better align and coordinate public mental health care with other systems, services and programs by:

- Ensuring coordination agreements between Medicaid Health Plans and specialty PIHPs.
- Promoting FQHC and CMHSP/PIHP collaboration.
- Exploring the option of pilot or demonstration integrated physical/mental health managed care plan for Medicaid beneficiaries with serious mental illness.

- Adopting, disseminating and promoting the principles of the Continuous, Comprehensive Integrated System of Care (CCISC) model for integrated treatment of co-occurring (mental illness and substance abuse) disorders.
- Sponsoring training on Integrated Dual Disorder Treatment (IDDT) and assisting PIHPs and Coordinating Agencies in developing “charter” agreements for care integration and coordination.
- Supporting “Learn and Share” meetings to disseminate innovations and exchange information among PIHPs and CAs.
- Providing technical assistance (coordinated through Wayne State University) to assist PIHPs in measuring “fidelity” of treatment approaches, and/or to carry out “readiness assessment” for IDDT.
- Making funds available for implementation of two additional evidence-based practices: supported employment and supported housing.
- Continuing discussions between child-serving agencies regarding coordinated services to children, mental health treatment in foster care, and blended funding arrangements.
- Encouraging participation and greater enrollment in the department’s Medicaid SED children’s waiver.
- Active participation and involvement in the MSHDA-led initiative to end chronic street homelessness.
- Funding CMHSPs and/or community agencies to expand permanent housing arrangements, treatment interventions, supports, and outreach for persons with mental illness who are homeless or at-risk of homelessness.

#### *User Involvement*

The involvement of consumers and families is crucial in the transformation of the public mental health system. To support the involvement and participation of consumers/families, MDCH will:

- Continue to expand (and emphasize) the role and significance of the Recovery Council in system transformation and the development of a recovery-oriented system of care.
- Continue training and certification of peer specialists, expanding the supply of certified specialists and enlarging the role of peers in CMHSP operations.
- Publishing an informational pamphlet, providing training and offering technical assistance to consumers, family members, advocates and other system stakeholders regarding advance directives for mental health care.

#### ESTABLISHMENT OF SECURE RESIDENTIAL FACILITIES

As indicated in the FY 06 Section 458 Report, the department has performed a preliminary analysis and limited feasibility study regarding the establishment of secure residential facilities (fewer than 16 beds). The previous report indicated that few states utilize “locked” residential facilities, presumably due to the legal complexities associated with such arrangements. The report further noted that most states that have residential facilities for consumers with certain high-risk characteristics describe their programs as “structured” (e.g., high staff to consumer ratios; certification of the facility; expectations of extensive in-facility programming, etc.) rather than “secure”.

Our prior analysis suggested that if the state truly intended to establish “locked” secure residential settings, it would likely require changes in the statute and rules regarding the licensing of dependent care settings and the certification of specialized residential programs. Another conclusion of the previous review was that, because of the constraints on personal liberty that such a facility entails, 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).

Assuming statutory and rule changes permitted the establishment of secure residential settings, the costs of such arrangements consist of start-up or capital costs for building (and/or conversion of an existing facility to a high structure environment) and equipment, and ongoing operational (24/7 staffing; consumables, energy, transportation, supplies, programming, medications, etc.) costs. At one time (circa 1980s), the department operated highly structured, service-intensive residential arrangements, and these settings had high staffing ratios, significant regulatory burden, and extensive programming requirements. Without further elaboration of recipient characteristics, security considerations, required staffing ratios, approximate average length of stay, and projected programming needs, it is extremely difficult to accurately estimate the likely operational costs of these arrangements. Moreover, while some portion of the service component costs (but not room and board) might be covered by Medicaid if the facility is under 16 beds, “federalizing” such costs requires that most (or all) of the potential residents qualify for Medicaid (presumably under the “disabled” pathways to categorical eligibility).

Secure residential settings appear to hold the most promise for certain individuals in our 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. However, it cannot be assumed that the benefits of these settings for the recipient will generate specific and predictable cost savings for the system. If the establishment of such settings diverts admissions, reduces utilization (days of care), or hastens discharge (i.e., by offering “step-down” settings for forensic patients or seriously mentally ill individuals released or paroled from correctional settings) at state hospitals, there may be potential cost savings over an extended time horizon (state facility costs behave in a step-wise fashion – costs recede only after significant census reduction). However, as noted in the previous report, there are (at present) no specific, reliable estimates of whether, how much, and/or how quickly such housing options might impact state hospital utilization, or of the possible (range) cost-offsets of the proposed arrangements.

#### ESTABLISHMENT OF SPECIALIZED MENTAL HEALTH COURT PROGRAM

There has been tremendous interest over the past several years regarding approaches to diverting individuals with serious mental illness from admission or deeper penetration into the criminal justice system. Various “intercept points” (pre-arrest diversion, pretrial diversion, post-booking “deferred prosecution”, jail mental health services, adjudication, etc.) to avert the “criminalization” of persons with mental illness have been identified, and model programs have been developed around each of these intercept points and opportunities. Descriptions of many of the intercept innovations have been published and widely disseminated by such entities as the Substance Abuse and Mental Health Services Administration (SAMHSA), the federally-funded National Gains Center, the Bureau of Justice Assistance, the Center for Court Innovation and the Council of State Governments. One such innovation, the “mental health court”, has proliferated over the past ten years. There are currently well over a hundred mental health specialized court dockets and judicially supervised compliance programs in operation nationally. These mental health courts and compliance programs are part of a broad spectrum of “problem-

solving courts” that have developed in response to various community concerns (e.g., drug courts, domestic violence courts, etc.).

While an increasing number of jurisdictions across the country are experimenting with dedicated mental health courts (defined as specialized separate court parts that handle only cases against defendants with mental illness), the Council of State Governments notes that while such programs are “promising”, planners should “...be aware of the limited evidence base for mental health courts.”<sup>1</sup> Some localities, where the size, configuration or resources of the court system makes such specialized dockets impractical, have implemented other types of court pretrial and deferred prosecution approaches as an alternative to dedicated mental health courts.<sup>2</sup>

Previously there were limited studies regarding the effectiveness of mental health courts, and very limited assessment of the costs of such arrangements. However, in early 2007, the RAND Corporation published a report titled “Justice, Treatment and Costs: An Evaluation of the Fiscal Impact of the Allegheny County Mental Health Court.” The research was sponsored by the Council of State Governments, and suggests that while special mental health courts that sentence mentally ill offenders (convicted of misdemeanors or low-level felonies) to supervised treatment rather than jail does not result in savings in the short term, such programs have the potential to significantly reduce total costs over a longer time frame . The study summarizes these conclusions in this way:

“The findings from our fiscal impact analyses show that entry into the MHC program leads to an increase in the use of mental treatment services in the first year after MHC entry, as well as a decrease in jail time for MHC participants. The decrease in jail expenditures mostly offsets the cost of the treatment services.

However, an analysis that followed a subsample of MHC participants for a longer period of time showed a dramatic decrease in jail costs in the second year of MHC participation. The treatment costs return to pre-MHC levels in the second year. The drop in jail costs more than offset the treatment costs, suggesting that the MHC program may help decrease total taxpayer costs over time. Although the total cost savings for the two years was not statistically significant, the leveling off of mental health treatment costs and the dramatic drop in jail costs yielded a large cost savings at the end of our period of observation. The lower cost associated with the MHC program in the last two quarters was over \$1,000 per quarter and is statistically significant in both quarters. We also found that more-seriously distressed subgroups (participants charged with felonies, people suffering from psychotic disorders, and people with scores indicating high psychiatric severity and low functioning) had larger estimated cost savings, although, again, none of the savings was statistically significant in the first year of MHC participation.

These findings generally suggest that the MHC program does not result in substantial incremental costs, at least in the short term, over status quo adjudication and processing for individuals who would otherwise pass through the criminal justice system. Although determining the fiscal impact of the MHC program by levels of government was beyond the study’s scope, it is worth noting that the federal government and the Commonwealth share any increased treatment costs. The findings also suggest that, over a longer time frame, the MHC program may actually result in net savings to government, to the extent that MHC participation is associated with reductions in criminal recidivism and utilization of the most expensive sorts of mental health treatment (i.e., hospitalization).”<sup>3</sup>

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<sup>1</sup> “A Guide to Mental Health Court Design and Implementation”, Council of State Governments, May 2005.

<sup>2</sup> “Non-Specialty First Appearance Court Models for Diverting Persons with Mental Illness: Alternatives to Mental Health Courts”, John Clark (author), February 2004.

<sup>3</sup> “Justice, Treatment and Costs: An Evaluation of the Fiscal Impact of the Allegheny County Mental Health Court”, page xi, RAND Corporation, 2007.

This research provides the most rigorous analysis to date of the fiscal impact (cost/benefit) of a specialized mental health court. However, the study indicates that total costs savings are not immediate, but rather accrue over time. These predicted net reductions in future costs would accrue to different branches and levels of government, and would have differential impact on court costs, incarceration expenditures, and mental health resources. The sharing of treatment costs (via Medicaid) versus incarceration costs (state and local funds) represents one significant component in the estimated eventual cost savings.

The potential long-term cost savings of a mental health court must be weighed against the start-up costs associated with a specialty court, as well as the more immediate costs/resources needed to treat and supervise the mentally ill offender in the community. It should also be emphasized, however, that continuation of practices that result in “criminalization” of persons with mental illness, and their penetration into the criminal justice system, generates unacceptable human suffering and high societal costs.