

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

(FY2012 Appropriation Bill - Public Act 63 of 2011)

April 15, 2012

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 nonserious into treatment prior to the filing of any charges.

*Michigan Department
of Community Health*



**Rick Snyder, Governor
Olga Dazzo, Director**

**AN UPDATED PLAN FOR IMPLEMENTING RECOMMENDATIONS
OF THE MICHIGAN MENTAL HEALTH COMMISSION MADE IN THE
COMMISSION'S REPORT DATED OCTOBER 15, 2004
FY2012**

APRIL 15, 2012

SECTION 458

An updated plan for implementing recommendations of the Michigan Mental Health Commission report. A report that evaluates the cost-benefit of establishing secure residential facilities of fewer than 17 beds for adults with serious mental illness. 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
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION
FY2012 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.*

Since 2005, the Michigan Department of Community Health (MDCH) through the Behavioral Health and Developmental Disabilities Administration (BHDDA) has focused on the overarching goal of Transforming Michigan's Mental Health System as well as implementing the seven goals outlined in the plan. To further refine and reinforce the Commission recommendations, MDCH issued a concept paper in 2008, an "Application for Renewal and Recommitment (ARR)", that was sent to PIHPs. In responses due June 1, 2009, the PIHPs had to conduct environmental scans and submit 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. Until the beginning of FY12, MDCH teams had routine conference calls with PIHPs to monitor and guide them as they implemented their plans for improvement. For this fiscal year, MDCH has asked that PIHPs report on their ARR progress in their annual quality improvement reports submitted to MDCH.

During FY12, 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 (MACMHB) 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 launched the campaign March 25, 2008, which continues through 2013. The focus is to eliminate stigma within the mental health system. A resource guide and tool kit which take a strength-based approach, help CMHSPs embrace recovery, progressing toward eliminating stigma. Quarterly meetings will continue in 2012 and 2013 for system updates.

Michigan has trained and certified over 938 Certified Peer Support Specialists (CPSS). The nationally recognized CPSS workforce is instrumental in providing public awareness in support of MDCH anti-stigma efforts.

Suicide Prevention. The Michigan Surgeon General unveiled the Michigan Suicide Prevention Plan 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 federal grant funding to provide implementation of youth suicide-prevention activities. Since the state plan was adopted, approximately two-thirds 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 and billboards to promote awareness of mental health issues) to post-vention activities (Survivor of Suicide Groups) in communities. The sixth community suicide-prevention conference is planned for October 2012. The workshop brings together national experts, community members (parents, professionals, community members) to learn new techniques in planning, programmatic development, and evaluation of youth suicide-prevention activities. MDCH has collaborated with the Michigan Association for Suicide Prevention and the MDCH-Injury Prevention Section to support an evaluation of the suicide prevention activities in Michigan since implementation of the state plan. It is anticipated that the report summarizing the evaluation will be finalized in FY12. The outcome of the evaluation will include planning/implementation of future suicide prevention activities.

While these partnerships have advanced proven health promotion strategies to address mental health issues, there has been no work on developing a single repository of mental health information.

GOAL 2: PRIORITY POPULATIONS AND EARLY INTERVENTION

Uniform Screening and Assessment. MDCH worked with The Standards Group (TSG) to develop a set of Access Standards aimed at making the screening and assessment process uniform across the access systems of Michigan's CMHSPs and PIHPs. In addition, MDCH is providing training to CMHSP children's services staff on the use of the Child and Adolescent Functional Assessment (CAFAS) tool, the Pre-School Early Childhood Assessment (PECFAS) Tool, the Devereaux Early Childhood Assessment, Infant/Toddler (DECA I/T) and the DECA Clinical tool. MDCH/PIHP and MDCH/CMHSP contracts require the CAFAS (for seven through 17 year-olds) to be administered at intake, quarterly, annually and at service exit. MDCH is moving toward requiring use of the PECFAS (four-seven year-olds), DECA I/T (ages one through 36 months), and the DECA Clinical tool (ages 37 through 47 months) as functional assessment instruments. A requirement for use of the PECFAS at intake, quarterly, annually, and at service exit is slated to be included in the MDCH/PIHP and MDCH/CMHSP contracts in FY13. Currently, three CMHSPs are piloting an online version of both the DECA/IT and DECA Clinical tool.

MDCH will continue to research and explore a standardized assessment tool to provide persons with Intellectual and Developmental Disabilities a consistent level of supports determination across the state's system.

GOAL 3: MODEL SERVICE ARRAY

Evidence-based Practices and Promising Practices.

The Practice Improvement Steering Committee (PISC) has continued to fulfill its updated charter to address its role in relation to the current status of evidence-based practice implementation and other efforts to improve service-provider practices. A primary focus of the group has been to address sustainability and outcome efficacy for those practices being implemented across the state. Consistent with federal transformation goals, MDCH has dedicated Mental Health Block Grant funds to support practice improvement for providers serving adults and children. As of October 1, 2009, all PIHPs were required to offer two of the SAMSHA-endorsed evidence-based practices as a choice for adults with serious mental illness: Family Psychoeducation (FPE) and Integrated Dual Disorders Treatment (IDDT) for persons with co-occurring mental health and substance use disorders. Additionally, a 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. Training and support for Supported Employment (SE), Motivational Interviewing (MI), and Dialectical Behavior Therapy (DBT) have also continued. Michigan now has 938 peers who have received training to become Certified Peer Support Specialists. 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. Almost all of the 46 CMHSPs across Michigan have clinicians already trained or in training for PMTO, and 31 CMHSPs have clinicians and supervisors trained or in training for TFCBT. In addition, PMTO has expanded to provide a Parenting Through Change (PTC) group model, and is providing two-day skill-based training on PMTO tools to non-certified clinicians and staff. Data reported for FY11 indicated 379 families were served in PMTO and 69 in PTC. The wraparound model (a promising practice) is being provided to children and their families across the state as well, and is a key component in the implementation of our 1915(c) SED Waiver. Michigan is also providing parent support partner training which is a promising/innovative practice that has grown both within our state and nationally.

PISC Subcommittees include Measurement, Family Psychoeducation (FPE), Parent Management Training-Oregon Model (PMTO), Assertive Community Treatment (ACT), and Supported Employment (SE), with additional work groups recently established to address co-occurring Mental Illness and Developmental Disabilities, and Trauma. Since April of 2011, the previously separate COD Change Agent Leaders (CAL) group and Co-occurring Disorders: Integrated Dual Disorder Treatment (COD:IDDT) subcommittee were successfully merged into the current Co-occurring Change Agent Leaders (CoCAL) subcommittee, in order to integrate resource-efficient efforts to advance co-occurring disorders treatment in what have been historically bifurcated mental health and substance abuse provider arenas.

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

The Michigan Mental Health Evidence Based Practices Initiative (MiMHEBPI) has been renamed the Michigan Quality Improvement Program (MQIP). Phase III of the project, the implementation of medication algorithms, has begun with development of the MQIP software module that includes a decision engine, to reside on a HIPAA compliant server, and a user-friendly interface for entry and display of critical data. The first iteration of this software, for which programming was initiated in late 2010, is intended to serve as a lean, web-based stand-alone electronic medical record (EMR). Subsequent versions will operate seamlessly within existing EMRs. The proof-of-concept version plans to begin *beta* testing in summer of 2012. The goal is implementation of algorithms statewide, with MQIP interfacing and working within disparate EHRs.

Over 500 CPSS have been training in Wellness Recovery Action Planning (WRAP) and/or the Chronic Disease Self Management Program (CDSMP). Such services will be provided in 2012 in Federally Qualified Health Centers (FQHC) through wellness coaches and system navigators. Michigan is currently part of a CDSMP research project in partnership with Stanford University to evaluate the effects that CPSS have in leading groups and sustaining wellness goals for individuals with a serious mental illness.

Supports and Services for Persons with Dementia and their Caregivers.

MDCH continues to provide 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 Mental Health Block Grant (MHBG) funding on dementia care education. The Administration is collaborating with the Alzheimer's Association (both Michigan chapters and the national office) and Northern Michigan University to disseminate a high school curriculum on dementia, which includes education standards and a module on careers in aging and dementia.

A relationship with the Geriatric Education Center-Michigan (GECM) has been developed to enhance continuing education for primary care professionals on mental health for older adults, including dementia care. MHBG funding is used to provide presenters to GECM continuing education forums, particularly reaching rural communities in upper Michigan.

The Michigan Dementia Coalition is a statewide collaboration of academic institutions, community groups and state government units, with Administration representation. After a year of gathering input from statewide stakeholders, the 2012 Michigan Dementia Plan was developed to provide direction and strategies for primary care education and outreach, increasing public awareness, and promotion of resources for caregiver support.

The three-year Michigan Dementia Intervention Support Project (MDISP) for Nursing Homes, funded with Civil Monetary Penalty funds, addresses challenges through a network of experienced, selected dementia educators who will create a self-sustaining system by working with a facility staff member to co-train and consult with direct care staff.

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 takes its direction from the “Quality Strategy” that is approved by the Centers for Medicare and Medicaid Services for oversight of the 1915(b)(c) waivers. This includes not only what MDCH does to oversee quality, but also the work of the External Quality Review Organization (EQRO) that 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 focused on streamlining the site review process.

Web-based information infrastructure. MDCH collaborated with PIHPs and CMHSPs to develop a web-based reporting system for individual-level critical incidents that commenced October 1, 2010. This system was designed to replace the aggregate-level sentinel event and death reporting. Critical incidents – suicide, non-suicide deaths, emergency medical treatment and hospitalizations due to injury or medication errors, and arrests - are reported within 60 days after their occurrence. MDCH developed an internal process for analyzing, tracking/trending, and follow-up on events that involve vulnerable people. This system has been refined for 2012.

Interagency Approach to Prevention, Early Intervention, and Treatment for Children. The implementation of Project LAUNCH is in its third year of funding. Early childhood mental health consultation is one of the services being provided to childcare providers in the Saginaw community. In addition, an early childhood mental health consultant is placed at three pediatric offices to assist with assuring administration of age-appropriate screening tools, mental health assessment, anticipatory guidance for parents, and referral to mental health and/or community services as needed.

MDCH in partnership with the MDHS, Wayne County Department of Human Services and Detroit-Wayne County Community Mental Health Agency (D-W CCMHA) was awarded a Flinn Foundation grant to implement the SCREENING KIDS IN PRIMARY CARE PLUS (SKIPP) model during 2012-13.

SKIPP will be evaluated by the Michigan State University Institute for Health Care Studies. The Institute will develop data collection processes, analyze the data, and provide recommendations regarding SKIPP’s replication. The Institute will analyze the data on number of children screened, assessments conducted, and referrals provided in targeted practices. The Institute will also develop a satisfaction survey to be used with the six primary care providers and their staff to understand their satisfaction with the training, implementation of screening and Mental Health Consultation services.

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, and 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. The Screening Committee is continuing to bring together stakeholders to provide training and technical assistance to primary care providers in the implementation of developmental/social-emotional screening. Recently, the Michigan Academy of Family Physicians has joined the Screening Committee to facilitate training and technical assistance to their members.

The Child Care Expulsion Prevention Project (CCEP), which was funded by the MDHS with federal childcare quality funds and administered by the MDCH through contracts with CMHSPs, had been expanded to 16 projects serving 31 counties. The CCEP is a mental health consultation model, whereby early childhood mental health clinicians provide consultation and support to childcare providers and parents of infants, toddlers and pre-school age children experiencing behavioral difficulties in childcare settings. Michigan State University completed a 3-year, control group evaluation of the program. Results of the evaluation were very positive and show that because of the CCEP, children's challenging behavior decreased significantly, childcare providers are significantly better able to manage the challenging behavior of the child and other children in the setting, and that parental stress is significantly lower causing less disruption in the parent's school or work. The Georgetown Training and Technical Assistance Center has recognized the CCEP program as it was implemented in Michigan nationally as a model for Child Mental Health.

MDCH has increasingly worked with Department of Human Services to identify those high-risk children that are identified in Foster Care and/or open with Child Protective Services to outreach and incentivize providers to provide those increases, intensive services through the CMHSP system.

FY 2012, MDCH along with multi system community partners, is in the final stages of developing a statewide plan on Autism.

GOAL 4: DIVERSION

Jail Diversion. Jail Diversion programs continue to operate in each CMHSP and PIHP. While diversion programs and services vary by size and location, they all have the same goal. The goal is 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. 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.

The Mental Health Block Grant supported post-booking diversion activities in Genesee and Kalamazoo counties through mental health court programs. FY11 data reported by the CMHSPs indicates that the number of pre-booking diversion incidents with adults having mental illness totaled 2,608 (up from 1,779 in FY10). The number of pre-booking diversion incidents with those having developmental disabilities totaled 45 (up

from 29), and the number of pre-booking diversion incidents with those having a co-occurring SUD totaled 452 (a newly tracked category). The number of post-booking diversion incidents of adults with mental illness totaled 1,068 (down from 1,537), the number of post-booking diversion incidents with those with developmental disabilities totaled 112 (up from 81), and the number of post-booking diversion incidents with those having co-occurring SUD totaled 938 (a newly tracked category). 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 needed. A new workgroup was started in February 2012 with the goal of further reducing the number of mentally ill behind bars. This group is the result of Governor Snyder's 2011 Health Message. An action plan will be finalized in July 2012.

GOAL 5: STRUCTURE, FUNDING, AND ACCOUNTABILITY

Statewide Standards. MDCH has co-sponsored TSG with the 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.

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 with 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. Standards are in place for:

- 1) Timeliness of access to the public mental health system
- 2) Recidivism
- 3) Competitive employment

In addition, practice standards for the Medicaid covered services described in the Medicaid Provider Manual are continually updated.

Sustainable Models of Collaboration. The SED Waiver is a collaborative effort of MDCH, CMHSPs, MDHS, and Juvenile Justice in that it is jointly funded by county childcare funds, local CMH general funds, state MDHS general funds and Medicaid, and serves children from the various systems. In FY11, 261 children in foster care were served under the SED Waiver and were assisted in reaching permanency through the provision of effective mental health services that met the child's needs. Twelve counties participated in the MDHS SED Waiver Pilot (Wayne, Oakland, Macomb, Genesee,

Ingham, Saginaw, Kent, Kalamazoo, Washtenaw, Clinton, Eaton and Muskegon). An SED Waiver amendment was submitted to the Center for Medicare and Medicaid (CMS) to expand the waiver to an additional twenty counties: (Allegan, Arenac, Bay, Midland, Isabella, Livingston, Grand Traverse, Leelanau, Roscommon, Wexford, Marquette, Cass, Van Buren, Gratiot, Berrien, St. Clair, Jackson, Hillsdale, Calhoun, and Newaygo). The proposed effective date for this amendment was April 1, 2012, and this expansion will increase the number of children in foster care who can be served to at least 411. In FY13, additional funds are proposed to increase the number of children in foster care who can be served. The SED Waiver is utilized to provide intense mental health services to children in the juvenile justice system. In FY11, 75 of these children were served, many through collaborative funding using the childcare fund to match Medicaid for the SED Waiver services provided by CMH.

In FY12, funds were offered for CMHSPs to develop joint projects with community partners to provide evidence-based and/or promising practices to children with SED who are also involved with the juvenile justice system. 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 for the Blind (MCB) to 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.

MDCH will continue to look at funding structure of 18 PIHP, 46 CMHSP's, and 16 Coordinating Agencies to further align geographic boundaries with Medicaid Health Plans. Data Analysis and current reporting structures are being refined in expectation of Medicaid expansion and Dual Eligible demonstration by 2014. In addition, overall commitment to further simplify both contractual agreements and site review process while assuring safety and quality oversight for vulnerable individuals. Provider agencies are currently, and into future, looking at models of integration including Health Homes/Medical Homes and formal partnering with Primary care, HMO's Rural Health Clinics and FQHC's.

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."

Since that date, the MDCH-ORR Director has met with the Department Director every other month.

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 fully completed, although ORR proposed code amendments would require rights offices to provide education, training and assistance in rights protection processes to consumers and family members.

Since 2009, MDCH-ORR has been a partner with the Michigan Family-to-Family Health Information and Education Center in presenting “Helping Families and Young Adults Protect Their Rights”. This is a five-hour session for anyone who wants a better understanding of complaint processes including timelines, complaint procedures and what someone could expect during the processes under:

- Children’s Special Health Care Services
- Community Mental Health Services
- Medicaid
- Special Education Services

Participants in the training receive resource information for groups and organizations available to assist in protecting an individual’s rights. Basic information is provided on how to gain access to what makes someone eligible under each system. Presenters include the MDCH-ORR Information and Referral Specialist, representatives from the MDCH Children’s Special Health Care Services and Michigan Protection and Advocacy Services and an Administrative Law Judge from the State Office of Administrative Hearings and Rules.

Additionally, MDCH-ORR has established a toll free number for information and referral services for use by consumers and family members as has most local CMHSP rights offices.

In the past year, MDCH-ORR reformatted its website based upon a suggestion by the Centers for Medicare/Medicaid Services to highlight where to report suspected abuse and neglect with links to the 46 CMHSP and approximately 70 licensed private psychiatric hospitals’ rights offices as well as the DHS toll free numbers.

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 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 Behavioral Health and Developmental Disabilities 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.

Many efforts across the state PIHP/CMHSP system have emerged for collaboration of physical and behavioral health care. Some of these initiatives have been through Health Home pilot project, as well as local collaborations with primary care, FQHCs, Hospitals, and Rural clinics. To further coordinate and support local care, MDCH has sponsored the Mental Health Advisory Committee (MHAC) comprising medical directors from PIHP and Medicaid Health Plans (MHP), representatives from Coordinating Agencies (CA), and staff from the Medical Services Administration (MSA).

During the past year, the MHAC has been a forum for presentations by recipients of block grant funds investigating new models for integrating mental health and general physical health care. These models have varied in both scope and success, providing important information for the medical leadership as it explores the implementation of medical homes pursuant to the Affordable Care Act and to goals articulated by the Governor and Department Director.

Currently, the MHAC is reexamining its structure. MSA and BHDDA are working with Health Plan and CMH partners to strengthen the clinical advisory function for both behavioral and physical health and increase the scope and number of collaborative projects that link the two systems.

The Michigan State Housing Development Authority (MSHDA)

MDCH is part of an interagency team (MSHDA, MDCH, and 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.

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.

Co-occurring Mental Health and Substance Use Disorders

MDCH has been working with all 18 PIHPs and the 16 Substance Abuse Coordinating Agencies (CAs) so that individuals with both mental health and substance use disorders receive services and supports in an integrated manner.

MDCH has been promoting co-occurring disorder system change at the state and local levels through the Co-Occurring Disorders (COD). The 2011 COD Conference

(featuring themes of outcome measurement, treatment skill building, and lived recovery experience) took place on April 25-26 of 2011 and was attended by a capacity crowd of 550. The 2012 Conference, scheduled for June 18-19, 2012, will feature the crosscutting and integrated practice areas of trauma, engagement/motivation, recovery support service delivery, and cognitive-behavioral approaches and models for effective COD services. Scheduled at a larger venue for 2012, a capacity crowd of 600 is expected to participate.

As part of the improving practice initiative, MDCH has continued working with certified trainers from the international Motivational Interviewing Network of Trainers (MINT) to support ongoing competency development and sustainability across Michigan's community mental health system.

Homelessness

The MDCH Homeless Programs consist of Housing Opportunities for People Living with AIDS, Projects to Assist in Transition from Homelessness (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: CONSUMER INVOLVEMENT

At the core of the system of care is a foundational focus on recovery. Working in partnership with consumers served by the public mental health system is integral in providing quality and cost effective services. The public mental health system is most effective when the individual receiving services has equal involvement and responsibility in creating services and supports designed to meet their needs. Michigan is nationally recognized for training, employing and certifying a peer support specialist workforce. Michigan was the recent recipient of the Association of State and Territorial Health Officials award for peer-led health and wellness.

In 2012, a Transformation Transfer Initiative grant, provided by SAMHSA and the National Association of State Mental Health Program Directors, was awarded to employ peer specialists in Federally Qualified Health Centers. The grant will provide opportunities to expand consumer involvement in mental health services in primary care settings.

Working in partnership with the Association for Children's Mental Health, MDCH has also been training and certifying parent support partners to work with parents that have children with a serious emotional disturbance. In FY12, there are fourteen counties

participating and forty-four certified parent support partners. Over 50% of these parent support partners are employed by CMHSPs.

Psychiatric Advance Directives. In 2012, the Office of Consumer Relations, MDCH continues to give consultation with CMHSPs and primary individuals on creating and implementing one's own Advance Directive. The Site Reviewers from MDCH monitor the activities of Advance Directives at the CMHSPs level statewide. Training also continues as part of the Peer Specialist Certification process; further promoting Advance Directives at the county level.

The long-term effectiveness of the Advance Directives law is not yet realized and it has not fully affected 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 voice to consumers when they are unable to advocate for themselves.

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. A preliminary analysis and limited feasibility study regarding the establishment of secure residential facilities (fewer than 16 beds) was conducted. 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 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 affect state hospital utilization, generate savings or reduce costs.

A newly formed DHS-DCH workgroup is examining operational practices that support and hold accountable licensed facilities that serve high-risk consumers, some of whom might be determined candidates for a secure facility. Pilots are anticipated in late 2012 for better ways to support successful community placements without a new "secure setting".

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 approved and funded for FY09 implementation. In his March 7, 2012, message, Governor Snyder recommended \$2.1 million to continue the eight existing mental health court pilots and create a new mental health court in Saginaw.

Although drug courts have been sufficiently researched to estimate cost and benefit, mental health courts are still in their pilot stage as an approach to diversion and their efficacy is still being established. DCH has contracted with MSU to conduct an outcome evaluation for Mental Health Courts spanning 2009-2011. The report is expected to be issued in late calendar year 2012.

The Diversion Strategies Work Group commenced in February in response to Governor Snyder's request for a plan addressing individuals with mental illness in the criminal justice system. The work group consists of representatives from Department of Corrections, Department of Community Health, PIHPs/CMHSPs, courts, jails, and advocates. The task of the work group is to develop and submit an Action Plan by July 2012. Primary areas that are currently addressed in the planning process include; Mental Health Courts/Integrated Treatment Courts, Diversion Programs, behavioral health services and Re-entry models for those who are incarcerated, Mental Health Parity, data pertaining to the prevalence of mental illness in jail/prison, and sharing information across systems.