

Michigan Mental Health Commission

Part I: Final Report

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Prepared for
Governor Jennifer M. Granholm

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Executive Summary

Governor Jennifer M. Granholm charged the Michigan Mental Health Commission with the tasks of identifying the most pressing issues that face our public mental health system and developing recommendations for improvements.¹ At its opening session, the governor said that the mental health system in Michigan is “broken.” Much of the public testimony to the commission verified that assessment.

Hundreds of people testified, with many sharing their personal stories, at public hearings, commission meetings, through the commission’s website, and by mail. Common themes emerged:

- ***Status of the current system:*** People urged the commission to rely on a community-based approach. The need for improvement in the community-based system was acknowledged, but people do not want to see services taken out of their local settings. Concerns were raised about accountability, the complexity of the system, inability to obtain timely assistance, and perceived unfairness in protection of rights for those served by the public mental health system.

- ***Service improvements and unmet needs:*** Many people reported that there should be a broader array of supportive and hospital services in the community to serve people from early childhood and through adulthood. Many also stressed the importance of outreach and greater clarity in the information that describes available services. People are frustrated at having to be in crisis before getting needed services. People described the cycle of not being able to get a job; not being able to get safe, affordable housing; and not getting any help. Those who spoke of loved ones living on the streets or in jail said there is no compassion for their situation. Also noted were differences in treatment experienced by minority population groups. Many people stressed the need to put “what works” into practice.

The commission heard descriptions of the unique mental health needs of our state’s growing population of older adults. Troubling testimony highlighted insufficient numbers and inadequate preparation of direct care workers and mental health care providers to respond to the needs of older adults.

- ***Children’s services:*** Many people noted serious gaps in mental health services for children, with some describing the need to relinquish custody of their children in order to get care. The gaps include training for parents, teachers and school administrators, and mental health providers on the needs of children with emotional disturbances; comprehensive school-based mental health services; respite care for families; crisis intervention; and “real support and advocacy” for families. Several parents described heartbreaking experiences, even to the point of the loss of their children to suicide.

- ***Interface with the criminal justice system:*** Very frequently, people addressing the commission stressed the need to take steps to make sure that people with serious

¹ See Appendix A for information about the commission and Appendix B for the crosswalk between the Executive Order and the commission’s recommendations.

mental illness do not end up in jail or prison and children with emotional disturbances do not end up in juvenile detention programs. There was considerable testimony about the adult and juvenile justice systems representing today's "institutions." Several people highlighted the need to expand jail diversion, including at the point of first contact, evaluating whether the person would be more appropriately served through mental health services than by the justice system itself. The need to better train first responders and law enforcement in mental health issues was also articulated. The commission heard family members describe tragic consequences of inadequate mental health treatment and services in some of our county jails, insufficient collaboration between community mental health agencies and jails in dealing with persons with mental illness, and inadequate preparation for continuity of mental health treatment as prisoners reenter society.

- ***Funding, Medicaid, and insurance coverage:*** People demanded more funding for mental health services. Insufficient funds lead to the loss of providers, the lack of services, and poor wages and benefits for direct care workers. Several people described being forced to live in poverty as the only means to assure community mental health services. People also demanded an end to the harmful discrimination resulting from the lack of parity in private insurance coverage of mental illness and emotional disturbance (as contrasted with coverage for other medical conditions).

Early on, the commission decided to develop a vision for a mental health system we could all be proud of and to make specific recommendations for actions that could be taken immediately to lead us toward that vision. Because of the enormity of the problem and time constraints confronting the commission, the work has just begun. The commission learned much about the workings of the current system and its challenges and opportunities. (See Appendix C for work group reports.) Above all, the commission concludes that Michigan must act on the proven treatments, services, and supports that lead to recovery and resiliency for adults experiencing mental illness and children with emotional disturbances. Remarkable advances have occurred in our understanding of mental disorders, and many effective treatments have been introduced. We live in a time of technological possibilities and we must take advantage of ever-increasing scientific knowledge of the brain and body.

We must deliver a message of hope and must break down the barrier of stigma. Only then will people with mental illness or emotional disturbances feel free to seek help without fear.

We must structure and fund our mental health system so that it can deliver on the promise of effective interventions. People facing difficult and potentially vulnerable situations due to mental illness and emotional disturbance deserve nothing less.

Among the populations with special needs are children and older adults. Children are grossly underserved by the public mental health system, and evidence shows that treatment is most effective and the possibility for full recovery greatest when problems are addressed at the earliest stage of illness. (See Appendix D for recommendations related to children.) We must close the gaps in care for children. We must attend to the mental health needs of older adults and ensure that there are sufficient numbers of appropriately trained providers and direct care workers to care for them.

A NEW VISION FOR MICHIGAN

For our children and adults, from Northern to Southern Michigan, the mental health system needs to be reinvigorated and reinvested in to deliver on Michigan’s constitutional promise that “institutions, programs, and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise seriously disabled shall always be fostered and supported.” To that end, the commission has determined that a new vision is essential for the mental health system in Michigan:

Michigan’s children and adults enjoy good mental health and are served by a mental health system that responds effectively to the needs of individuals with mental illness and emotional disturbance while promoting resiliency and recovery.

Making this vision a reality requires adherence to the following values for the system:

- *It must be shaped by the individuals who use mental health services and their families.*
- *It must be focused on promoting recovery and resiliency and advancing good mental health.*
- *It must be effective, focusing on clinical quality and system performance.*
- *It must be equitable, providing accessible, available, and high-quality care to all Michigan citizens.*
- *It must provide timely and easy access to a full array of services, with “no wrong door” to that care.*
- *It should be efficient and work in conjunction with the rest of Michigan’s human service network.*
- *It must be accountable, integrated, coordinated, and collaborative. Mental health services must be integrated into the other parts of our system of opportunities and care for state residents.*

SEVEN GOALS TO TRANSFORM MICHIGAN’S MENTAL HEALTH SYSTEM

Converting our vision and values into reality requires the pursuit of seven goals, which can be achieved through the recommendations presented in this report. Key recommendations are highlighted under each goal.

Goal 1: The public knows that mental illness and emotional disturbance are treatable, recovery is possible, and people with mental illness lead productive lives. (See detailed recommendations, pages 27–29.)

- *The governor should convene Michigan leaders across many sectors as a private and public partnership to develop and launch a public education campaign.*
- *The partnership should advance proven health promotion strategies to address mental health issues such as suicide and develop a single repository of mental health information.*

Goal 2: The public mental health system will define clearly those persons it will serve and will address the needs of those persons at the earliest time possible to reduce crisis situations. (See detailed recommendations, pages 29–35.)

- *Early intervention, screening, and assessment should be strengthened.*
- *Assessment of individuals needing mental health services should be simplified and clarified.*
- *Uniform guidelines for serving individuals eligible for public mental health services should be put in place across the state.*

Goal 3: A full array of high-quality mental health treatment, services, and supports is accessible to improve the quality of life for individuals with mental illness and their families. (See detailed recommendations, pages 36–39.)

- *A comprehensive, high-quality array of services should be established.*
- *As a first step, adequate core service options and crisis response services should be assured for those who qualify for “enhanced access.”*
- *A mental health institute should be created to develop evidence-based practice and practice-based evidence research and state clinical leadership should be strengthened.*
- *The special needs of children and older adults should be addressed.*

Goal 4: No one enters the juvenile and criminal justice systems because of inadequate mental health care. (See detailed recommendations, pages 39–40.)

- *The array of mental health services should be available and accessible to eliminate the use of the juvenile and criminal justice systems as “providers of last resort.”*
- *Diversion programs should be required, legal duty should be formalized, and responsibility should be clarified for mental health services.*
- *Screening and assessment of children and adults at first contact should be ensured and pre-release planning should address mental health and other needs.*

Goal 5: Michigan’s mental health system is structured and funded so that high-quality care is delivered effectively and efficiently by accountable providers. (See detailed recommendations, pages 41–49.)

- *Create and maintain a structure that better clarifies and coordinates state, regional, and local roles, responsibility, and accountability.*
- *A new funding strategy should be adopted for public mental health services, including dedicated state funding, full and flexible use of federal funds, adoption of new executive-branch budget policy, maintenance of county matching funds, and passage of a state parity law.*
- *Recipient rights protection should be strengthened to increase accountability.*

Goal 6: Recovery is supported by access to integrated mental and physical health care and housing, education, and employment services. (See detailed recommendations, pages 49–52.)

- *Mental health and physical health care should be more integrated, as well as mental health and substance abuse treatment.*
- *Children with disabilities and risk factors for emotional disturbance should be proactively identified in the education and health care environments.*
- *Programs for housing, supported education, and supported employment should be expanded and laws should be enforced to help individuals with mental illness secure housing, education, and employment.*

Goal 7: Consumers and families are actively involved in service planning, delivery, and monitoring at all levels of the public mental health system. (See detailed recommendations, page 52.)

- *Community mental health boards should have at least one representative of individuals with developmental disabilities, individuals with mental illness, and children with emotional disturbance.*
- *A mechanism should be implemented to obtain service recipient and family feedback on satisfaction with services and progress toward outcomes.*
- *Service providers should be required to formally offer and strongly encourage the establishment of advance psychiatric directives.*

The journey to transforming Michigan’s mental health system requires fundamental prerequisites:

- Strong state leadership supported by resources sufficient to improve and enforce statewide standards for administration, performance, eligibility determination, and service delivery
- Funding streams dedicated to public mental health services and treatment
- A full array of effective and available services and treatment options

Finally, the public must be better informed about the benefits of mental health services in order to generate demand—not just support—for a mental health system that benefits everyone in the state by providing the services that Michigan residents need to live healthy and productive lives.

Foreword

At the first meeting of the Mental Health Commission that she convened, Governor Jennifer Granholm called on commissioners to fix a broken public mental health system in Michigan. The Michigan Mental Health Commission believes that the public mental health system must be reinvigorated by focusing and building on success—the recovery and resiliency of people with mental illness, evidence-based and best practices that truly improve lives, and the dedication of professionals who work in the system. This report is the commission’s committed, forward-looking response to Governor Granholm’s challenge.

The Michigan Mental Health Commission strongly believes that the mental health system must embody these values.

- It must be shaped by the individuals who use mental health services and their families.
- It must be focused on promoting recovery and resiliency and advancing good mental health.
- It must be effective, focusing on clinical quality and system performance.
- It must be equitable, providing accessible, available, and high-quality care to all Michigan citizens.
- It must provide timely and easy access to a full array of services, with “no wrong door” to that care.
- It should be efficient and work in conjunction with the rest of Michigan’s human service network.
- It must be accountable, integrated, coordinated, and collaborative. Mental health services must be integrated into the other parts of our system of opportunities and care for state residents.

To assure such a system, Governor Granholm established the Michigan Mental Health Commission to develop a vision for an optimal mental health system, identify the most pressing issues and challenges confronting the current system, and make recommendations that will improve Michigan’s public mental health policies and programs. While the public mental health system serves two distinct populations—persons with developmental disabilities and persons with mental illness and emotional disturbance—this commission was charged to focus on persons with mental illness and emotional disturbances. Therefore, this report does, as well.

Because strengthening the public mental health system requires stronger public and private partnerships that recognize the importance of mental health for all, recommendations are also directed toward improvements in the overall mental health system, both public and private. The need for a stronger public-private partnership is clearly evident in purchase-of-service contracts with private providers, licensure of health professionals, and private health insurance coverage of mental illness (parity).

Michigan's constitutions since 1850 have consistently emphasized state policies and programs concerning mental health. In 1963, the people of the State of Michigan adopted a new constitution that explicitly stated that public health was a matter of "primary public concern" and directed the legislature "to pass suitable laws for the protection and promotion of the public health." The new constitution continued and extended language stating that "programs and services," and not just institutions, "for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise seriously disabled shall always be fostered and supported."

We believe that Michigan's mental health system must recognize this constitutional commitment and reflect the fundamental values identified by the commission in order to achieve the mission as set forth by the people in our constitution.

To deliver on the promise of our constitution, a system with new relationships must be put in place and adequately funded. This means a structure that coordinates and defines state, regional, and local roles and responsibilities. Such a structure should improve and enforce statewide standards for administration and performance, coordinating these functions regionally, and preserving the role of community mental health service programs (CMHSPs) in assuring local assessment and delivery while making CMHSPs, prepaid inpatient health plans (PIHPs), and providers accountable to the system, its users, and the public.

Such a structure would create the vehicle whereby the values advanced by the commission could be implemented and used to measure the system and its programs and outcomes.

We believe this new structure, following these values, will provide more consistent, timely care to more people in Michigan, thereby improving the health status of those who have a mental illness or emotional disturbance and avoiding some of the serious consequences that result from the failures of the current system.

Brief Overview of Michigan's Public Mental Health System

The commission provides a detailed overview of Michigan's public mental health system in Appendix E of this report. The detailed overview tracks the major historical developments that led to the present system, from the institutional era through the shift to community-based care and up to the era of managed public mental health care.

The overview concludes with the key challenges facing the Michigan public mental health system and mental health systems across the nation. Among the principal challenges to be overcome are:

- The increasing numbers of individuals with significant mental health problems who are showing up among the clientele served by other public systems (i.e., child welfare, juvenile justice, law enforcement, courts, corrections, and education)
- The tremendous complexity in the administration of mental health programs that are supported by multiple funding streams, each with varying eligibility standards, differential access policies, dissimilar service obligations and benefits, and various complaint processes
- Fragmentation of the state's efforts to address the mental health needs of its citizens

These fundamental challenges are complicated by the increasing numbers of individuals lacking health insurance and those with private coverage whose mental health benefits do not adequately cover services needed by persons with serious mental illness and emotional disturbance.

Our current system evolved over time, beginning in 1963 when President Kennedy signed the Community Mental Health Act that, for the first time, created a role for the federal government. Michigan quickly followed the federal lead with the passage of the state Community Mental Health Act (P.A. 54) in 1964. A key feature of that act and subsequent federal policy was the agreement of the federal government to pay for the treatment of persons experiencing mental illness, unless they were adult patients in a specialized state or private mental hospital. This created a huge incentive for the states to deinstitutionalize patients to obtain funding from Washington. Deinstitutionalization, as well as more effective psychotropic medicines and advances in therapy, resulted in a reduction in the number of persons in state mental hospitals in the United States from more than 559,000 to 50,000. In Michigan the number decreased from 20,000 to fewer than 1,000, while at the same time, Michigan's jail population saw a dramatic increase in the number of persons with a mental illness.²

The shift to federal funding had an unintended consequence. Michigan, like most states, has maximized its general fund dollars to bring in federal dollars. This leaves little help for those not Medicaid-eligible and without private insurance coverage for mental illness services. Too often, those who do not meet the Medicaid eligibility rules or who are not

² *"Incidence of Serious Mental Illness of the Jail Population in the State of Michigan."* Michigan Department of Community Health, Office of Psychiatric Affairs, February 1999.

in crisis are not able to access the system. Timely and clinically appropriate intervention is not available for too many patients who are attempting to manage their chronic disease. Those who are not Medicaid eligible and have mild to moderate mental illness cannot receive the care they need when it would be most effective.

The unintended result of several factors and policies that were well meaning but not always far-sighted has been a state/community mental health system that is uncoordinated and fragmented, with few real quality controls and dispersed accountability. The current system fosters an unacceptably wide variation in funding, quality of care, rights protection and promotion, and access to care, and suffers from administrative redundancy and unproductive variance in payer reporting requirements. While there is strong evidence that people with mental illness and emotional disturbances benefit from early intervention, the system lacks the capacity to respond in a timely manner for far too many children and adults diagnosed with a serious mental illness or emotional disturbance.

Pressing Issues and Key Findings

The commission was charged with identifying pressing issues and significant challenges to preserving and improving services for adults and children with serious mental illness or emotional disturbances. Public testimony at hearings (see Appendix F) and public comment, both written and provided during commission meetings, was extensive and helpful to the commission and its work groups in identifying the following key issues:

1. Public misconceptions about mental illness and emotional disturbance lead to stigma that impedes timely diagnosis and appropriate treatment.
2. Too often, people must be in crisis to receive mental health care.
3. Many people with mental illness and emotional disturbance are not receiving the care they need and too much of the care provided is not of acceptable quality or appropriate to the need.
4. There is inappropriate use of the juvenile and criminal justice systems for people with mental illness and emotional disturbance.
5. Michigan's public mental health system is neither structured nor funded to deliver care to people with mental illness or emotional disturbance effectively, efficiently, and in a timely fashion.
6. The lack of access to integrated mental health and physical health care and supports for housing, education, and employment impedes recovery and the development of resilience for people with mental illness and emotional disturbance.
7. The needs of people with mental illness and emotional disturbances and their families do not drive the care and services provided to the degree they could and should.

The commission's major findings pertaining to each key issue are summarized below.

1. Public misconceptions about mental illness and emotional disturbance lead to stigma that impedes timely diagnosis and appropriate treatment.

The public's lack of understanding and misconceptions about mental illness and emotional disturbances produce stigmatizing stereotypes that fuel fear, discrimination, and mistreatment.³ At the individual level, the most significant impact of stigma is that people do not seek the treatment, services, and supports they need. Adults fear that disclosure of their mental illness will have negative consequences for their employment, family, friendships, and participation in community life. For children, the symptoms of emotional disturbance lead to social isolation, victimization/bullying, and marginalization and/or expulsion within education settings. At the policy level, stigma negatively affects the investment of federal, state, local, and private funds in mental health treatment, services, and supports. This lack of public recognition that mental illness and emotional disturbances are diseases that are responsive to specific treatment has, in large part,

³ Patrick Corrigan, "How Stigma Interferes with Mental Health Care," *American Psychologist*, Vol. 59, No. 7, 614-625, October 2004.

resulted in a drastically lower level of public and private investment for mental health than is provided for physical health. According to *Mental Health: A Report of the Surgeon General*, in 1996 national mental health expenditures were 7 percent of all health care expenditures, 8 percent of public health care expenditures, and 6 percent of private health care expenditures.⁴ Additionally, the public's lack of understanding about the services that are available and the population that is currently served by the mental health system, given current resources, fuels unreasonable expectations of the system.

For individuals to recover and achieve resilience, providers, families, and the entire community must know that with appropriate treatment individuals with mental illness can become contributing members of their communities.

2. Too often, people must be in crisis to receive mental health care.

The President's New Freedom Commission on Mental Health defines recovery as "the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery."⁵ Treatment advances have significantly increased the possibility that adults with serious mental illness will recover and children with severe emotional disturbance will develop resilience.

For the system to promote "recovery" and "resilience," four key issues must be addressed.

- Providers must believe that adults with serious mental illness can and do recover and are able to exercise control over significant aspects of their lives. The service delivery system must be constructed on this knowledge.
- Health care and other service providers and educators must believe that children with serious emotional disturbance can develop resilience and grow into healthy adults. The service delivery and education systems must be based on this knowledge.
- Adults with mental illness and children with emotional disturbance must have hope that they will lead full, productive lives, regardless of their disability.
- Additional resources are necessary to ensure that screening, preventive, and treatment services are also available for children and adults at the earliest stage of their illness when treatment would be the most effective and possibility of full recovery the greatest.

The lack of resources for early screening, prevention, and treatment limits the system to managing symptoms instead of promoting recovery. Current prevention and early intervention efforts do not reflect the significant advances made over the last two decades in brain research and the development of effective treatments.

⁴ See <http://www.surgeongeneral.gov/library/mentalhealth/chapter6/sec2.html>.

⁵ *President's New Freedom Commission on Mental Health*, Department of Health and Human Services, July 2003, p. 5.

The focus of public mental health policy in Michigan has been on those individuals with the most severe and persistent mental illnesses. This focus has been intensified by the evolution of Michigan's choices for funding the public mental health system. Prior to 1999, the state legislature funded community mental health services programs (CMHSPs) for treatment and support services through one line item that did not depend on a consumer's Medicaid status (the shift to Medicaid funding had begun even earlier, before the line item change in the budget). Since that time, basic community mental health care dollars have been split into Medicaid and non-Medicaid lines, with a federal prohibition against using any of the former to benefit a non-Medicaid recipient. The decline in the system's capacity for responding to persons not enrolled in Medicaid (or fluctuating in and out each month by having to "spend down" income) has left CMHSPs with fewer resources for screening, early intervention, or treatment of persons whose conditions are of moderate or mild severity and who are not Medicaid-eligible.

Current Michigan law makes almost all diagnoses of mental illness and emotional disturbance eligible for consideration of treatment and support services. A mental illness must involve impairment that substantially interferes with at least one major life activity; impairment for an emotional disturbance must substantially interfere with or limit one's role or functioning in family, school, or community activities. The public mental health system by law must give "preference for and dedication of a major proportion of resources" to priority populations. *Vis-à-vis* mental illness and emotional disturbance, these are persons experiencing emergency or urgent situations (both of which are defined), and individuals experiencing the most severe forms (undefined) of mental illness and emotional disturbance.

The legally defined preferences giving eligibility to certain individuals and circumstances are not based on a single factor, but perhaps the most compelling is the long held belief of state policymakers that it would be unethical in a finite-resource system not to prioritize services for those most in need. There is, however, a fairly widespread perception across the mental health field in Michigan that the practical fiscal situation today limits public mental health treatment and support service in some communities to only priority populations, leaving out those with legitimate care needs who are legally eligible for public care. In many instances, consumers with such needs might be seen in the early stages of disease history, at a lower cost than what society might have to bear down the road if those needs worsen.⁶ This is especially true for children under supervision of Family Court, the Family Independence Agency (FIA), or those identified for Special Education Services. These children are not routinely seen for mental health services and should be designated as a priority population.

⁶ Based on the work of the President's New Freedom Commission on Mental Health, Michigan likely has between 450,000 and 650,000 adults and minors experiencing serious mental illness or serious emotional disturbance. The Michigan Department of Community Health (MDCH) projects that over 200,000 of these are adults with "serious and persistent mental illness." Michigan's Community Mental Health system reports annually serving about 160,000 adults and minors with mental illness or emotional disorder. Given MDCH's numbers on public system consumers internally classified as "serious," perhaps one-third or more of the 160,000 service population would not meet federal definition of serious mental illness or serious emotional disturbance. Differing caseloads, case mixes, and funding situations across CMHSPs mean some can do more than others regarding service to nonpriority populations, and some cannot consider accepting any new clients who lack priority criteria.

Clearly, the mental health system must retain a priority emphasis and its ability to respond with multiple options, which may vary in mix and intensity over time, for persons experiencing severe mental illness or emotional disturbance. Yet, to respond effectively and efficiently to the mental health needs of all, our focus must expand to encompass not only our response to the most severe mental illnesses and emotional disturbances, but also an array of treatments, services, and supports that gets the right care to people at the earliest opportunity. There is ample evidence that early intervention is effective, preserving the health and quality of life of persons with mental illness and saving costs in the long term because more intensive care is often unnecessary. Strengthening early identification, screening, and prevention and early intervention services is required to meet mental health needs at the earliest opportunity. Consequently, the expansion of services to children and families needs to be a priority.

Finally, the complexity of the policies regarding who is served by the system and the services that are available makes it difficult for people to access care and fuels expectations on the part of the public that cannot be met by the current system.

3. Many people with mental illness and emotional disturbance are not receiving the care they need and too much of the care provided is not of acceptable quality or appropriate to the need.

During the 1980s and early 1990s Michigan was a national leader in the development of Assertive Community Treatment programming, person-centered planning policies and family-centered practice, creating clubhouse programs across the state, wraparound service delivery, community-based services, and greater state department integration of mental illness and substance abuse treatment. The erosion of state funding and other policy support in the past decade, however, has contributed to serious gaps in both availability and quality of essential services that must be addressed.

In addition, the mental health field is plagued by disparities in the availability of and access to its services—even more than other areas of health and medicine, according to the U.S. Surgeon General’s report on mental health.⁷ (The executive summary of this report, along with other references, is available from the commission on request; see Appendix G.) These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender. The U.S. Surgeon General’s report confirms the existence of several disparities affecting mental health care of racial and ethnic minorities compared with whites, i.e.,

- Minorities have less access to available mental health services
- Minorities are less likely to receive needed mental health services
- Minorities who receive treatment often receive poor quality mental health care
- Minorities are underrepresented in mental health research

⁷ U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

For adults, high-quality treatment, services, and supports are not uniformly available throughout the state in the appropriate quantities to meet their mental health needs. In particular, there is a lack of attention to the mental health needs of aging adults, including unique issues of access for older adults whose living arrangements affect their eligibility for services and insufficient numbers of appropriately trained providers and direct care workers⁸ to care for those who have chronic conditions such as depression and dementia. This problem will become much more acute as the population ages. By 2030, the population of Americans over age 65 is expected to reach almost 72 million, compared to 35.6 million in 2002.⁹ In Michigan, it is estimated that those aged 65 and older will grow from 1.2 million in 2000 to 2.1 million in 2030, or from 12.4 percent to 19.8 percent of the state population.¹⁰ *Mental Health: A Report of the Surgeon General—Executive Summary* asserts, “The capacity for sound mental health among older adults notwithstanding, a substantial proportion of the population 55 and older—almost 20 percent of this age group—experience specific mental disorders that are not part of “normal” aging.”¹¹ Of nearly 34 million adults in the United States, it is estimated that 2 million have a depressive disorder and the biggest cause of psychosis and behavioral disturbance in older adults is dementia.¹² Other issues specific to older adults with mental illness include medication mismanagement or lack of access to needed medications due to decreased income in retirement.¹³

In addition to the variability in services throughout the state, several gaps have been brought to the attention of the commission. Some communities report an apparent shortage of acute care inpatient psychiatric beds, especially for children and adolescents. There is also limited inpatient care capacity across the state for those needing intermediate and extended inpatient psychiatric treatment. There are relatively few appropriate residential beds for adults and children in the public mental health system. State hospital closures have left the state with one facility for children and three for adults, all of which are located in the southern half of the state. This requires many individuals to be placed far from home. While there is not a need for more large state institutions, there is a need for geographically accessible, small, secure public and private residential treatment units that can augment short-term inpatient care, state hospital care and community care.

For children, the level and structure of funding for mental health services is the most significant factor limiting the promotion of mental health in children, screening and assessment, and provision of services and supports to those in need. Many children with mental health needs are not receiving care, nor are we acting upon the increasing

⁸ Maureen Mickus, Clare Luz, and Andrew Hogan, *Voices from the Front: Recruitment and Retention of Direct Care Worker in Long Term Care Across Michigan*, April 2004.

⁹ *Substance Abuse and Mental Health Services Administration News* 12, no. 4 (July/August 2004).

¹⁰ “*State Health Expenditures in Michigan*,” CRC Notes, Citizens Research Council of Michigan, August 2001.

¹¹ U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

¹² Public comment.

¹³ Public comment.

knowledge of the mental health field to identify the early antecedents of mental illness and emotional disturbance and intervene as early as possible. Five to 9 percent of children have serious emotional disturbances, yet only 1 percent of all Michigan children receive public mental health services (some mental health services for children are provided through schools, FIA, and private funding).¹⁴

Children who do not meet income or severity criteria for Medicaid have limited access to the public mental health system and often do not have sufficient private insurance coverage. There is also uneven geographic access to services for children due to variations in funding among community mental health service programs. Efforts to contain costs result in state and local policies and procedures that encourage inappropriate handoffs among systems, including, but not limited to, mental health, juvenile justice, child welfare, substance abuse, and education.

There are major gaps in care for children, including the lack of prevention and early intervention services, limits in the number of outpatient visits that restrict treatment to short-term duration, and a paucity of crisis and other residential services. Families testified that entering the mental health system to get care for their children is complicated, confusing, and operates to limit access to services. Mental health services for children are fragmented across many systems, including child welfare, juvenile justice, substance abuse, and education, making it difficult for families to know where to turn. These gaps in services and challenges for families create a chasm between the number of children who need services and the number who receive them.

Regarding the quality and appropriateness of services for children, their families, and adults, there is variation across the state in the use of best practices by agencies providing mental health services. Particularly for children, Michigan has limited capacity to identify, disseminate, and apply the increasing knowledge about the nature of emotional disorders in children to public and private screening, diagnostic, and treatment efforts. Many professionals who work with children have not been provided the training and tools necessary to screen children for mental health needs, make the necessary referrals for services, and offer culturally competent services that assure individualized care with regard to race, ethnicity, disability, gender, sexual orientation, socioeconomic status, geography, and the culture of families of children with serious emotional disorders.

4. There is inappropriate use of the juvenile and criminal justice systems for people with mental illness and emotional disturbance.

One of the most negative consequences of not adequately addressing mental illness and emotional disturbance (at all stages) is the overuse of costly and inappropriate services for children and adults with mental health needs. There are too many children and adults in the criminal justice system (juvenile justice, jails, and prisons) who should be served by the mental health system. Screening indicates that 61 percent of males and 74 percent of females entering the juvenile justice system in Michigan may have mental health needs.¹⁵

¹⁴ New Freedom Commission Report.

¹⁵ Michigan Mental Health Juvenile Justice Screening, Assessment, and Diversion Project.

In advance of an individual coming into contact with either the juvenile or criminal justice system, we do not adequately assess early risk factors or symptoms of mental illness in order to address problems at the earliest opportunity. Nor do we reach out to seriously disordered individuals who have not found their way into the mental health system or always match recipients with services that most appropriately meet clinical needs. There are several obstacles to reducing the overuse of the justice system for mental health care.

- Limited and uneven access to publicly funded mental health care is a barrier for those who are not experiencing serious and persistent mental illness or emotional disturbance, creating a gap in effective services that would support diversion from the justice system.
- Current CMHSP funding and programs do not prioritize pre- and post-booking diversion efforts, resulting in inadequate capacity and missed opportunities to foster collaboration between mental health and criminal justice at the community level.
- While there is a statutory (only for the public mental health system) and administrative requirement for diversion, efforts are insufficient. There are too many adults in the jail and prison system and too many children in the juvenile justice system who should be served and supported by the mental health system.
- Many people with serious mental illness or emotional disturbance enter the criminal justice system due to inadequate involuntary treatment policies. There is no clear and generally accepted understanding or agreement regarding who has the right to compel treatment, the circumstances under which treatment may be compelled, or what types of treatment may be compelled.
- The county of adjudication (where a crime is committed) may not be the county where community mental health services can be provided. Because the county of residence is currently financially responsible for services, the county where a crime is committed must rely on the county of residence for the resources to support care.
- There is insufficient training and collaboration across service providers, first responders, law enforcement, defense attorneys, prosecutors, and the judiciary, corrections, and probation, e.g., there is a lack of joint training and common use of best practices for screening and assessment at entry into juvenile detention facilities, jails, and prisons.

There are specific issues confronting children in the juvenile justice system and adults in the correctional system who have mental health needs. These include:

- Within jails, prisons, and juvenile detention facilities, there are problems with timely and accurate clinical screening and assessment (and therefore, treatment).
- While the Michigan Department of Community Health (MDCH) has supported evidence-based treatment services for children and adolescents, a full array of such services is not consistently available.
- There is not a full array of evidence-based treatment services for adults, including effective alternative secure residential treatment for those in jail or prison.
- Treatment for individuals with the co-occurring disorders of substance abuse and mental illness is not integrated, particularly at the point of accessing and entering

services for these two conditions. This is a particularly significant problem for children and adolescents.

- There is no unified system of coordinated and collaborative support to ensure a smooth transition for individuals from detention or incarceration to community-based treatment and care.

An overall concern is Michigan's lack of an all-inclusive mechanism for collecting and applying national, evidence-based practices in the mental health, juvenile, and criminal justice systems.

5. Michigan's public mental health system is neither structured nor adequately funded to deliver care to people with mental illness or emotional disturbance effectively, efficiently, and in a timely fashion.

The current structure of the mental health system—that is, the relationships and responsibilities of the state, prepaid inpatient health plans (PIHPs), CMHSPs, providers, and consumers—is characterized by bureaucratic processes that overlap, are redundant, and add costs that significantly reduce the amount of resources available for direct services and care for persons with mental illness and emotional disturbance. The structure has fostered the following problems:

- *Significant variation in funding and administrative costs among counties and therefore service provision and access.* Although the state implemented a new, more equitable funding distribution formula in 1997,¹⁶ which was updated in 1999, and some redistribution of funds has occurred, current general fund allocations to CMHSPs vary from between 52 percent to 142 percent of the amount a CMHSP would have received with full implementation of a revised funding formula model. Reported administrative costs among CMHSPs from 1999 through 2003 varied from 4 percent to 31 percent (an average of 8 percent) reflecting different cost reporting methodologies, challenges calculating administrative cost distribution within newly formed CMHSP affiliations, disparate treatment of subcontractor administrative costs, and differing sizes of agencies and their budgets.¹⁷ The variation in funding across community mental health entities was even greater in the 1980s and 1990s, but continues as a key issue to be addressed.
- *Inefficiency because of variation in regulation between the two major funding sources (Medicaid and the state general fund).* PIHPs and providers struggle to manage two different major sources of funding for public mental health services: Medicaid and the general fund. These sources have very different requirements, which confuse and frustrate people needing services and drive unnecessary duplication of effort among PIHPs and providers that must conform to these regulations.
- *Inefficiency due to the absence of a standard method of collecting information from PIHPs, CMHSPs, and providers to meet the large number of administrative requirements.* While there has been some progress recently with clinical uniformity and data submission, the state lacks the staffing and resources to monitor and enforce

¹⁶ *Funding Community Mental Health in Michigan*; Citizens Research Council, Report No. 318, January 1997.

¹⁷ Steve Angelotti, "Background Information on Mental Health Issues," Michigan Senate Fiscal Agency, September/October 2003. The full text of this report is provided in Appendix K.

statewide standards when doing so will reduce administrative costs and improve quality.

- *Too much variation in the quality of mental health care.*¹⁸ This is due to (a) wide variation in funding among CMHSPs and (b) federal and state regulations that do not require the measurement of outcomes that matter most to consumers and reflect the commission's values.

The structure and funding of Michigan's mental health system are also compromised by the gap between public and private coverage and responsibility. While two-thirds of Michigan residents have private health insurance, most have coverage for mental health that is much more limited than that for physical health. This includes more stringent limits on outpatient visits, inpatient days, copays, deductibles, and annual dollar limits. Nationally, four out of five health plans have benefit coverage for mental illnesses and emotional disturbances that is less than coverage for physical illnesses. Moreover, there is little or no incentive for private health plans to offer care to people with serious mental illness or emotional disturbance, which forces the public system to attempt to fill the gaps in coverage and access with inadequate resources. The shortcomings of the public and private sectors reinforce each other.

The commission recognizes that some parties outside the mental health community fear the "costs" of mental health insurance parity. These fears are unfounded (and were not shared by the voting public in 2000, when 83 percent of respondents in a statewide poll favored a parity law for Michigan).¹⁹ The Michigan Partners for Parity Coalition, which commissioned the survey, began seeking state law to end insurance discrimination in 1998. All the leading evidence from around the country in recent years has shown parity to involve very small direct cost increases, which can be more than made up by the benefits that employers and society gain from increased access to mental health care. Some examples of findings include:

- The Congressional Budget Office has reported that President Clinton's Executive Order (implemented 2001) of comprehensive mental health and addiction disorder parity for nine million federal employees resulted in an average insurance premium increase of 1.3 percent.²⁰
- A federal Substance Abuse and Mental Health Services Administration (SAMHSA) study released in 2003 regarding parity in Vermont²¹ was the most comprehensive evaluation undertaken of a state parity law's effects. The investigation found:
 - Overall probability of receiving mental health service increased and more people received outpatient mental health care following implementation of parity.
 - Consumers paid a smaller share of the total amount spent on mental health services following parity. Among persons with serious mental illness, the

¹⁸ MDCH site review reports show variation in compliance with quality standards.

¹⁹ "Michigan Voters Want End to Mental Health Insurance Discrimination; Are Lawmakers Up to the Task?" THE ADVOCATE, v. 24, no. 3, June 2000.

²⁰ Ronald Bachmsn, FSA, MAAA (PricewaterhouseCoopers), testimony before the Michigan Senate Health Policy Committee, June 4, 2003.

²¹ SAMHSA, 2003. *Effects of the Vermont Mental Health and Substance Abuse Parity Law.*

- proportion of consumers spending more than \$1,000 out of pocket annually was cut in half.
- In one of Vermont’s two major health plans (covering 80 percent of the state’s privately insured population), combined spending for mental illness and addiction disorders actually decreased. The cost of comprehensive parity for the other plan equated to 19 cents per covered member per month (i.e., \$2.32 per member annually).
 - Only 0.3 percent of Vermont employers (three out of every 1,000) reported dropping employee health coverage because of parity law.
 - Renowned actuarial parity expert Ronald Bachman (PricewaterhouseCoopers) told Michigan’s Senate Health Policy Committee in 2003, “Actual experience, economic forecasting, and actuarial projections indicate that the [mental health parity] cost debate is over. How many studies are needed to prove the point?”²²
 - Not one of the 35-plus states that have adopted parity law has ever repealed the law.²³
 - The U.S. Surgeon General’s 1999 report on mental illness²⁴ estimated the direct business cost of lack of parity for mental illness to be over \$70 billion a year, mostly in the form of lost productivity and increased absenteeism and sick leave.
 - A study published by the American Medical Association in 2003²⁵ reported that depression alone cost employers nationally \$44 billion per year in lost productive time (LPT). This was \$31 billion more than the LPT cost seen in workers without depression.
 - According to the American Chamber of Commerce Executives,²⁶ “Approximately \$24 billion... is lost annually in productivity and workdays [due to mental disorders]. Despite the obvious need for treatment, only one in four people affected receive medical treatment. Why?”
 - A 30 percent reduction in mental health services at a large Connecticut corporation triggered a 37 percent increase in medical care use and sick leave by employees with mental disorders, thus costing the corporation more money rather than less.²⁷

Funding challenges go hand in hand with structure problems. Michigan’s long tradition of progressive public policy for mental health services has been undermined by inadequate funding. State policy decisions to (a) maximize federal revenue through Medicaid, MICHild, and the Adult Benefits Waiver, and (b) limit general fund appropriations to public mental health services have resulted in a two-tiered system of coverage and services: people eligible for Medicaid, which legally entitles them to covered services, are much more likely to receive public mental health services than

²² Bachman, testimony.

²³ Thomas Carli, MD, Medical Director, U-M Medical Management Center, testimony before Michigan Senate Health Policy Committee, May 14, 2003.

²⁴ *Surgeon General’s Report*, 1999.

²⁵ Stewart et al., “Cost of Lost Productive Work Time among U.S. Workers with Depression,” *JAMA* 289 (2003): 3135–44.

²⁶ Lisa Burtch, February 2, 2000. “Impact of Mental Health Disorders on Business.” ACCE Manager Benefits Member Services.

²⁷ Rosenheck et al., “Effect of Declining Mental Health Service Use on Employees of a Large Corporation,” *Health Affairs* 18, no. 5 (September 1999).

those who must rely on the general fund, which does not entitle the uninsured to services. Even so, Medicaid does not cover many people with serious mental illness or emotional disturbance because eligibility requires meeting a restrictive definition of disability and restrictive income requirements. The effect of this two-tier system is exacerbated by the differences in general fund support for mental health services among Michigan's counties. These inequities mark a crisis in the delivery of appropriate and effective services and supports throughout the state.

In its September/October 2003 report on funding for Michigan's public mental health system, the Michigan Senate Fiscal Agency (SFA) explains that

Ever since deinstitutionalization began in the 1960s, mental health responsibilities and funding have been transferred from State institutions and State-funded group homes to the CMH system. Thus, much of the increase in CMH expenditures over the years has not been an actual funding increase, but rather has been a shift in funding from state-run programs to locally run programs.²⁸

Average base funding increases to Michigan mental health general fund expenditures in the past 20 years have been less than the base reductions: the average annual increase of 1.0 percent has been more than offset by the average annual base reduction of 1.2 percent.²⁹ In comparison, the state's total general fund spending rose 83 percent in the same period. General fund appropriations to mental health are a proposed \$313 million for fiscal year 2005, \$57 million less than they would be if consumer price index (CPI) increases were granted for fiscal years 1999–2005.³⁰

Limited economic increases have even hit Medicaid mental health services. As the SFA report notes, "the rate of growth since FY 1998–99 has been far lower than the previous growth." After setting Medicaid capitation rates in FY 1998–99, which provided a funding increase for CMHSPs, "there were no Medicaid rate increases until the 'local match' program went into effect during FY 2002–2003," the SFA report says. The local match program delivered a 2 percent increase in Medicaid rates, but it was accomplished using local, not state, funds to acquire federal matching dollars. In the same period, CMHSPs saw a 1.1 percent decline in Medicaid rates effective March 2003 and a general fund rate cut of 2.5 percent starting in February 2003, both from executive orders in December 2002. The only state-funded rate increase since FY 1998–99 was 1.6 percent in FY 2003–2004 for Medicaid, an increase in which the state match was provided through a reduction in general fund mental health spending. Increases in overall funding for Medicaid mental health funding between FY 1998–99 and FY 2003–2004 reflect a substantial increase in caseload, not in rates.

Viewed another way, Medicaid funding for mental health services has not benefited from CPI increases. Proposed FY 2005 Medicaid funding of \$1.4 billion is \$235 million less

²⁸ Angelotti, "Background Information on Mental Health Issues."

²⁹ Judith Taylor, "CMH Financing History: Summary of 20 Years of the State Financing Strategy for CMH." Presented to the Mental Health Commission on May 20, 2004. The full text of this report, as well as other background materials prepared by Taylor, is provided in Appendix H.

³⁰ Taylor, "CMH Financing History."

than it would be if CPI increases had been appropriated starting in FY 1999. As a result of this policy, the state has lost \$130 million in federal Medicaid matching dollars.³¹

Two areas in particular have been hardest hit by the underfunding of public mental health services. National prevalence data for children aged 9–17 indicate that 5 to 9 percent have a serious emotional disturbance (SED) with severe functional impairment and 9 to 13 percent have a SED with substantial functional impairment.³² Michigan’s Mental Health Code defines a SED as “substantially” interfering with functioning. Yet, in 2002, just 1 percent of the total child population (aged 0–18) of Michigan was treated for SED by Michigan’s public mental health system, suggesting that children are grossly underserved by the system.³³ Prevention and early intervention services also merit much stronger funding, as the current focus on treating persons with the most severe and persistent mental illness or emotional disturbance—a trend nationwide—does not help children and adults at the early stages of their illnesses when treatment would be most effective.

The public mental health system is not sufficiently accountable to consumers and families. Recipient rights are one area where this is most evident. It has been difficult for consumers to take their complaints outside the realm of their service managers. The one exception is the so-called Medicaid “fair hearing,” where an individual can go before an MDCH administrative law judge who does not necessarily possess any clinical background. This less-than-ideal appeal is only available to persons enrolled in Medicaid (roughly half of CMHSP recipients experiencing mental illness are not) and is limited to questions of whether a Medicaid service was inappropriately denied, reduced, suspended or terminated.³⁴ The director of the State Office of Recipient Rights does not have sufficient operational authority within MDCH, and the department lacks practical authority to initiate meaningful sanctions when an investigation of a CMHSP has been authorized and has found major noncompliance with rights protection. There is concern among some parties about the degree of practical autonomy that CMHSP recipient rights directors have. Additionally, when a rights violation has been substantiated, state law allows the provider to determine “appropriate remedial action” to be taken. These are potential conflict-of-interest situations. The commission heard considerable testimony on rights issues. The commission believes that consumers and families should be empowered by redesigned and improved rights protection and promotion measures.

³¹ Taylor, “CMH Financing History.”

³² *Federal Register* 63 (137), Friday, July 17, 1998.

³³ This is consistent with studies that estimate that 70 to 80 percent of children go without care. See National Health Policy Forum, “Children with Mental Disorders,” Issue Brief No. 799, June 4, 2004.

³⁴ Michigan’s public mental health system has used managed care funding principles for years, and now heavily relies on those methodologies. Despite that, CMHSP clients do not enjoy the same opportunity the state accords clients of Blue Cross, HMOs, and private insurers to request a service appeal before a clinician not connected to their health care manager or the executive branch of government.

6. The lack of access to integrated mental health and physical health care and supports for housing, education, and employment impedes recovery and the development of resilience for people with mental illness and emotional disturbance.

Recovery—the process of people with mental illness or emotional disturbance living, working, learning, and participating fully in their communities—requires coordination across mental health treatment and services, physical health care, and social supports such as education, housing, and employment. However, these services and supports exist separately and coordination among them is often inadequate, making it difficult for people with mental illness or emotional disturbance to bring together the mental health care and support services that would make their recovery possible.

One of the most important connections is between mental health and physical health care. Currently, there are few efforts under way to restructure primary care with a recovery and community membership focus for the whole person, including clear clinical expectations and integration of mental health professionals in the primary care setting. Treatment is particularly poorly integrated for those who have the co-occurring disorders of substance abuse and mental illness. And, lack of coordination between mental health and physical health care is especially difficult on the older adult population who tend to have more complex medical conditions.³⁵

Nationally, it is estimated that 200,000 people experience chronic homelessness. Recent estimates suggest that 25 percent of this population suffers from serious mental illness and at least 40 percent have a substance use disorder. Often, these conditions are co-occurring.³⁶ The human and financial toll exacted on these individuals is incalculable. People with serious mental illness and/or co-occurring substance use disorders who are homeless often cycle between the streets, jails, and high-cost care, including emergency rooms and psychiatric hospitals.³⁷

Although people with mental illness want to work, programs that are designed to help them obtain employment often fall short. Prevocational counseling and training are insufficient or lead them into a career path that is not commensurate with their interest, skills, or education. Individuals with mental illness who are covered by Medicaid may risk losing their health insurance coverage when they go to work. Most entry-level jobs obtained by these individuals when they initially seek employment do not offer health benefits.

Data from the National Health Interview Survey on Disability (1994–95) indicate that 48 percent of individuals with mental illness are employed and 37 percent of those with serious mental illness are working. Furthermore, employment rates among individuals with mental disorders are 20 percentage points below those for people with physical

³⁵ Public comment.

³⁶ D. Culhane, Pre-conference institute presentation at “We Can Do This! Ending Homelessness for People with Mental Illnesses and Substance Use Disorders,” December 5, 2001.

³⁷ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and/or Co-Occurring Substance Use Disorders*. 2003.

disorders.³⁸ This suggests there is a long way to go in providing the supports individuals with mental illness need to obtain and maintain employment.

Although supported employment is a promising approach to improve work opportunities for adults with mental illness, many lack the education necessary to obtain competitive employment in a position they desire. They also may need additional skills training before they attempt to apply for work. These issues may be addressed through supported education. Michigan's Supported Education Program, although well documented in its success, is being used only in small portions of the state.

7. The needs of people with mental illness and emotional disturbance and their families do not drive the care and services provided to the degree they could and should.

While progress has been made in Michigan's consumer and family movement to shape the direction of mental health services, more needs to be done to increase the involvement of individuals with mental illness or emotional disturbance and their families in mutual support services, consumer-run services, and advocacy. Frequently mentioned in public testimony to the commission was the need to more consistently involve families in planning care for their children.

³⁸ D. Mechanic, S. Bilder, and D. McAlpine, "Employing Persons with Serious Mental Illness," *Health Affairs* 21, no. 5 (2002): 242–53.

Vision and Values for Transforming the Michigan Mental Health System

VISION

Michigan's children and adults enjoy good mental health and are served by a mental health system that responds effectively to the needs of individuals with mental illness and emotional disturbance while promoting resiliency and recovery.

VALUES

The commission developed the following values for transforming the Michigan mental health system. Each recommendation of the commission strives to address these values. A transformed mental health system should be:

■ *Shaped by the individuals who use mental health services and their families*

A primary goal of the public mental health system is to improve the quality of life for individuals with mental illness and emotional disturbance and their families. To achieve this goal, the active and informed participation of adults, children, and adolescents who use public mental health services and their family members should be promoted and supported in all aspects of system governance, including planning, delivering, and evaluating mental health services.

The services and supports provided by the public mental health system should be respectful of and responsive to each individual's preferences, needs, and values. A partnership should exist among the caregiver, the person with mental illness or emotional disturbance, and their family or legal guardian, if applicable, and any advocate they may wish to involve from their natural support network or the mental health system. Services to children with emotional disturbance and their families must be individualized and family centered. The system should be driven by the needs of individuals and families served and should be accountable to the residents of Michigan.

■ *Focused on promoting recovery and resiliency and advancing good mental health*

Services and supports for individuals and family members served by the system should focus on recovery (people able to live, work, learn, and participate fully in their communities) and resiliency (people able to rebound from adversity and other stresses with mastery, competence, and hope) to maximize stability and functioning. The system should integrate people into community settings, encourage the use of natural supports in communities, and promote awareness that mental health is essential to overall health.

■ *Effective*

Services and supports should be aligned with contemporary and emerging scientific knowledge and qualitative as well as quantitative evidence-based practices and provided to all who could benefit. Services must meet the highest standards of quality and promote positive outcomes. Service delivery must be guided by the management

of outcomes. The effectiveness of caregivers, providers, and the system should be measured by increased quality, improved outcomes, and higher satisfaction for all those served. Accountability for outcomes must focus on clinical quality and system performance.

■ ***Equitable***

Services and supports should be accessible, available, and high quality for all, without regard for personal characteristics such as ability to pay, age, disability, ethnicity, gender, geographic location, race, and sexual orientation. Disparities in access to high-quality and culturally competent care must be eliminated. The system should have a method for prioritizing services that does not harm those with the most need.

■ ***Timely and with easy access to a continuum of care***

The system should assure timely and easy access to the most current treatments and best support services, with the earliest possible detection and assessment throughout the life cycle. Uniform mental health screening must be implemented across systems serving children and families. A continuum of care should provide the right care at the right place at the right time.

■ ***Efficient***

The system should work closely with the rest of the human service network to maximize efficiency, reduce redundancy, and assure prompt access to appropriate services. There must be a quick and easy way to transfer individuals from the criminal justice system, where appropriate, to mental health services when public safety is not jeopardized. Service plans for children and families must be developed in collaboration with all other systems serving the family. Resources must be directed to evidence-based treatments and used flexibly and creatively.

■ ***Integrated, coordinated, and collaborative***

Individuals and families in our mental health system are part of other systems of care, e.g., physical health, substance abuse services, rehabilitation, education, the justice system, the Family Independence Agency, and other human service organizations. We should always strive to form linkages and coordinated programs with these other areas of service. An ideal system is integrated; for consumers entering a confusing array of services, there is “no wrong door.” All entry points should lead to coordinated care.

Goals and Recommendations to Achieve Them

The commission developed seven goals to address the most pressing issues and challenges confronting the Michigan mental health system and recommendations for reaching the goals.

GOALS

1. The public knows that mental illness and emotional disturbance are treatable, recovery is possible, and people with mental illness and emotional disturbance lead productive lives.
2. The public mental health system will clearly define those persons it will serve and will address the needs of those persons at the earliest time possible to reduce crisis situations.
3. A full array of high-quality mental health treatment, services, and supports is accessible to improve the quality of life for individuals with mental illness or emotional disturbance and their families.
4. No one enters the juvenile and criminal justice systems because of inadequate mental health care.
5. Michigan's mental health system is structured and funded to deliver high-quality care effectively and efficiently by accountable providers.
6. Recovery and resilience is supported by access to integrated mental and physical health care and housing, education, and employment services.
7. Consumers and families are actively involved in service planning, delivery, and monitoring at all levels of the public mental health system.

RECOMMENDATIONS TO ACHIEVE THE GOALS

Goal 1: The public knows that mental illness and emotional disturbance are treatable, recovery is possible, and people with mental illness and emotional disturbance lead productive lives.

The public's view of mental illness and emotional disturbance must be changed if Michigan's mental health system is to support the full participation of people in society. Research shows that knowledge of mental illness and emotional disturbance is not sufficient in dispelling stigma.³⁹ There must be widespread recognition of medication advances, new evidence-based best practices, multidisciplinary treatments, and the impact of those advances as well as the resulting successful recovery stories. Fortunately, research continues to yield increasingly effective treatments for mental and emotional disorders. This information should be disseminated as part of an education campaign to

³⁹ Phelan et al., Surgeon General's Report, 1997.

help people understand the nature of mental illness and emotional disturbance as diseases and their effective treatment.

In addition to the public education campaign, broad-based health promotion strategies should be initiated to both reduce stigma and to help prevent mental health problems. The strategy of launching broad-based health promotion campaigns to address mental health issues has demonstrated success, yet remains untapped by most state mental health programs. Suicide, the 10th leading cause of death in Michigan in 2002, is increasingly seen as a preventable health problem.⁴⁰ Due to the dramatic reduction in suicide achieved by the United States Air Force through the training of all its members in suicide risk awareness and prevention, many states are now pursuing public health promotion strategies to reduce suicide. The Air Force suicide rate fell from 14.1 per 100,000 active duty service members (1991–96) to 9.1 per 100,000 (1997–2002). The national suicide rate has remained unchanged for 50 years, so promising findings such as the Air Force results should be seriously considered. According to *Governing* magazine, “because the majority of people who are suicidal go undiagnosed until it’s too late to treat the illness, the only effective strategy may be to stress prevention in messages aimed at the entire population.”⁴¹

Key Recommendation

1. Create a continuing public education campaign.

The governor should convene Michigan leaders in the media, business and labor, faith community, state and local government, advocacy organizations, education community, and individuals using mental health services, to create a public and private partnership to develop and launch a continuing campaign to educate the public that mental illness and emotional disturbance are physical illnesses and to combat the public’s misconceptions about mental illness and emotional disturbance and the mental health system. Campaign strategies should be modeled after effective media advocacy on such issues as tobacco control, reducing drunk driving, and the importance of investing in early childhood development, which have changed the public view and influenced behavior.

The recommendations of the draft Michigan Plan for Suicide Prevention to implement a statewide awareness campaign to reach all citizens about suicide prevention should be incorporated into the strategies of the statewide public awareness campaign.

Additional recommendations

2. The partnership should also develop a single, Web-based repository of information for the media, mental health professionals, and the public on mental illness and emotional disturbance.
3. Enlist the support of the MEDC and local economic development groups to embellish the “life sciences corridor” by attracting to Michigan pharmaceutical and other related

⁴⁰ Michigan Suicide Prevention Coalition, *Draft Suicide Prevention Plan for Michigan*, 2004.

⁴¹ *Governing*, August 2004.

private industries that will capitalize on research into the causes and treatments of mental illness and attract mental health professionals and experts to the state.

4. Michigan's Surgeon General should lead the implementation of the draft Suicide Prevention Plan of the Michigan Suicide Prevention Coalition.

Goal 2: The public mental health system will clearly define those persons it will serve and will address the needs of those persons at the earliest time possible to reduce crisis situations.

A recent national analysis concluded that access to care for persons with serious mental illnesses has generally been maintained, but access and services for individuals with less severe conditions (which constitute a relatively large group) have declined considerably.⁴² The latter is widely accepted as applicable to Michigan; the former is more open to debate. Several related assessments in recent years from in-state and out-of-state organizations and the media have given Michigan low marks in policies, service access, and results.⁴³ Prevention and early intervention services have also been greatly diminished. A key challenge over the next several years will be to devise strategies that can enhance access for individuals across all stages of mental illness, including persons with less severe disorders, and will promote prevention and early intervention efforts.

As Michigan moves in that direction, the state's broad statutory eligibility policies for potential assistance from the public mental health system should continue. State and CMHSP implementation strategies to facilitate service to persons requiring clinical intervention to prevent a crisis, as well as primary prevention targeted to at-risk youth, should be strengthened. However, the existing "major proportion of resources" priority emphasis for persons experiencing severe conditions and/or psychiatric emergencies must remain for the foreseeable future. While the commission strongly recommends that significantly increased financial support should be devoted to the public mental health system to appropriately serve a full range of consumer needs, it is recognized that in the near future Michigan still will be dealing with a limited-resource system. In the state's current dire economic circumstances, if rationing decisions have to be made, first preference must continue to be given to those for whom extreme harm can be expected absent immediate attention. The commission reaffirms Michigan's long-held position that doing otherwise would be unethical. It would also take away a central focus for accountability that must be applied to the public system's efforts so that stakeholders and government can make reasoned judgments about its degree of success.

⁴² David Mechanic and Scott Bilder, "Treatment of People with Mental Illness: A Decade-Long Perspective," *Health Affairs*, July/August 2004.

⁴³ See, for example, Barrett et al., "A Case of Neglect," *Governing* (February 2004); Krupa and Brooks, *Detroit News* special series on mental health, July 20–22 and August 8, 2003; National Mental Health Association, *Can't Make the Grade: NMHA's State Mental Health Assessment Project* (2003); Bernasek et al., *Case Study: Michigan's Medicaid Prescription Drug Benefit* (Kaiser Commission on Medicaid and the Uninsured, January 2003); and Alliance for the Mentally Ill of Michigan, Association for Children's Mental Health, Mental Health Association in Michigan, Michigan Association for Children with Emotional Disorders, and Michigan Psychiatric Society, *Evaluating the Provisions of Long-Term Psychiatric Care in Michigan's Publicly Funded Mental Health System: An Assessment Tool for Consumers, Families, Advocates, Providers, and Policymakers*, June 2001.

In order to retain priority emphasis for certain conditions and circumstances, while also facilitating consistent system capabilities across the state to do more for persons with mild and moderate disorders, clear and uniform operational definitions and service selection guidelines are necessary. At the same time, immediate steps should be taken to strengthen prevention and early intervention, screening, and assessment, and to reduce the need for involuntary services through person-centered planning and family-centered practice. Services for children and youth require an interagency approach, involving mental and physical health care, child welfare, juvenile justice, and education.

The following recommendations reflect the commission's emphasis on strengthening early intervention, screening, and assessment that aims to detect and address mental, emotional, or behavioral problems before they become established and more difficult to treat. The recommendations also recognize that involuntary treatment is always a last resort. The aim is to use other methods to maximize choice. The likelihood of successful treatment is greater when persons with mental illness choose to be treated.

Key Recommendations

5. Case finding: Early identification and screening should be strengthened throughout all health care and service systems, consistent with other health conditions. Early identification and screening is essential for good physical health outcomes and just as essential for good mental health outcomes. The State of Michigan should seek funding partners that will support innovations in the application of physical disease management to mental health care, beginning with the primary care setting and including (a) understanding current practices to identify and screen for mental health problems, in the primary care setting; (b) evaluating effectiveness of treatment in the primary care setting for diseases such as depression, which is the leading cause of disability in established market economies;⁴⁴ and (c) developing educational interventions for primary care physicians to help recognize and manage patient care. (See additional recommendations regarding physical and mental health care integration under Goal 6.)
6. Hierarchy of choice: The legislature should amend the Michigan Mental Health Code and the Estates and Protected Individuals Code (EPIC), MCL 700.1, to simplify the assessment of persons who may need mental health services and assure care more quickly. Current law is based on the previous inpatient model of care, while the mental health system is now based more on an outpatient model of care. Changes should be made in our state's involuntary treatment policy to gain more consistency with person-centered planning and family-centered practice with the goal of making every effort to avoid involuntary services through the active participation of consumers, or their representative when the consumer is unable to choose care, in all decisions regarding treatment and service planning.

The goal of the following hierarchy is to make every effort to avoid involuntary treatment unless the consumer's understanding of his or her need for treatment is impaired to the point that the individual is at risk for significant physical harm to self

⁴⁴ Anthony F. Lehman, Howard H. Goldman, Lisa B. Dixon, and Rachel Churchill, *Evidence-Based Mental Health Treatments and Services: Examples to Inform Public Policy*, Milbank Memorial Fund, 2004, p. 13.

or others in the near future. The hierarchy also reflects the fact that a number of tools need to be in the toolbox in order to provide the right care at the right time. Where possible, facilitative mediation should be employed to achieve consumer ownership of the process. Facilitative mediation is important because it gives people with mental illness ownership of the decision.

At each step along the hierarchy, from A to D, individuals should have the opportunity to begin at the top of the hierarchy, even if there is a guardian in place.

The decisions or steps that make up the hierarchy of choice include:

- A. Voluntary
- B. Advance psychiatric directive or durable medical power of attorney to cover psychiatric disorders⁴⁵ (*new statutory language*)
- C. Involuntary (if A and B are not available)
 - (1) Voluntary (Under current law, if a patient declines treatment and a petition for involuntary treatment is filed, the patient is given a second opportunity to sign as a “voluntary.”)
 - (2) Deferral hearing at hospital
 - (3) Waiver and consent
 - (4) Trial (With right to independent medical examination, appointed counsel and jury trial. Where the court does enter an order for involuntary treatment, an option should be available for up to 180 days for CMHSP-directed outpatient care and CMHSP-coordinated combined outpatient/inpatient care.) (*new statutory language*) (Objection: E. Bauer)
- D. Permit the guardian of a legally incapacitated individual to petition the court for authority to consent to mental health treatment where there is a history of involuntary treatment and the ward lacks the capacity to consent to a durable power of attorney for psychiatric care or advance directive for psychiatric care. (Objection: W. Allen, E. Bauer, J. Patton)

The success of the hierarchy of choice should be measured by a reduction in the number of people treated involuntarily and a reduction in hospital days needed for all persons with mental illness.

7. Clarify assessment for people needing treatment.

The legislature should amend the Michigan Mental Health Code to clarify and promote more uniform assessment of persons who may need mental health services and get those who need them into care more quickly. Court and mental health professionals should be trained in the uniform application of assessment as required by the Mental Health Code.

Section 401 (1) (a)–(c) of the Mental Health Code sets out the criteria for involuntary treatment. The first subsection, (a), is often interpreted to mean that an individual must be threatening homicide or suicide to be considered for an involuntary petition.

⁴⁵ See Glossary.

The second, (b), says that a person is at serious risk of harm by being unable to attend to his/her basic needs for food, clothing, and shelter. The third, (c), states that a person must have a demonstrated mental illness and lacks the ability to understand his/her need for treatment. As a result, s/he is at risk for significant physical harm to self or others in the near future.

The current Mental Health Code criteria should be reorganized and restated in law to call greater attention to the options presented by (b) and (c) above. The new language should read, “A person requiring treatment is an individual who has mental illness and as a result of that mental illness represents a danger to self or others, or an individual who has mental illness and without treatment of that mental illness can reasonably be expected, based on competent clinical opinion, to represent a threat to self or others in the near future because of inability to understand the need for treatment or attend to basic physical needs such as food, clothing, or shelter.”

8. MDCH should (a) implement uniform screening and assessment for priority populations, as well as all other populations, and uniform operational definitions and service selection guidelines statewide for individuals eligible for public mental health treatment and support service and (b) expand the system’s capability for serving those with serious mental illness and individuals with mild and moderate disorders.
 - A. Persons who meet uniform statewide criteria for severity should be given permanent “enhanced access” status, providing them with access to any item or items from the statewide service array (under Goal 4). Such items may vary in mix and intensity over time in response to the needs of a person with mental illness or emotional disturbance. Even if an enhanced access individual reaches the point of requiring no service, his or her case should not be closed, and the system should initiate periodic contact with the consumer unless s/he does not wish it. It is assumed that even in a recovery model, enhanced access cases often will represent chronic and lifelong circumstances, and a proper system of care serves, or is available to, people over a lifetime. Enhanced access classification should be applied through any of the following:
 - (1) *Diagnosis-only*: An adult or minor experiencing schizophrenia, schizoaffective disorder, bipolar disorder, recurrent major depression, delusional disorder, or psychotic condition not attributable to general medical condition shall automatically have enhanced access status.
 - (2) *Diagnosis and Level of Impairment*: Persons with other diagnoses of mental illness or emotional disturbance may be classified with enhanced access if their level of impairment crosses a certain threshold. By January 2006, and after appropriate consultation with stakeholders, MDCH should have in place enhanced access impairment criteria for statewide application to minors, nongeriatric adults, and seniors, respectively.
 - (3) *Diagnosis and Illness History*: Persons with diagnosis of mental illness or emotional disturbance other than in (1) above may be classified as enhanced access if their illness history crosses a certain threshold (one example might be X number of hospitalizations or incarcerations over a given period). By January 2006, and after appropriate consultation with stakeholders, MDCH

should have in place enhanced access illness history criteria for statewide application to minors, nongeriatric adults, and seniors, respectively.⁴⁶

- B. The public mental health system should continue under the requirement of managing crisis stabilization responses to psychiatric emergencies experienced by individuals for whom the system is a needed safety net. By January 2006, and after consultation with stakeholders, MDCH and/or the legislature should establish which items from the statewide service array are appropriate sole-step responses to a psychiatric emergency, and which items would be part of an acceptable multistep package for generalized “community crisis stabilization.”
- C. Persons with mild or moderate disorders that do not qualify for Enhanced Access should be able to access coordinating assistance and a more limited safety net service benefit (see service array section in Appendix I).
 - (1) To facilitate what the system may do in this regard with respect to Medicaid and Medicaid-like covered lives,⁴⁷
 - a. The department should include in Medicaid health maintenance organization (HMO) contracts that the HMO demonstrates its capacity to deliver the required 20-visit mental health outpatient benefit. Agreements between an HMO and CMHSP should support appropriate referrals. HMOs may contract with CMHSPs to deliver any portion of that benefit
 - b. Make certain that within the federal Early Periodic Screening, Diagnosis, and Treatment program a uniform, standardized, and valid tool for mental health screening and assessment is used throughout the state and that CMHSPs are sufficiently integrated into the program. Require that uniform and routine mental health screenings are implemented at major life transition points such as entering school, transition to middle and high school, etc.
 - c. Take better advantage of recent federal legislation and rules regarding matters such as Medicaid opportunities for the working disabled and income disregards that can be factored into Medicaid eligibility calculations
 - (2) To facilitate what the system may do regarding prevention and assistance to non-Medicaid cases of mild and moderate intensity, Michigan should:
 - a. Restore annual funding for a prevention services demonstration function (targeted to infants, children, and adolescents at risk of emotional disturbance, as well as adults with special risk needs) in the mental health portion of the MDCH budget

⁴⁶Severity classifications can vary considerably across CMHSP catchment areas. Michigan currently recognizes no specific diagnoses as automatic qualifiers for priority status, and in many parts of the state illness history is used to prevent rather than enhance priority status, i.e., whatever other criteria a CMHSP may have, there might also be an additional requirement about illness history before someone is accepted as a priority client.

⁴⁷ Examples of existing federally supported mental health service in Michigan that do not require consumer priority status include the Children’s Health Insurance Program and the state’s Adult Benefits Waiver.

- b. Establish MDCH as a statewide informational and coordinating leadership source in preventive/early intervention technology, best practices, and training
 - c. Assure that CMHSPs are familiar with other community resources capable of providing services such as counseling and medication management, and that linkage of consumers to those resources is being effectively made and followed through on as appropriate
 - d. Increase the coordination of mental health treatment and services with Federally Qualified Health Centers in the state, thus creating additional resources for care
 - e. The established source of annual funding (per Chapter 8 of the Michigan Mental Health Code) should be accompanied by updated ability to pay schedules consistent with the current economic times.⁴⁸
- D. Adopt the *Service Selection Guideline Principles* listed below to aid persons with mental illness or emotional disturbance, families, providers, and managers in the matching of mental illness and emotional disturbance treatment/support options to a recipient's needs, desires and circumstances:
- (1) Service development must incorporate person- and family-centered planning.
 - (2) Recipients must receive the most clinically appropriate treatment and support they require.
 - (3) Medical necessity criteria utilized should be broad enough to support the provision of clinically appropriate services. These criteria should be transparent and open to public review. Criteria should be uniform across the state and updated regularly to reflect advances in diagnosis and treatment.
 - (4) Criteria for responding to acute psychiatric crises must be well defined.
 - (5) Procedures for responding to persons with developmental disability who are in acute psychiatric crisis must be included.
 - (6) Procedures for responding to persons with substance abuse disorder who are in acute psychiatric crisis must be included.
 - (7) Criteria for enhanced service eligibility for persons with severe psychiatric disorders must be included.
 - (8) Certain diagnoses should automatically qualify an individual for enhanced access.⁴⁹

⁴⁸ Michigan can establish a limited benefit package for non-Medicaid-eligible individuals with mild and moderate mental illness through state law/policy. Having a limited package for Medicaid-eligible individuals with mild and moderate mental illness may require federal approval, which the state should seek as necessary. If Michigan cannot implement this concept within Medicaid, the distinction is perhaps largely academic, as Medicaid is not an entitlement to all state Medicaid Plan services, but rather those that are deemed medically necessary for a given consumer and his or her condition and circumstances.

⁴⁹Recommended are the following if experienced by an adult or minor: schizophrenia, schizoaffective disorder, bipolar disorder, recurrent major depression, delusional disorder, and psychotic disorder not attributable to general medical condition. There must also be respective statewide criteria so that other

- (9) Respective criteria for high acuity and enhanced service eligibility should be identical for both Medicaid and non-Medicaid recipients.
 - (10) Criteria for high acuity and enhanced service eligibility should cover both adults and children.
 - (11) Criteria for service to individuals who have neither acute psychiatric crisis nor severe mental disorder must be included.
 - (12) Criteria for the continuation of a service must be in place and need not be at the same level as those at the initiation of the service.
 - (13) Planning for transition from a given service must include the recipient and the family of a minor recipient as soon as possible.
 - (14) Discharge from a given service may not occur if a clinically appropriate alternative service is unavailable and the recipient or family of a minor recipient chooses to remain with the existing service.
 - (15) Substance abuse should not disqualify an individual from receipt of service for treatment/support of a diagnosed mental illness or emotional disorder.
 - (16) Guidelines must address collaborative and boundary issues between mental health and other human service systems (public and private).
 - (17) Guidelines must be uniform throughout the state and readily understandable by consumers and their advocates (across various cultural groups), with sufficient detail so that these individuals can determine whether or not they meet criteria for any given service.
9. The disparity between physical and mental illness in private health insurance coverage should be ended by early enactment of pending state legislation. In addition, the commission urges that the Michigan congressional delegation be requested to support national parity laws that cover all health insurance plans regulated or supported under federal law.

The commission recognizes that the implementation of an effective parity policy is complicated in the current health care finance market. It is further recommended that, after the state parity legislation is enacted, the governor designate the director of the MDCH and the state commissioner of financial and insurance services to jointly convene a working task force of leaders from business, labor, insurance, mental health provider/clinician, mental health advocacy, mental health consumer organizations, provider associations, and state and local mental health administrators to develop effective plans to implement the state's new parity policy and to examine and recommend strategies to extend the benefit of the state's parity policy to employees (and beneficiaries) of employer supported health plans that are not regulated by state law.

diagnoses can combine with level-of-impairment or illness history to establish enhanced service eligibility for adults and minors.

Goal 3: A full array of high-quality mental health treatment, services, and supports is accessible to improve the quality of life for individuals with mental illness and emotional disturbance and their families.

If Michigan's mental health system is to provide the right care at the right time and in the right setting, we must work toward the establishment of an appropriate array of high-quality mental health treatment, services, and supports that address the entire life span from birth to old age. The current orientation of services is too limited and potentially harmful because the severity of mental illness and emotional disturbance in adults and children advances when treatment is postponed until illness becomes "serious."

In fact, consideration of a model array of publicly funded service regarding mental illness and emotional disturbance is a critical task to which all states, including Michigan, must give attention. The concept of an array is that any appropriate service required by a recipient's circumstances may be reasonably accessed, regardless of where one lives, his/her reimbursement status, and who is managing the service. The existence of an array does not mean a recipient experiencing circumstance X automatically receives service Y at time Z. Rather, it means there are multiple service options available for appropriate response to a recipient's needs—both at a given point in time and over the course of time.

To support the implementation of a model array of mental health services, the commission emphasizes that Michigan's public mental health system needs to identify, promote, disseminate, implement, and operationalize the use of research and evidenced-based practices. One state has already passed legislation mandating evidenced-based practices for its publicly funded programs. Evidenced-based practice (EBP) includes program practices and models identified as evidence based by credible organizations, other best and evidence-based practices and models, emerging best practices and models, and exemplary service delivery systems. Beyond the mere identification of existing research and EBP, the public mental health system must promote research, development, and assessment of promising and innovative practices and models, especially those in Michigan. EBP should also be used to address the specific needs of populations such as children and older adults.

The public mental health system needs state-of-the-art information technology in order to implement and operationalize EBP. Integrated medical record systems are necessary for the assessment, evaluation, and data collection that will produce continual quality improvement systems. State-of-the-art technology is itself an EBP that facilitates both integrated physical and mental health care and information sharing across physical boundaries between facilities and maximizes efficiencies while improving accuracy. As CMHSPs explore the use of state-of-the-art technology, the MDCH will need to coordinate information systems across the state to ensure compatibility.

Above all, the delivery of services in the model array must be based on the knowledge that individuals with mental illness and emotional disturbance can not only learn to manage symptoms, they can regain control over significant aspects of their lives and develop a sense of identity and purpose, including social, professional/vocational, educational, physical, spiritual, and financial, where they can direct their own life. Individuals can create lives that are personally rewarding and live, work, and learn at the places of their choice, in addition to managing and living with symptoms. Scientific

studies have shown that for recovery to work, providers must believe that individuals can recover from mental illness. A personal sense of hope plays an integral role in an individual's recovery.

Key Recommendations

10. MDCH, in cooperation with other state departments, should establish a clear policy and timetable to have in place a comprehensive, high-quality statewide service array that will increase the volume of appropriate services and improve quality of care; give consumers and families increased confidence in the system's **ability to respond** effectively to recipients' requirements; and position Michigan as an exemplary state for national emulation. The model array is described in Appendix I.
11. As a first step in assuring a full array of services for children and youth with serious emotional disturbance and adults with serious mental illness, the state policy plan should identify, fund, and assure adequate core service options available on a 24-hour basis to adults and minors who qualify for enhanced access within Michigan's publicly funded mental health system (see material on enhanced access in the recommendations under Goal 2) and crisis response services available to any person experiencing psychiatric emergency.
12. Any appropriate service required by a recipient's circumstances may be reasonably accessed, regardless of where one lives, his/her reimbursement status, and who is managing the service.
13. All array components should be available, consistent with Medicaid requirements, within 60 minutes/miles of a recipient's residence in rural areas and 30 minutes/miles in urban areas, and the MDCH should assure that best-practice standards and guidelines are developed and implemented statewide for each.
14. Individuals anywhere in the state should have access to inpatient psychiatric or secure residential treatment when appropriate and as close to their residence as possible. In order to accomplish this, the following policies should be pursued:
 - A. Inpatient psychiatric treatment should be delivered as much as possible by small, regionally based public and private hospital programs.
 - B. Additional small, regional public hospitals should be available for individuals who are or may become dangerous to self or others as a result of mental illness.
 - C. The state should pursue pilot development of small, residential treatment programs for adults who require either intermediate or long-term intensive residential care. The Oregon model should serve as the conceptual starting point for these facilities. In order to develop these facilities, changes are required to the AFC licensing rules, the Mental Health Code, and FIA rules concerning dependent care settings.
 - D. Efforts should be made to change or waive federal law to allow for Medicaid eligibility for individuals treated in these facilities.

15. If it is not feasible to provide inpatient psychiatric care within these guidelines, then transportation services should be provided by CMHSPs, as necessary, and mobile intensive treatment teams should be deployed to help local hospitals provide this care.
16. The array should provide maximum comparability across Medicaid and non-Medicaid populations. If a given option is deemed worthy or important enough for Medicaid availability, that service or a comparable version of it should be available as needed to non-Medicaid recipients.
17. The state should create a mental health institute to develop evidence-based practices and research at both the community and state level, supporting implementation of the model array of high-quality services. The mental health institute should utilize the resources of the state's excellent academic institutions to help identify evidenced-based practices and practice-based evidence and assess the implementation and delivery of care and services models to develop best practices. The MDCH medical director for mental health should lead activities that will link the evidence-based practices and practice-based evidence promoted by the mental health institute with the continuous implementation of quality improvement practices in the mental health system. (See related recommendation 36.) The mental health institute should assist the MDCH medical director in implementing and operationalizing the results from evidence-based practice research in a manner that promotes appropriate and efficient treatments without additional administrative burden on clinicians.
18. Strengthen the MDCH quality management system, building on the mission based performance system and other existing quality management endeavors, so that it better integrates compliance and quality measures, which the department should set with input from consumers, PIHPs, CMHSPs, and providers. The early work of MDCH's quality improvement council is promising in this regard. (Also see recommendation 36.)
19. Michigan's public mental health system should be supported by a Web-based information infrastructure, beginning with a simple system and slowly improving it using feedback from stakeholders. The information infrastructure should:
 - A. Link diverse local CMHSPs into a single, standardized virtual treatment system
 - B. Provide Web-based education, training, and conferences
 - C. Provide wide access to patient treatment information while maintaining confidentiality
 - D. Provide medical integration with primary care providers
 - E. Provide continuity of care tracking
 - F. Provide real-time auditing capabilities
20. Michigan's interagency approach to prevention, early intervention, and treatment for children should be strengthened by the following actions:
 - A. Michigan's developing early childhood comprehensive system of care for children from birth to age five should coordinate and connect early childhood services and supports with the mental health services in the model array.

- B. The State Board of Education should enforce the Individuals with Disabilities Education Act (IDEA) and mandate in-service training for teachers throughout Michigan to help them recognize mental health issues.
 - C. The legislature should mandate in-service training for teachers throughout Michigan to help them recognize mental health issues.
 - D. The governor should assign responsibility to MDCH to assess and forecast mental health treatment needs for Michigan children and families across departments and publicly funded programs.
 - E. The governor should charge MDCH, FIA, and other appropriate state agencies to develop an integrated policy and plan for children with serious emotional disturbances and at risk for mental illness. This should include a collaborative interagency process to review prior interventions for appropriateness and effectiveness before determining placement.
 - F. In partnership with Michigan universities, the State of Michigan should provide incentive programs to increase the number of child and adolescent psychiatrists, social workers, psychologists, advanced practice nurses, and infant mental health specialists across the state. Michigan should pursue federal Nurse Reinvestment Act funds to support new traineeships to help address the nursing shortage, particularly in the area of mental health. Another strategy that should be considered is forgiving college loans of those who agree to practice in child and adolescent mental health specialties.
21. A stakeholder group including academic institutions and mental health provider agencies (perhaps through the Mental Health Institute) should be convened to assess Michigan’s capacity to serve older adults with mental health needs, to encourage and develop mental health and aging curricula in academic institutions, and to help providers identify methods to retain the current workforce.
 22. Specific outreach efforts need to be targeted to older adults, persons with dementia, and their caregivers.
 23. CMHSP screening and intake systems should be revised where necessary to assure that they are “elder-friendly.”
 24. Screening tools should be identified to increase the ability of medical providers to identify depression and other mental health problems in older adults.

Goal 4: No one enters the juvenile and criminal justice systems because of inadequate mental health care.

Michigan must move forward on many fronts to assure that children and adults do not enter the justice system due to the lack of available mental health care. Clarifications can be made in our state’s involuntary treatment policy consistent with person-centered planning and with the goal of making every effort to avoid involuntary treatment unless necessary. A clear hierarchy of choice in mental health care (see Goal 3), accompanied by screening and assessment to identify at-risk individuals, joint training for the mental health and justice systems, and a full array of evidence-based treatment services (see Goal 3), are essential.

The commission identified models of diversion in Michigan and elsewhere in the country that can be implemented to achieve more appropriate and cost-effective care for children and adults outside the justice system. There is also evidence that treating mental health and substance abuse can help cut exploding correctional costs by dramatically reducing recidivism. According to the President’s New Freedom Commission on Mental Health, cost studies suggest that taxpayers can save money by placing people in mental health and substance abuse treatment programs instead of jails and prisons.

Key Recommendations

25. The array of mental health services (see Goal 3) must be available and accessible to eliminate use of the juvenile and criminal justice systems as “providers of last resort.”
26. The legislature, the executive branch, the judiciary, and law enforcement should require effective and measurable, evidence-based pre- and post-booking diversion programs, including formalizing the shared legal duty of CMHSPs, law enforcement, and jails for diversion and revising law to include “diversion from the juvenile justice system” and expanding mental health and drug courts throughout the state.
27. Joint training should be ensured across CMHSPs, first responders, service providers, law enforcement, defense attorneys, prosecutors, judiciary, and corrections and probation officers on the implementation of established and required pre- and post-booking diversion programs throughout the state.
28. State and local law enforcement, including police, corrections, and judicial authorities, and the Michigan Department of Corrections (MDOC) should ensure screening and assessment for mental health at their point of entry, booking or reception for children and adults, and at first contact with the juvenile and criminal justice systems.
29. The legislature should clarify responsibility for the provision of mental health diversion services where the “county of crime” is not the “county of residence” by directing that the CMHSP of the county in which a crime is committed is responsible for the provision of diversion services, including arrangements with the county of residence, where appropriate.
30. The transition from detention or incarceration to community-based treatment and services should be strengthened by initiating pre-release programming at the point of reception or intake, and training for release supervisors on what to expect from mental health clients. Pre-release planning should address the person’s mental health and other needs, and include such areas as
 - A. collaborative interagency release plans and improved release guidelines;
 - B. linkages to community resources during supervision or upon release (e.g., housing, vocational, and education support);
 - C. risk/need reduction; and
 - D. relapse prevention.

Goal 5: Michigan’s mental health system is structured and funded to deliver high-quality care effectively and efficiently by accountable providers.

Form should follow function in the structure of the public mental health system in Michigan. Structure should clarify and coordinate state, regional, and local roles and lines of transparent accountability; preserve local delivery of services; involve consumers meaningfully in governance; ensure that services are necessary, high quality, and the best value for the community; and limit administrative costs to only those needed to accomplish the previous four objectives. **In other words, structure should foster accountability but reduce administrative costs and bureaucracy so that the maximum amount of funding is devoted to direct care.** To accomplish these objectives, the structure should (a) standardize certain functions (data, claims, financial management, performance reporting, information technology, and others) across counties, (b) strengthen state oversight and enforcement of agreed-upon standards and policies, and (c) foster local responsiveness to and consumer input into needs and delivery of services. Importantly, the structure should promote collaboration—including meaningful input—among the state, PIHPs, CMHSPs, providers, and consumers to serve the needs of children and adults with mental illness and emotional disturbance.

For Michigan to have a truly effective mental health system, state leadership is necessary to clarify the appropriate roles and responsibilities for the public and private sectors in funding and caring for adults and children with mental illness and emotional disturbance. Only through a public-private *partnership* will gaps in coverage, access, and quality be addressed meaningfully.

Michigan’s constitutions since 1850 have clearly established as priorities state policies and programs to serve state residents with mental illnesses. This constitutional priority has, in large part, been reflected in progressive statutory policy. However, based on hours of public testimony and a careful review of available reports and other documents, it is apparent to the commission that funding strategies adopted by the state in the 1990s have failed to fully reflect the state’s constitutional directive to always foster and support programs and services for the care and treatment for state residents with serious mental illness.

During the past twenty years, the base reductions in state general fund appropriations for mental health programs have exceeded base state authorizations for both those same programs. In comparison, the state’s total general fund spending rose 83 percent in the same period. The FY 2005 \$313 million general fund appropriations to mental health is actually \$57 million less than it would be if CPI increases were granted for fiscal years 1999–2005.

During the 1990s, state budget policy concentrated on maximizing federal support through Medicaid waivers, while reducing the amount of state funds for mental health programs. The current community mental health funding sources reflect the impact of this funding strategy, with 50 percent of the CMH funding for mental health services coming from the Medicaid capitation program, 32 percent from the state general fund, 2 percent from the federal mental block grant, and 16 percent from other sources. While the acquisition of federal waivers represents careful and innovative planning, this shift to

federal funding has had unintended consequences. Placing a heavy emphasis on categorical funding sources (with both low financial eligibility thresholds and an inflexible definition of disability) creates major challenges in adequately funding a population-based program such as public services for residents with mental illness and emotional disturbance. As a result, the public mental health system's capacity to appropriately respond to the needs of consumers who are not Medicaid-eligible and who lack adequate private insurance coverage for mental illness services has been significantly diminished. Too often, those who do not meet the Medicaid eligibility rules or who are not in crisis are not able to access the system. Timely and clinically appropriate intervention is not available for too many patients who are attempting to manage their chronic disease. Those who are not Medicaid eligible and experience mild to moderate mental illness too frequently do not receive the care they need when it would be most effective.

A transformed state mental health system should fund equitable, consistent, and routine access to an effective and efficient array of core services and supports, regardless of eligibility for Medicaid or county of residence. Public funding strategies should include federal, state, and local funds. The sources of these funds should have growth potential (beyond CPI inflation increases), be stable (that is, noncyclical), and be sufficient to appropriately serve state residents with serious and persistent mental illness or serious emotional disturbances who are clinically determined to have permanent enhanced access status as recommended in Goal 2.

In addition, the state has used Medicaid waivers to fund a wider array of services and supports—especially psychological and social supports—than most, if not all, states. Michigan has the opportunity to bring continued creativity to seek Medicaid waivers that provide flexibility to serve more people.

STRUCTURE

Key Recommendation

31. Create a true mental health system through a structure that better clarifies and coordinates state, regional, and local roles, responsibilities, and accountability for services to persons with mental illness and emotional disturbance. Such a structure should consist of (a) state leadership, with input from all stakeholders, to improve and enforce statewide standards for administration, performance (see below), and eligibility determination; (b) regional coordination of functions that include, but are not limited to, health plan-like administrative and information infrastructure; reporting and quality programs; assurance of equitable access to services; and shared components of some clinical services that would offer economies of scale without sacrificing access; and (c) preservation of local control, including CMHSP application of eligibility criteria and assessment of needs and service delivery. The state should develop a specific plan for regionalization of appropriate mental health system functions in the next two years.

Additional recommendations

32. The state should offer financial incentives to counties that coordinate and streamline the regional functions described in the previous recommendation. These incentives should drive regionalization in the next 3–5 years.
33. Invest more resources for MDCH to (a) continue setting standards for payment, performance, and other administrative functions (billing, computer systems) and (b) provide training in these areas so that accountability is achieved without micromanagement. Have the state and other stakeholders develop a uniform, unobtrusive way of standardizing administrative and performance monitoring systems and complying with federal regulations. This would draw on best practices from across the state and allow more funding to go to direct care.
34. The state should set a range for acceptable administrative costs for PIHPs, CMHSPs, and providers. In addition, PIHPs and CMHSPs should be required to report to MDCH all financial information, including employee salaries and fees to contractors such as consultants and attorneys, so that the department can effectively monitor adherence to the established standards.
35. Amend the Mental Health Code to strengthen MDCH enforcement. MDCH currently has little recourse when CMHSPs or PIHPs fail to meet statutory and contractual requirements. The department cannot sanction agencies until all administrative remedies have been exhausted. More importantly, it cannot, during that time, take action to assure that problems affecting service delivery are corrected. In such cases, the department—like the Insurance Commissioner with health plans and insurers—should have the authority to assume supervision of a CMHSP or PIHP while a complaint is adjudicated. This provides a timely remedy for persons with mental illness or emotional disturbance who need continuity of care.
36. Strengthen the role of the current MDCH medical director of mental health so that s/he becomes the leader in the development and adoption of evidence-based practice in the mental health system. In this role, the medical director should work closely with the CMHSP and PIHP medical directors to help MDCH reach the following goals.
 - A. Reduce variation in care through the identification, adoption, and measurement of evidence-based practices, moving over time to financial incentives for high-quality care. If providers of mental health services and supports can demonstrate reduction of waste, they can use the savings to deliver more services to persons in need.
 - B. All current care and treatment programs and services supported with public funds in Michigan should be assessed and evaluated as to the level of evidence and/or scientific support. Wider dissemination of EBP to all stakeholders will improve quality of care.
 - C. Ensure that state contracts for mental health services encourage the use of evidence-based pharmaceutical guidelines and algorithms recommended by a

steering committee of experts in the Flinn Foundation-sponsored Closing the Quality Gap in Michigan: A Prescription for Mental Health Care (August 2004).

- D. Incorporate into Michigan's quality improvement plan evidence-based and experiential-based best practices for children involved in child welfare and juvenile justice.
 - E. Incorporate into Michigan's quality improvement plan the findings of the federal Targeted Capacity Expansion Grant Program to Improve Older Adult Mental Health Services, which will disseminate evidence-based practices for all states to consider.
 - F. MDCH and the Michigan Department of Corrections should develop best practices for screening and assessment of adults at entry into incarceration, including jails in consultation with the sheriffs of the state.
 - G. Implement a standardized quality improvement system throughout the state's community mental health system and determine how to meaningfully monitor adherence to clinical practice guidelines and compare monitoring results across CMHSPs.
37. Expand the charge of the current MDCH Advisory Council on Mental Illness to assist the MDCH director and the governor with implementation of the commission's recommendations. The MDCH director should appoint advisory council members.
38. By January 2006, MDCH should issue a progress report on outcomes related to recommendations 31–36. For recommendations that have not been achieved, the report should specify a timetable for completion. The report should further specify (after appropriate consultation with stakeholders and with the federal government as necessary) the following:
- A. A timetable for achieving consolidation of the state's CMHSPs to a number greater than 17 but less than 40. (Objection: M. Thome)
 - B. How the state can return to a system in which each CMHSP is directly responsible for service to both Medicaid and non-Medicaid recipients.
 - C. An analysis of the degree to which different provider models have proven to enhance or impair service access and delivery across the state.
 - D. Recommendations and timetable for expanding or disbanding use of different provider models, based on the results of the previous bullet.
 - E. Recommendations and timetable for steps that will assure opportunities for local citizen input and involvement continue under a reduced number of CMHSPs.
 - F. Recommendations necessitated by any of the above for state law changes regarding the structure, governance, function, and operation of CMHSPs.

(Objections to lack of commission approval of recommendations addressing the Wayne County Mental Health Agency: F. Amos, B. Hammerstrom, S. Mashni)

FUNDING

Key Recommendation

39. The governor and the legislature should adopt a new funding strategy for services to state residents with mental illness and emotional disturbance. The following could provide a seamless matrix of funding support for community-based services.

A. Dedicate state funding for treatment services for residents with mental illness and emotional disturbance

We propose the establishment of a new mental health fund dedicated for the support of an array of services for the priority populations recommended by this report. The legislature should annually allocate appropriations from the fund to support community mental health and state hospital services. The legislature should consider dedicated revenue sources that will include but are not limited to the following:

- (1) An annual appropriation of state general funds. This appropriation shall at least equal the amount appropriated to the MDCH for services for people with mental illness and emotional disturbance (as documented by CMHSP annual plans), including state match for Medicaid and other federal funds and state purchase of services allocations to community mental health programs, in FY 2004–based years, adjusted by not less than the overall percentage of state general fund appropriations for each subsequent fiscal year. (Objection: B. Hammerstrom)
- (2) Restricted revenue from a dedicated mental health fund established by the closure of selected state tax exemptions (see Appendix J for a list of options and the cost of each current state tax exemption). It is further recommended that the base year appropriation of \$300,000,000 to \$350,000,000 be adjusted annually by the prior year’s growth of the restricted revenues comprising the fund. (Objection: B. Hammerstrom)
- (3) Revenue from insurance and first party payments for state psychiatric hospital services and from the sale of state mental health facilities and properties.
- (4) Other restricted revenue and federal grants that are allocated for services for state residents with mental illness.
- (5) Grants, gifts, and bequests from private parties.

B. Full and flexible use of federal funds

Michigan should revise its current policies concerning federal funding to achieve full and flexible use of all available funding streams to support an array of community services for state residents with mental illness and emotional disturbance, while preserving growth potential. This includes:

- (1) Establish policy for the full, flexible, and appropriate use of Medicaid funding options while preserving growth potential and maintaining actuarial soundness in any capitation system

- (2) Adopt a community-based, small (16 beds), secure residential program for adults who require either intermediate or long-term intensive residential care. (Also see recommendation 14.)
- (3) Implement the Section 1931 expansion option, which provides the state latitude to set earnings disregards and asset tests for low-income workers who would otherwise be eligible for Medicaid assistance.
- (4) Implement the Ticket to Work and Work Incentives Act of 1999 (TWWIA) “basic eligibility” and “medical improvement” policies to extend Medicaid income and resource eligibility standards for adult consumers who otherwise meet the SSI standard of disability and are between the ages of 16 and 64.
- (5) Implement the medical improvement option to continue coverage for people with severe and persistent mental illness that respond to psychotropic drug therapy.
- (6) Implement Section 1619(b) to continue Medicaid eligibility for consumers who currently receive SSI and return to work.
- (7) Investigate the development of appropriate steps to deal with the negative impact on mental health consumers of the current Medicaid spend down process.

C. Adoption of a new executive branch budget policy

- (1) Blend funding streams through state agency compacts, including special education, child welfare, workforce development, and other funding streams.
- (2) Pilot the creation of joint purchasing and alignment of mental health services among local CMHSPs, family courts, and local FIA offices.
- (3) Fund mental health services for children at levels authorized in special education and school aid appropriations.
- (4) Develop specific sustainable models of collaboration at the state and local levels. Maximize resources earmarked for providing mental health services across all public agencies.
- (5) Coordinate the delivery of mental health services by both federally qualified health clinics and community mental health programs.
- (6) Fully utilize the Early Periodic Screening, Diagnosis, and Treatment Program to serve children with emotional disturbance.
- (7) Create local authority for funding and organize local sources of funding to access additional federal matching dollars for children’s mental health services.

D. County Funds

Maintain the current statutory policies requiring county matching funds for public mental health services.

E. Private Funds

End the disparity between physical and mental illness in private health insurance coverage through passage of a state parity law and work for national parity laws

- that cover all health insurance plans. (Objection: B. Blaney. Disapproved the entire report)
40. By January 2006, and after consultation with stakeholders, MDCH should complete a comprehensive analysis of whether the state's various mechanisms for determining allocations across CMHSPs can and should include to some degree a case rate funding methodology.
 41. To address disparities between urban and rural areas, establish a work group to examine the delivery and financing of mental health services in rural areas. This group should recommend changes to the current structure to assure that rural residents' needs are met. Assure funding among and within CMHSPs to provide and fund a comparable and quality array of services in each region.
 42. Payment for mental health services should be driven by incentives for delivering high-quality care, which is the model toward which physical health has been moving in recent years.
 43. Develop specific sustainable models of collaboration at the state and local levels. Maximize resources earmarked for providing mental health services across all public agencies.
 44. Within MDCH's mental health division, there should be an office following and working on policy and clinical issues pertaining to mental illness and emotional disturbance and another office following and working on policy and clinical issues pertaining to developmental disabilities.

ACCOUNTABILITY

RECIPIENT RIGHTS

Michigan needs consumer and family rights protections and procedures that are fair, timely, streamlined, useful to service applicants and recipients, and as independent as possible from potential conflicts of interest. Without such steps, other desired system reforms may be jeopardized. Consumer and family complaint processes should include some hearing mechanisms outside the realm of their service managers. The commission strongly endorses consumer involvement in system governance and planning. The commission also recognizes the importance of empowering consumers with the most impartial determinations possible of their service concerns. This can also serve as a quality improvement incentive for the public mental health system.

Key Recommendations

Accountability for Rights Protection

45. The director of the state Office of Recipient Rights should report directly and solely to the director of MDCH (requires a state Mental Health Code revision).
46. Medicaid Fair Hearings related to public mental health services should require a clinical consultation component.

47. The designated appeals division within MDCH for Medicaid Fair Hearings should also oversee a corresponding hearing process for non-Medicaid CMHSP recipients and applicants, also including a required clinical consultation component.
48. To further strengthen accountability for rights protection, the recipient rights portion of the state's Mental Health Code should be amended to do the following:
 - A. When a recipient rights violation has been substantiated against a respondent the remedy recommended by the recipient rights office with jurisdiction shall be implemented until and unless overturned by appeal. A recipient rights office may not dictate how a respondent agency shall discipline an employee, but may require that disciplinary action be taken with documentation of this action to the recipient rights office, subject to any relevant collective bargaining agreement.
 - B. Broaden the responsibilities of the state recipient rights appeal committee to include the following:
 - (1) Conduct hearings on the merits of appealed cases.
 - (2) Conduct hearings on matters regarding undue influence of the local CMHSP administration on a recipient rights case. Such action may be brought by the consumer (or his/her representative), a local recipient rights officer, or the local recipient rights advisory committee.
 - C. The responsibilities of the CMHSP executive director shall not include participation in recipient rights investigations.
 - D. Disciplinary action cannot be taken against recipient rights staff due to a finding of a recipient rights violation or for appealing a matter to the state recipient rights appeal committee.
 - E. Broaden the power of the state Office of Recipient Rights to take action when a CMHSP is out of compliance with recipient rights requirements. Such action could include various sanctions, including the state Office of Recipient Rights assigning or assuming responsibility and authority for the local recipient rights system for a set period of time.

Additional Recommendations

Improvements to Rights Protection

49. The state rights office should develop uniform methodologies and programs for statewide use in the protection of recipient rights under the state's Mental Health Code.
50. The state rights office, in collaboration with local rights offices, should review and revise current forms, handouts, brochures, booklets, and other materials that are used within the system to inform consumers and families about their rights and available programs, in order to make these materials more user-friendly, culturally appropriate, and uniform across the state.
51. The state and local rights offices should engage in education, training, evaluation, and assistance to primary and secondary mental health consumers in navigating the public mental health and other human service systems.

52. MDCH should lead a review and revision of recipient rights policies to ensure culturally competent practices sensitive to ethnic, racial, economic, disability, sexual preference, and gender differences.
53. MDCH should establish a standard database and statewide reporting system to track applicants who are denied service. MDCH should also revise the existing quality improvement plan to more comprehensively address issues related to access to services for persons who are not currently part of the mental health system.
54. The state rights office should examine recipient and applicant fatalities and sentinel events for issues of possible rights violations.
55. Licensing agency and state agency reviews related to publicly funded mental health providers should require documentation of policies/procedures for training, quality improvement, and the grievance process for individuals who may not have had their rights respected.
56. Legislative changes should be made that would permit the state rights office to investigate and make recommendations to the MDCH Bureau of Health Systems regarding the recipient rights programs of licensed hospitals.

Goal 6: Recovery and resilience is supported by access to integrated mental and physical health care and housing, education, and employment services.

The mental health system alone is not sufficient to assure that everything is done to support the full participation of individuals with mental illness or emotional disturbance in their community. Many services, e.g., housing, education, and employment, are not focused solely or primarily on mental health, but are often essential to assure that persons experiencing mental illness have access to supports that promote recovery. It is critical that specific steps be taken to integrate mental and physical health care as a cornerstone of recovery.

Screening and collaborative care in primary health care settings for individuals with mental illness or emotional disturbance must be expanded with an emphasis on disease management. The commission applauds the Michigan Surgeon General's Prescription for a Healthier Michigan, and encourages her to extend the call to action to health providers to screen for and recognize early signs of emotional and behavioral issues and to offer connections to appropriate interventions, incorporating "social and emotional check-ups" in routine primary care. It has been demonstrated that integrating mental health professionals into primary care settings can have both clinical and financial benefits if protocols for care are in place, the doctor-patient relationship is preserved, and mental health professionals are allowed the flexibility they need in the primary care setting.⁵⁰ In particular, increased integration, communication and education between primary and

⁵⁰ Frank deGruy, MD, *Mental Health in a Primary Care Setting*, Appendix D to "Primary care: American's Health in a new Era," Washington, D.C.: National Academy of Sciences, National Academy Press, 1996; and *The World Health Report 2001, Mental Health: New Understanding, New Hope*, World Health Organization, 2001.

behavioral health care providers should be encouraged to more effectively co-manage the complex medical conditions found in the elderly population.

Recent research provides evidence for the effectiveness of a broad range of strategies for addressing housing for individuals with serious mental illness and emotional disturbance. Broadly, the research shows that what was once thought to be an unreachable population, homeless individuals with serious mental illness, can be engaged in services and supported in ways that allow them the opportunity to maintain stable housing.⁵¹ SAMHSA's *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illness and/or Co-Occurring Substance Use Disorders* outlines steps that communities can take to implement such programs, including a chapter devoted to examining evidence-based and promising practices.

While employment has been viewed as the primary avenue through which people in recovery can reach their full potential as contributing members of society, many of these individuals have increasingly expressed an interest in advancing their education as well. Supported education can provide this opportunity for those who wish to receive education beyond the high school level. Supported education provides assistance, preparation, and ongoing counseling to individuals seeking postsecondary education, and it is being recognized by rehabilitation practitioners as a desirable, valid, and viable option. The Michigan Supported Education Program, which was piloted as a demonstration project in the mid-1990s, had proven success in preparing individuals in recovery from mental illness and emotional disturbance for matriculation at a community college. At follow-up interviews, participants in the program showed significant improvements in quality of life, self-esteem, and social adjustment, and greater participation in college or vocational training.⁵²

Community mental health practice and policy should address the vocational needs and preferences of individuals with mental illness. There are effective, evidence-based supported employment programs that return people to the workforce at greater rates than traditional rehabilitation programs. In some programs, as many as 60 percent of people with serious mental illness have competitive jobs after one year, compared to 20 percent in traditional programs.⁵³ Supported employment models are based on the idea that access to mental health treatment will enhance functioning and increase the ability to return to work and maintain employment. These programs typically emphasize the need to accelerate entry into competitive work while integrating mental health services and offering ongoing supports to clients. Services offered to recipients can include job coaches, specialized job training, and transportation.⁵⁴

⁵¹ J. A. Lam and R. Rosenheck, Street outreach for homeless persons with serious mental illness. *Medical Care* 37(9, 1999): 894–907.

⁵² Carol Mowbray, PhD, The Michigan Supported Education Program, *Psychiatric Services* 51, no. 11 (November 2000): 1355–57

⁵³ G. R. Bond, et al., “Implementing Supported Employment as an Evidence-Based Practice,” *Psychiatric Services* 52, no. 3 (2001): 313–22.

⁵⁴ D. McAlpine and L. Warner, “Barriers to Employment among Persons with Mental Illness: A Review of the Literature,” Institute for Health, Health Care Policy, and Aging Research, Rutgers University, 2002.

While Michigan lacks a statewide coordinated system for addressing the employment needs of individuals with serious mental illness, communities throughout the state have developed supported employment programs for individuals with disabilities. Other states have implemented statewide supported employment programs as integral to the overall effort to assist individuals with serious mental illness. With funding from the U.S. Department of Education/National Institute on Disabilities and Rehabilitation Research, Indiana has developed a Supported Employment Consultation and Training Center within its Center for Mental Health.⁵⁵ The New York State Office of Mental Health provides information on its web site regarding supported employment and offers an online directory of supported employment programs in the state.⁵⁶

The commission recommends the following specific actions to strengthen connections among all available resources in support of recovery.

Key Recommendations

57. MDCH should promote and facilitate efforts to create collaborative models to integrate and coordinate mental health services with primary health care and broadly disseminate the results for implementation.
58. MDCH should develop a plan to reduce barriers to treatment for people with co-occurring disorders, with a focus on integrating the care provided, perhaps through consolidation of regional and community substance abuse and mental health services and the development of plans to implement model treatment programs.
59. The Michigan Department of Education should promote education policies that proactively identify children with disabilities and children exhibiting risk indicators and lead an evaluation of the state's school discipline code to determine the effects of zero tolerance education policy, including the disparate impact on children of color. The department should promote clear standards for alternative education.⁵⁷
60. The Michigan State Housing Development Authority should consider expansion of the Housing Trust Fund to address housing issues of individuals eligible for community mental health services, leveraging additional funding from Community Developmental Financial Institutions of the U.S. Department of Treasury for such strategies as enhancing opportunities for home ownership or to make permanent supportive rental housing more affordable.
61. MDCH should use SAMHSA's *Blueprint for Change* to work with CMHSPs and other local community agencies to implement appropriate programs and supports to address homelessness among individuals with serious mental illness.

⁵⁵ Information about the center is available online at www.sectcenter.org.

⁵⁶ Information is available online at www.omh.state.ny.us/omhweb/ebp/adult_supportedemployment.htm.

⁵⁷ Zero tolerance: school discipline practice that mandates automatic suspension and/or expulsion from school for offenses perceived to be a threat to the safety of other children, school employees, or the school community itself; Ruth Zweifler and Julia De Beers, "The Children Left Behind: How Zero Tolerance Impacts our Most Vulnerable Youth," *Michigan Journal of Race and Law*, University of Michigan Law School, Fall 2002, vol. 8, issue 1.

62. MDCH should promote compliance with the Americans with Disabilities Act (ADA) to reduce barriers to housing, education, and employment and facilitate recovery.
63. MDCH should promote compliance with the Michigan Persons with Disabilities Civil Rights Act (1990 P.A. 220) and work with the Michigan Department of Civil Rights to assure enforcement of its tenets to assist persons with mental illness to secure housing, education, and employment and facilitate recovery.
64. MDCH, FIA, and other appropriate state agencies should implement an interagency process to review prior interventions for appropriateness and effectiveness before determining placement, e.g., out-of-home placement, from one foster care placement to another, or placement in residential care.
65. All CMHSP programs serving adults diagnosed with a serious mental illness should offer supported employment services.
66. MDCH should review the efforts of other states (e.g., Indiana and New York) to explore the possibility of implementing a coordinated statewide effort to providing supported employment.
67. MDCH should work with colleges and universities to disseminate and expand the Michigan Supported Education Program throughout the state.

Goal 7: Consumers and families are actively involved in service planning, delivery, and monitoring at all levels of the public mental health system.

Michigan's public mental health system has made significant efforts to engage consumers and families in planning, delivery, and monitoring of public mental health services. However, the commission heard extensive public testimony that demonstrated the need for strengthening the roles of consumers and families. Not only is the full participation of consumers essential in the design and improvement of services, that participation is in itself a factor in recovery and resiliency. We must do more to assure that individuals using the mental health system, and their families, are full and equal partners.

Key Recommendations

68. MDCH should require that CMHSP boards must have at least one representative from each of the following populations: individuals with developmental disabilities, individuals with mental illness, and children with emotional disturbances.
69. MDCH should develop and require implementation of a formal mechanism to utilize service recipient and family feedback on user satisfaction and outcomes in an ongoing quality assurance process.
70. MDCH should require service providers to formally offer and strongly encourage the establishment of advance psychiatric directives; directives should ideally include consumer preferences regarding release of records to family, domestic partners, or agents named in the directive in the event of death, and in the absence of any preference, records should be available to closest surviving family member(s).
71. MDCH should take the lead in assisting CMHSPs in utilizing Medicaid for family advocates.

Glossary

(All definitions are from the Substance Abuse and Mental Health Services Administration “Mental Health Dictionary,” unless footnoted.)

ADA: Americans with Disabilities Act

Advance psychiatric directive: Traditionally, advance directives have been used primarily for “end of life” decisions, for example, specifying the wishes of individuals to be withdrawn from life support when there is no longer any reasonable hope of survival. Recently, advance psychiatric directives have been recognized as potentially helpful in empowering individuals with mental illness to communicate treatment preferences in advance of periods of incapacity.⁵⁸ Also see “Frequently Asked Questions” and forms for advance psychiatric directives provided by the Bazelon Center for Mental Health Law, www.bazelon.org/issues/advancedirectives/index.htm.

AFC: Adult Foster Care

Assertive community treatment: A multidisciplinary clinical team approach of providing 24-hour, intensive community services in the individual’s natural setting that help individuals with serious mental illness live in the community.

Children: As referenced in this report, children are individuals under the age of 18.

CMHSP (Community Mental Health Services Program): A program operated under chapter 2 of Michigan Compiled Law as a county community mental health agency, a community mental health authority, or a community mental health organization.⁵⁹

Community Mental Health Authority: A separate legal public governmental entity created under section 205 of the Mental Health Code to operate as a community mental health services program.

COLA: Cost of living adjustment

Consumer: Any individual who does or could receive health care or services. Includes other more specialized terms, such as beneficiary, client, customer, eligible member, recipient, or patient.

DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition): An official manual of mental health problems developed by the American Psychiatric Association. Psychiatrists, psychologists, social workers, and other health and mental health care providers use this reference book to understand and diagnose mental health problems. Insurance companies and health care providers also use the terms and explanations in this book when discussing mental health problems.

⁵⁸ Ronald S. Honberg, *Advance Directives*, National Association for the Mentally Ill, www.nami.org/Content/ContentGroups/Legal/Advance_Directives.htm.

⁵⁹ Michigan Mental Health Code, 330.1100a.

Durable power of attorney: A document that gives a person of your choosing the power to sign documents and make health care or other decisions, e.g., financial, on your behalf, where that power continues during a period in which the person granting the power is incapable of legally making such a decision.⁶⁰

Early intervention: A process used to recognize warning signs for mental health problems and to take early action against factors that put individuals at risk for serious mental illness.

Evidence-based practice: (EBP): The “conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.”⁶¹ EBP encompasses practices with a wide range of evidence including:

- Practices that have been rigorously tested using controlled research designs
- Promising or emerging practices with research or evaluation results suggesting the intervention may be effective
- Practices that are highly valued by consumers, families, ethnic or cultural groups, and/or providers because of the perceived (and documented over time) positive impact on individuals with mental health needs, referred to as “practice-based evidence”

Family-centered practice: Help designed to meet the specific needs of each individual child up to age 18 and their family. “Family-centered service delivery, across disciplines and settings, recognizes the centrality of the family in the lives of individuals. It is guided by fully informed choices made by the family and focuses upon the strengths and capabilities of these families.”⁶²

FIA: Family Independence Agency

IDEA: Individuals with Disabilities Education Act

Income disregards: Governments can use various approaches to supplement earnings for the working poor. Earned income disregards are one tool that states have used to create an incentive for welfare recipients to work. Earned income disregards discount a portion of applicants' earned income in determining eligibility for welfare assistance (TANF), thereby enabling working welfare recipients to keep a larger share of their benefits than they otherwise would. At least 35 states have expanded their earned income disregards beyond federal guidelines.⁶³

MDCH: Michigan Department of Community Health

MDOC: Michigan Department of Corrections

MEDC: Michigan Economic Development Corporation

⁶⁰ See www.legalzoom.com.

⁶¹ D.L. Sackett, S.E. Strauss, W.S. Richardson, et al., *Evidence-Based Medicine: How to Practice and Teach EBM*, 2d ed. (New York: Churchill Livingstone, 2000). As quoted in Gregory E. Gray, *Concise Guide to Evidence-Based Psychiatry* (Washington, D.C.: American Psychiatric Publishing, 2004), 3.

⁶² Families and Disability Newsletter, Vol. 8, Number 2, Summer 1997. Beach Center on Families and Disability, University of Kansas.

⁶³ Welfare Information Network. See <http://www.financeprojectinfo.org/win/disregard.asp>.

Medicaid HMO: Health maintenance organizations with whom states contract to provide medical services to Medicaid recipients.

Mental health: Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society.⁶⁴

Mental Health Problems: Signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder.⁶⁵

Mental illness: Mental illness is a term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.⁶⁶

Many mental illnesses are believed to have biological causes, just like cancer, diabetes and heart disease, but some mental disorders are caused by a person's environment and experiences.⁶⁷

Parity: Mental health parity refers to providing the same insurance coverage for mental health treatment as that offered for medical and surgical treatments.

Person-centered planning: Person-centered planning is a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.⁶⁸

PIHP: Prepaid Inpatient Health Plan

Prevention: Those interventions that occur before the onset of a mental disorder. Three levels of preventive interventions are (1) *universal preventive interventions* for mental disorders are targeted to the general public or a whole population that has not been identified on the basis of individual risk; (2) *selective preventive interventions* for mental disorders are targeted to individuals or subgroups of the population whose risk of developing mental disorders is significantly higher than average. The risk may be imminent or it may be a lifetime risk. Risk groups may be identified on the basis of biological, psychological, or social factors that are known to be associated with the onset of a mental disorder; and (3) *indicated preventive interventions* for mental disorders are targeted to high risk individuals who are identified as having minimal but detectable signs or symptoms foreshadowing mental disorder or biological markers indicating

⁶⁴ Surgeon General's Report on Mental Health, p. 4.

⁶⁵ Surgeon General's Report on Mental Health, p. 5.

⁶⁶ Ibid.

⁶⁷ National Mental Health Association. See www.nmha.org/infoctr/factsheets/14.cfm.

⁶⁸ Michigan Mental Health Code, 330.1700.

predisposition for the mental disorder but who do not meet DSM IV diagnostic levels at the current time.⁶⁹

Recovery: The process in which people are able to live, work, learn, (cultivate interpersonal relationships), participate fully in their communities, (and develop a quality life of personal choice through empowerment and self-directedness). For some individuals recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery.⁷⁰

Resiliency: The personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses—and to go on with life with a sense of mastery, competence, and hope.⁷¹

Serious emotional disturbance: A serious emotional disturbance is a mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the Michigan Department of Community Health and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities.⁷²

Serious mental illness: A serious mental illness is a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the Michigan Department of Community Health and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities.⁷³

Spend-down: Some people have too much income to qualify for Medicaid. This amount is called excess income. Some of these people may qualify for Medicaid if they spend the excess income on medical bills. This is called a spend-down.⁷⁴

For example, a person over 65 is denied Medicaid because her monthly income is \$50 more than the limit for Medicaid eligibility. If she incurs medical bills of \$50 per month, the rest of her medical bills will be covered by Medicaid. The spend-down in this case is the \$50 of medical bills she incurs.

SSI: Supplemental Security Income

Stigma: Stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses.

⁶⁹ P. J. Mrazek and R. J. Haggerty, *Reducing Risks for Mental Disorders*. Committee on Prevention of Mental Disorders, Institute of Medicine, Washington, D.C.: National Academy Press, 1994.

⁷⁰ New Freedom Commission Report, p. 5.

⁷¹ Ibid.

⁷² Michigan Mental Health Code, 330.1100d.

⁷³ Ibid.

⁷⁴ See http://mclac.com/spend_down.htm

Stigma leads others to avoid living, socializing, or working with, renting to, or employing people with mental disorders—especially severe disorders, such as schizophrenia. It leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking and wanting to pay for care. Responding to stigma, people with mental health problems internalize public attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment.⁷⁵

TWWIA: Ticket to Work and Work Incentives Improvement Act of 1999

Wraparound Service: A unique set of community services and natural supports for a child/adolescent with serious emotional disturbances based on a definable planning process, individualized for the child and family to achieve a positive set of outcomes.

⁷⁵ New Freedom Commission Report, p. 4.