A ONE-YEAR REPORT CARD

Progress by the State of Michigan in Implementing Recommendations of the Governor's Commission on Mental Health: November 2004 – October 2005

Issued by:

The Ethel & James Flinn Foundation
Detroit

The Mental Health Association in Michigan
Southfield
(A United Way Agency)

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FOREWORD

The Ethel & James Flinn Foundation and the Mental Health Association in Michigan were two of the organizations intimately involved with the work of Governor Jennifer Granholm's special Commission on Mental Health in 2004. The Flinn Foundation funded the Commission's support costs, and the Foundation's President served on the Commission's Project Management Team. The Mental Health Association had been the leading statewide voice for establishment of a Commission in 2003, and the Association's CEO was one of 29 voting Commissioners appointed by the Governor.

With a Commission report having been presented to the Governor in October 2004, the Flinn Foundation and Mental Health Association consider it essential that the public be apprised annually about progress achieved by state government toward implementation of Commission recommendations. Governor Granholm's Commission represented Michigan's first mental health policy examination of such magnitude in over 20 years. Another two decades could pass before an effort like this is seen again. Thus, every individual and organization concerned about mental health issues has a major stake in following the Commission's recommendations and assessing what happens to them. The following pages provide our approach to doing so for the first 12 months (November 2004 – October 2005) since completion of the Commission report.

Our assessments were based on the degree of evidence found in public statements, actions or documents by state government during the time period in question. We should note, however, that from October 2005 through mid-December, we are aware of two additional public occurrences involving the Department of Community Health; a presentation at a Michigan Association of Community Mental Health Boards conference in late October and an early December mass meeting of stakeholders, events which began a dialogue regarding mental health system structure and financing. These meetings were reportedly the first of several such sessions that will be held.

This report is not an attempt to evaluate the sum and substance of mental health- related activities with which state government is involved. Nor is the report's perspective confined to any one component of state government. Rather, our focus is on what has or has not happened with Mental Health Commission (MHC) recommendations, and our framework for examination crosses all of state government, including the Legislature, Governor's Office, and multiple state departments with the potential for relating to recommendations of the Commission.

We respectfully invite your inspection of this document, and we urge you to join us in being ongoing monitors of the progress shown regarding implementation of Mental Health Commission recommendations.

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MICHIGAN MENTAL HEALTH COMMISSION IMPLEMENTATION REPORT CARD

The final report of the Michigan Mental Health Commission was presented to Governor Granholm on October 15, 2004. One year later, this implementation report card is issued with the intent of prompting action from the state to implement the Commission's recommendations. Since the Commission's report was presented, several efforts to address the recommendations of the report have taken place—i.e., an informal group of commissioners met in early 2005 to suggest prioritized recommendations and action plans; the Michigan Department of Community Health issued a 12-month plan for implementing some Commission recommendations in April 2005; a mental health advisory committee led by the Governor's office began to prioritize recommendations but disbanded and suggested transfer of its work to the Department of Community Health Advisory Council on Mental Illness; the Advisory Council on Mental Illness is considering a small number of the Commission's recommendations; the Legislature addressed aspects of a few Commission recommendations in Fiscal Year-2006 Budget Bill Boilerplate; and one or more of the legislators who served on the Commission may be preparing additional legislation to implement **c**ertain recommendations. However, even with such activity, this Implementation Report Card concludes that one year later there is little documented evidence of significant progress toward implementation of the Commission's recommendations. Rather, the major problems confronting Michigan's mental health system remain in place, essentially to the same degree they did prior to the Commission's work. In large part the lack of tangible progress has resulted from the absence of a systematic and coordinated top-down action plan that fully involves the executive and legislative branches of our state government**.** Some may attribute this situation to a lack of money and resources. Others may attribute it to a lack of political will.

This report card is divided into two sections. Section one assesses in narrative form progress toward implementation of the goals and key recommendations advanced in the Commission report's executive summary. Section two examines in tabular form the progress toward implementation of all 71 recommendations set forth in the body of the Commission report. (See Appendix A for a summative description of each recommendation.)

SECTION ONE

The executive summary describes seven goals to transform Michigan's mental health system and under these seven goals sets forth 21 key recommendations. Below we restate each of the seven goals with recommendations thereunder, followed by a brief assessment of implementation progress through October 2005.

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

- *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.*

The governor did not take steps to convene Michigan leaders to launch a public education campaign. No progress was made toward implementation of Goal 1 and its recommendations.

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.*

- *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.*

Although reportedly there was work undertaken to address portions of the above recommendations, no concrete progress was made toward implementing these recommendations. It remains to be seen whether the recommendations are addressed by bills that could be introduced later this legislative session (which runs through December 2006).

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.*

- *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.*

No steps were taken to establish the Commission's recommended array of services or, as a first step, adequate core service options and clarification of crisis response services. A privately established mental health institute was created but the state took no concrete steps to develop a public-private institute model. The Department of Community Health reported some steps to address the special needs of children, but the needs of older adults were not adequately addressed.

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

- *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.*

There was no documented progress toward addressing this goal and its recommendations. Whether or not related bills are introduced later this legislative session remains to be seen.

Goal 5: *Michigan's mental health system is structured and funded so that high-quality care is delivered effectively and efficiently by accountable providers.*

- *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.*

Although the Michigan Department of Community Health started modest work on some of the recommendations detailed in the body of the report under the above goal (see Section two), there was not adequate progress toward tackling the larger issues described in the three recommendations above.

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

- *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.*

The Department of Community Health has taken several steps to better integrate mental health and physical health care as well as mental health and substance abuse treatment. The identification of children with disabilities and risk factors for emotional disturbances, as well as programs for housing, supported education and supported employment, were not adequately addressed.

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

- *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.*

There was no reported evidence of progress was toward implementing the above goal and recommendations. {NOTE: Legislation recognizing psychiatric advance directives was enacted December 2004. This legislation was going to be introduced independent of any Commission recommendation.}

Finally, the Executive Summary states that "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"*

If we all agree that strong state leadership, dedicated funding streams and a full array of effective and available services and treatment are prerequisites to transforming mental health care in Michigan, then these broad prerequisites should be immediately addressed by Michigan's executive and legislative leaders.

SECTION TWO

Detailed Scorecard, MHC Recommendations, November 2005

Rec.	Accomplished	Work Fully or Partly Underway	Work Reportedly Coming	Inaction
1			X	
2				X
3				X
4		X		
5				X
6			X	
7			X	
8			X	
9[1]			X	
10				X
11				X
12				X
13				X
14[2]		X[3]	X[4]	
15				X
16				X
17				X
18		X		
19				X
20		X		
21				X
22				X
23				X
24				X
25				X
26[5]				X
27				X
28				X
29				X
30			X	
31				X
32			X	
33			X	
34			X	
35			X	
36			X	
37	X			
38			X	
39				X

[1] Parity bills introduced earlier this legislative session; would have happened without the MHC.
[2] Partly addressed in FY2006 Budget Bill Boilerplate.
[3] Through the Department of Human Services (DHS).
[4] Through the Department of Community Health (DCH).
[5] Partly addressed in FY2006 Budget Bill Boilerplate.

Rec.	Accomplished	Work Fully or Partly Underway	Work Reportedly Coming	Inaction
40				X
41				X
42				X
43				X
44				X
45			X	
46				X
47			X	
48			X	
49				X
50			X	
51			X	
52			X	
53				X
54				X
55				X
56			X	
57			X	
58		X		
59				X
60			X	
61			X	
62		X		
63			X	
64				X
65				X
66				X
67				X
68				X
69				X
70			X	
71				X

APPENDIX A

Summative Description of Each Commission Recommendation

1. Creation of an ongoing public education campaign.
2. Web-based repository of mental health information within the educational campaign.
3. Within economic development programs, attract pharmaceutical and other private investment in Michigan-based mental health research.
4. State Surgeon General should lead implementation of suicide prevention plan of the Michigan Suicide Prevention Coalition.
5. Early identification and screening should be strengthened throughout all health care and service systems.
6. Hierarchy of choice for simplifying decisions about need for service. Includes voluntary and involuntary procedures.
7. Amend Mental Health Code for greater clarity of circumstances justifying court-ordered care.
8. Implement uniform criteria for service eligibility and priority status; expand capability to address both severe and mild/moderate disorders; and adopt suggested Service Selection Guideline Principles.
9. Enact pending state legislation on mental health insurance parity.
10. Policy and timetable for implementation of a comprehensive and high-quality statewide service array.
11. (As first sep toward array) Identify, fund and assure adequate core service options available to persons experiencing crises and individuals qualifying for priority service status.
12. Assurance of reasonable access to service, regardless of geography, reimbursement status or type of service manager.
13. Sixty-mile/minute service array accessibility in rural areas, and 30 minutes/miles for urban areas.
14. Statewide access, as close to one's residence as possible, for inpatient psychiatric care or secure residential treatment when appropriate.
15. Transportation or mobile intensive treatment team options when psychiatric inpatient access not feasible.
16. Maximum comparability of service array across Medicaid and non-Medicaid populations.
17. Creation of a mental health institute to develop evidence-based practices and research at the community and state levels.
18. Strengthen the state's mental health quality management program.
19. Web-based information infrastructure for the state's publicly funded mental health system.
20. Strengthen Michigan's interagency approach to prevention, early intervention and treatment for children.
21. Convene a stakeholder group including universities and providers regarding mental health service needs and workforce preparation/retention issues related to older adults.

22. Specific outreach efforts targeted to older adults, persons with dementia and their caregivers.
23. Make Community Mental Health screening and intake systems more "elder-friendly."
24. Better screening tools for medical providers to identify depression and other problems in older adults.
25. Eliminate use of juvenile and criminal justice systems as "providers of last resort."
26. Require effective and measurable justice diversion programs, including expansion of mental health courts.
27. Improved training of all appropriate parties regarding justice diversion programs.
28. Screening and assessment for mental health at point of entry to or first contact with justice systems.
29. Clarify responsibility for provision of mental health diversion services between "county of crime" and "county of residence" (former preferred).
30. Improved justice system pre-release planning for mental health needs.
31. Improved mental health system through structure that better clarifies and coordinates state, regional and local roles, responsibilities and accountability.
32. Financial incentives for counties that coordinate and streamline regional mental health functions.
33. Improved state standard-setting and training regarding mental health administrative matters.
34. Range of acceptable administrative costs for publicly funded mental health service managers and providers.
35. Strengthen state enforcement options relative to Community Mental Health services.
36. Strengthen Department of Community Health medical director for mental health, and involve him/her in leadership regarding evidence-based practice.
37. Involve State Advisory Council on Mental Illness with implementation of Commission recommendations.
38. By January 2006, progress report on #s 31–36 and other matters related to system structure/organization.
39. New funding strategies for better support of mental health services.
40. Analysis of utilizing case rate funding methodologies in public mental health system.
41. Analysis of issues pertaining to mental health service delivery and financing in rural areas.
42. Linking service payment to quality of care delivered.
43. Improved, sustainable models of collaboration at state and local levels.
44. Separate offices within Department of Community Health's mental health division for policy and clinical issues involving, respectively, developmental disability and mental illness/emotional disturbance.
45. Legislation on director of state office of recipient rights reporting directly and solely to director of Department of Community Health.
46. Medicaid Fair Hearings (appeals) related to public mental health services should require a clinical consultation component.

47. Non-Medicaid recipients and applicants in the public mental health system should have an appeal mechanism comparable to the Medicaid Fair Hearing, with a clinical consultation component included.
48. Amend state law on recipient rights regarding: implementation of rights office recommendations; responsibilities of the state recipient rights appeals committee; who may participate in a rights investigation; protection of recipient rights staff; and state enforcement of non-compliance with rights requirements by Community Mental Health agencies.
49. Uniform methodologies and programs for statewide use in protection of recipient rights.
50. Review and revise current recipient rights written material toward more user-friendliness, cultural appropriateness and statewide uniformity.
51. Rights office education, training, evaluation and assistance to primary and secondary consumers in navigating the public mental health and other human service systems.
52. Review and revision of recipient rights policies for cultural competence.
53. Tracking of and database on applicants denied service.
54. Examination of recipient and applicant fatalities and sentinel events for possible rights violations.
55. Licensing and state agency reviews of providers should require documentation of training, quality improvement and consumer grievance processes.
56. Amend statute to permit state rights office to investigate and make recommendations about recipient rights programs in licensed hospitals.
57. Better integration/coordination of mental health and primary care services.
58. Reduce barriers to treatment of co-occurring (mental health and substance abuse) disorders; focus on integration, perhaps through regional/local consolidation of programs.
59. Michigan Department of Education identification of children with or at risk of disabilities, and evaluation of state's school discipline code to determine effects of zero tolerance education policy.
60. Michigan State Housing Development Authority consideration of expanded Housing Trust Fund.
61. Improved programs to address homelessness among individuals with mental illness.
62. Promote compliance with Americans with Disabilities Act (ADA).
63. Promote compliance with Michigan Persons with Disabilities Civil Rights Act.
64. State interagency review process for pre-placement interventions with children.
65. All Community Mental Health programs should offer supported employment service for persons with serious mental illness.
66. Review of other states' efforts in implementing coordinated statewide programs for supported employment.
67. Expansion of the Michigan Supported Education Program.
68. Require Community Mental Health Boards to have at least one representative from each of the following: individuals with developmental disability; persons with mental illness; and children with emotional disturbance.

69. Better mechanisms to obtain consumer and family input on user satisfaction and outcomes.
70. Require service providers to offer and strongly encourage establishment of psychiatric advance directives; unless prohibited by such a directive, closest family member(s) of a deceased recipient should have unqualified access to his/her case records.
71. State should assist Community Mental Health programs in utilizing Medicaid for family advocate services.

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The Ethel and James Flinn Foundation is a charitable foundation located in Detroit, Michigan. The Foundation is committed to improving the lives of those with mental illness by improving the quality, scope and delivery of mental health services.

The Mental Health Association in Michigan (MHAM) is the state's oldest advocacy organization for persons experiencing mental illness. Headquartered in Southfield, partly funded by United Ways and affiliated with the National Mental Health Association, MHAM engages in policy analysis and system-level advocacy, primarily at the state government level.

The Flinn Foundation and the Mental Health Association are non-profit, non-partisan organizations.