

A THREE-YEAR REPORT CARD
Progress by the State of Michigan in Implementing Recommendations of the
Governor's Mental Health Commission: October 2004 – December 2007

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The Mental Health Association in Michigan

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Introduction

In February 2004, citing a mental health system she termed “broken,” Governor Granholm convened a special Mental Health Commission, consisting of 29 voting members from multiple backgrounds and interests across the state. The Commission represented the most comprehensive, broadly based citizen review of state mental health policy in approximately a quarter-century. The President & CEO of the Mental Health Association in Michigan (MHAM) was one of the Commission’s members.

In October of 2004, the Commission presented the Governor with 71 recommendations for improving mental health services in Michigan. The Governor told Commission members as she accepted their report that she agreed with “90 percent” of the recommendations, and there would be room to talk about the remaining ten percent.

In December 2005, MHAM published a one-year report card on state government progress in implementing Commission recommendations. We did not at that time assign a letter grade to state progress. Had we done so, the grade would have been “F” as virtually nothing had been accomplished. We wrote in the first report card that “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.” We further determined in December 2005 that one Commission recommendation had been accomplished, and that work was “fully or partly underway” regarding six others.

We are sad to report that the situation is virtually unchanged in January of 2008, some 39 months since the Commission report was delivered to the Governor (see appendix). Michigan’s state government collectively deserves and is assigned in this report a grade of “F” for a dismal record to date of implementing Commission recommendations.

This grade is not a sole indictment of the Governor. It is not a sole indictment of state departments such as Community Health, Corrections, and Human Services. It is not a sole indictment of the Legislature. The bottom line is that our entire state government has failed collectively to step up to the plate in addressing a situation that, if “broken” in February 2004, is surely still broken today.

Our report is also not meant to imply that the Michigan Department of Community Health (DCH) – the state’s lead agency for public mental health services – and the system it heads are bereft of worthwhile endeavors. DCH’s response to our 2005 report card was to catalogue a laundry list of system activities, which totally begged the question of whether and to what degree any Commission recommendations had been implemented.

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We readily acknowledge and appreciate the help provided to tens of thousands of people annually by the public mental health system. Unfortunately, that system isn't nearly what it could or should be, and the needs that exist encompass several hundreds of thousands of our state residents. That is why the Governor established her Commission, and that is why it is so disappointing to note such little progress in implementation of Commission recommendations.

Finally, we recognize that Michigan is in difficult financial circumstances (although we note the state closed FY-07 with a \$250 million General Fund surplus). Some of the Commission's recommendations would cost money, which is hard to come by right now. But other recommendations would cost nothing or little, and some would save state government money. Additionally, the Commission did come up with ways to generate new state money for mental health that would impact only a few isolated sectors of the Michigan economy. The state's current budget difficulties provide a convenient excuse for failing to act on Commission recommendations, but the overarching factor here has not been a lack of money. Rather, it has been a lack of political will. Until that will surfaces, a status quo that wasn't (and shouldn't have been) good enough for the Governor in 2004 remains constant in 2008, to the detriment of the hundreds of thousands of Michigan residents experiencing serious mental illness.

The Commission's Recommendations

We believe most of the Commission's recommendations can be distilled to seven critical areas, as follow:

● ***The executive branch should facilitate an ongoing public-private campaign for community education about mental disorders.*** One of the biggest drawbacks to advancing mental health service is the stigmatizing view of mental disorders still held by too many people in our state. The public needs to know that mental illness and emotional disturbance are highly common – affecting all population groups – and highly treatable, with success rates greater than for many other medical conditions. Recovery from mental illness is the rule rather than the exception if treatment is available and accessible. The Commission called for the Governor to convene Michigan leaders across multiple sectors for a public-private partnership to develop and launch a public education campaign on mental illness. It was further recommended that the campaign advance proven health promotion strategies to address mental health issues, as well as develop a statewide web-based repository of related information.

The overarching factor has been a lack of political will. Until that will surfaces, a status quo that wasn't (and shouldn't have been) good enough for the Governor in 2004 remains constant in 2008.

•*The need for greater uniformity of service management, provision, and structure across the state.*

DCH and state government must play a more effective and aggressive role in assuring that service eligibility, availability, and access are guided across the state's Community Mental Health Services Programs (CMHSPs) by uniform standards, definitions, operating procedures, and structure. Among Commission recommendations were calls for statewide Service Selection Guideline Principles, and for certain serious diagnoses (e.g., schizophrenia) or specified levels of dysfunction to qualify an individual automatically for ongoing priority access to a statewide array of comprehensive services. The suggested array includes intensive, protected therapeutic care for persons whose clinical circumstances require a hospital or specialized residential stay of greater than short-term length. This is a service that the state hasn't always been willing to foster, but one which the Commission characterized as an "immediate attention area." (Recognizing that Michigan has few state-operated hospital beds left, the Commission recommended the piloting of small, secure residential programming with a recovery focus.) It was further recommended that, by January 2006, DCH should have a plan for: reducing the state's number of CMHSPs (currently 46) by at least seven; evaluating the different service models presently employed by various CMHSPs across the state; and returning to a system where state contracts with all CMHSPs are for both Medicaid and non-Medicaid service. (Right now, the state contracts with all CMHSPs for non-Medicaid, but with only 18 for Medicaid service. Some of these 18 sub-contract to other CMHSPs local Medicaid service provision.)

•*Michigan must develop ways to better assist adults with mental illness and minors experiencing emotional disorders in the early stages of their disease.* The Commission concluded that, far too often, individuals must be in psychiatric crisis before the publicly funded mental health system (or anyone else) will respond to their mental illness. The Commission called for:

- ~Better case-finding;
- ~More education of primary care physicians;
- ~Improved CMHSP capability to make and follow-up on referrals to other resources;
- ~More in-service training of teachers;
- ~Renewed attention to prevention programming targeted to at-risk children;
- ~Increased outreach to older adults;
- ~Greater authority for guardians of legally incapacitated individuals to initiate treatment;
- ~Reorganizing Mental Health Code language to clarify that imminent danger to self or others isn't the sole criterion for treatment intervention;
- ~Enacting state law for private sector mental health insurance parity (discussed in detail immediately below).

The suggested (service) array includes intensive, protected therapeutic care for persons whose clinical circumstances require a hospital or residential stay of greater than short-term length. This is a service that the state hasn't always been willing to foster.

● ***Michigan must join the (now 42) states which have adopted mental health insurance parity (equality) law.*** It is still legal in Michigan for private insurers to discriminate against persons with mental disorders, forcing them for mental health care to pay considerably more out-of-pocket and accept significantly fewer benefits than is the case for other medical coverage. The Commission concluded that Michigan must do what the vast majority of states have done – i.e., end such discrimination through enactment of mental health parity law. The Commission determined that such law can be extremely helpful in reaching individuals earlier in their disease states; takes some pressure off the publicly funded mental health system; has minuscule direct cost implications for employers; and has the potential for major long-term cost-savings to businesses and society.

● ***The rights of persons receiving publicly funded mental health service in Michigan must be better protected and promoted.*** The Commission heard much testimony that the public mental health system is not accountable to consumers and families through adequate rights protections and grievance mechanisms. Prominent among recommendations in this area was the call for all CMHSP recipients and applicants to have the opportunity to appeal a local service decision to the state, with the state’s hearing of the appeal to incorporate review by and input from an independent clinician. The Commission report also recommended:

- ~Promoting consumer use of advance psychiatric directives;
- ~Stronger authority for local and state recipient rights offices in the investigation, determination, and remediation of possible violations of consumer and family rights accorded by law;
- ~Greater state enforcement authority;
- ~Allowing the state recipient rights appeals committee to conduct hearings on the merits of appealed cases;
- ~Tracking outcomes for applicants denied service;
- ~Improving examination of recipient and applicant fatalities and sentinel (adverse) events for possible rights violations;
- ~Allowing the state to review recipient rights programs in licensed psychiatric hospitals;
- ~Permitting the closest surviving relative of a deceased recipient to access the recipient’s case records (unless the recipient had prohibited such access while still alive).

● ***Michigan must stop the excessive flow of persons with mental illness and emotional disturbance into the adult and juvenile justice systems.*** There is some evidence to suggest that Michigan could have one of the nation’s highest rates of adults with mental illness becoming incarcerated. (The state’s 1999 study of county jails in Wayne, Kent, and Clinton found mental illness prevalence rates over three times higher than the U.S.

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Justice Department’s national average for that year.) Major problems were also seen with respect to emotional disturbance in juvenile justice facilities and mental illness in state prisons. The Commission had several related recommendations, including the need for establishment of specialized Mental Health Courts in Michigan and improvements to training, coordination, entry screening and assessment, and pre-release planning.

●***Funding of public treatment and support services for mental illness and emotional disturbance must be improved.*** Michigan’s public mental health system has not been armed with resources to keep pace with service demand. This has been especially true for adults and minors with mental illness, who make up a large majority of the system’s clients. (Persons with developmental disabilities and some individuals with addiction disorders are also eligible for services through CMHSPs.) Funding problems have been exacerbated by the state’s push to place as much service provision as possible under the umbrella of Medicaid. This allows the state to receive federal matching dollars for many services, but leaves relatively little unencumbered state General Fund money for mental illness service. That is important because roughly half of statewide CMHSP mental illness clients are not enrolled in Medicaid. When Medicaid spending in the “mental health” portion of the DCH budget is coupled with related health expenditures in other portions of that budget (including prescriptions), there is no question that we have a two-tiered system of public response to the health needs of persons experiencing mental illness, with non-Medicaid individuals at the sparse lower end of the spectrum. The Commission advanced a number of recommendations across multiple fronts for improving mental illness system support. Included was a proposal for a dedicated state fund that would annually improve funding without taking dollars away from other state budget areas or the mainstream state economy. Toward this end, the Commission identified thirteen tax loophole closures or use fees that collectively could double the current \$300 million in unencumbered state General Fund appropriations presently available to mental health.

Outcomes as of December 2007

●***Executive Branch Facilitation of Public-Private Anti-Stigma Campaign***

Several CMHSPs have been pursuing anti-stigma education in their catchment areas, and at least one CMHSP (Detroit-Wayne) is working with DCH on an anti-stigma conference for 2008. The Community Mental Health Boards Association has recently initiated dialogue with and is expecting participation from DCH in a statewide education campaign which the Boards Association intends to implement in concert with other mental health interests.

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Those activities by Community Mental Health are most commendable. The Commission's recommendation, however, called for the Governor to initiate a major, statewide public-private campaign, recognizing that the weight of the Governor's office can draw private sector involvement, resource contributions, and public attention far greater than what the mental health field can do on its own. The executive branch has not initiated the campaign for which the Commission called. In April 2006, DCH brought together representatives of approximately ten organizations (including MHAM) for a meeting to get started on such a campaign. Meeting attendees were told they'd be called back together in another month or so. No such meeting was ever scheduled or held subsequently.

● ***System Structure, Uniformity, and Scope***

DCH did not issue by January 2006 (or anytime since) the report called for on reducing the number of CMHSPs, returning to a system in which each CMHSP is responsible for both Medicaid and non-Medicaid service, and other system structure issues.

Additionally, DCH has been under legislative directive in three consecutive budget bills (FY-06 through FY-08) to conduct a cost-benefit analysis of serving some adult mental illness consumers through one or more small, secure residential programs with a recovery focus. (At a level of 16 beds or less, such programs would be eligible for some Medicaid reimbursement.) DCH has provided two related reports so far, the first issued April 2007 but dated April 2006, and the second issued at the end of 2007 but dated April '07. Neither report offered a cost-benefit analysis of small, secure residential programming.

In 2006, legislative bills were introduced for the following:

- ~Utilizing the terminology of the Commission's model service array;
- ~Implementing the Commission's recommended Service Selection Guideline Principles;
- ~Establishing statewide operationalization of what constitutes the "most severe forms" of mental illness and emotional disorder (important for service priority determinations);
- ~Conferring permanence to priority service status once a consumer has received such designation;
- ~Reducing the number of CMHSPs statewide from 46 to 18;
- ~Requiring a medical director for mental health within DCH's mental health and substance abuse division.

The bill requiring a medical director for mental health was enacted. The remainder did not receive committee attention and are expected to be reintroduced (along with other structure-and-uniformity bills) in 2008.

In April 2006, DCH brought together representatives of about ten organizations for a meeting to get started on a major, statewide public-private anti-stigma campaign. Meeting attendees were told they'd be called back together soon. No such meeting was subsequently scheduled or held.

In 2006, DCH worked with the Michigan Association of Community Mental Health Boards so that the latter established a subsidiary known as The Standards Group (TSG). DCH suggested that this new entity would do developmental work on ten issues that could benefit from greater standardization and/or collective approaches. DCH further suggested that TSG could help flesh out some Commission recommendations (and that any TSG recommendations in conflict with the Commission's work would be rejected by DCH).

TSG has done work on seven of these issues through December (and has added two more to its list). Perhaps the most advanced and relevant product (for purposes of this report) has been on common values, functions, and standards for access to CMH services. An access document from TSG awaited official DCH response as of December. It is important to note that the TSG document uses as its framework existing laws, rules, and policies. That is an understandable approach, of which we are not critical. But some of the Commission's most significant recommendations concerning service access would require revision of existing regulations. Thus, not reflected in the TSG access report are Commission recommendations for vitally important changes such as:

- ~Legally operationalizing what constitutes the "most severe forms" of mental illness and emotional disturbance, as current law uses this terminology (undefined) as an important criterion for priority service determinations;
- ~Assuring that a consumer who has received designation as a priority case retains that status permanently;
- ~Utilizing statewide a specifically recommended set of Service Selection Guideline Principles to aid consumers, families, and providers in making service determinations;
- ~Allowing consumers to contest a local service decision before an independent clinician not connected to their case or CMHSP.

● *Assisting Individuals Pre-Crisis*

Legislation introduced in 2006 but not acted upon at the committee level would have: (1) combined Mental Health Code subsections 401(a)-(c) into a single subsection to better foster that imminent danger to self or others isn't the sole criterion for legal treatment intervention; (2) allowed guardians of legally incapacitated consumers to initiate treatment for their wards; and (3) added referrals, case-finding outreach, and screening as specific items among the list of required Community Mental Health services. It is anticipated that these initiatives will be reintroduced in 2008.

Additionally, DCH has consistently resisted reestablishing what had been an internationally renowned prevention services unit within the department since that unit

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was closed (ostensibly for financial reasons) in 2002. In budget development work for FY-2008, advocates attempted to gain a \$175,000 appropriation for reestablishing a single-person unit, but DCH was unwilling for \$175,000 of its \$12-billion total appropriation to be designated for mental health prevention, and legislators decided not to press the issue in light of the Department's position.

● ***Mental Health Parity Law***

The Commission's recommendation for parity law did not newly bring this issue to Michigan. The statewide mental health community has been working for it in united fashion since 1999. Yet Michigan shamefully remains one of eight states that legally discriminate against and oppress vulnerable individuals and families experiencing mental health disorders. There are legislators from both political parties who support parity, but there are also lawmakers on both sides of the aisle who fear it because of aggressive opposition from businesses and some unions. Their anti-parity arguments are totally debunked by the facts, but the well-being of Michigan citizens and families is held hostage by powerful political contributors. Through December 2007, no legislative committee hearings or actions had been taken on the parity bills introduced for the 2007-08 legislative session.

As for the Governor, she made comments in her first campaign for that office which some interpreted as being pro-parity. Since she assumed office, we are aware of no statement from the Governor in support of parity law for Michigan.

{NOTE: The 2007-08 session of Congress may result in improvements to the weak federal parity law that took effect January 1998. Should those improvements be made, their exclusionary provisions would still leave perhaps up to two million otherwise privately insured Michiganders without mental health coverage comparable to the coverage they have for other medical care. Thus, state law would be necessary even if Congress acts this session.}

● ***Better Promotion and Protection of Consumer and Family Rights***

In late 2004, legislation was enacted to legally recognize psychiatric advance directives in Michigan. Work on the legislation had begun before the Mental Health Commission, and likely would have proceeded as it did with or without the Commission.

In 2006, legislation was introduced to do the following:

~Require the state-level recipient rights office to report directly and solely, without qualification, to the director of DCH;

The Governor made comments in her first campaign that some interpreted as pro-parity. We're aware of no subsequent statement from the Governor supporting state parity law.

- ~Track outcomes of mental health system applicants denied service;
- ~Improve examination of recipient and applicant fatalities and sentinel events for possible rights violations;
- ~Allow the state to review recipient rights programs in licensed psychiatric hospitals;
- ~Allow the closest surviving family member of a deceased recipient to access his or her case records (unless the recipient prohibited such access while still alive).

The first of these was enacted. The remainder did not receive committee hearings or action.

It is anticipated that the 2006 bills not acted upon will be reintroduced in 2008, along with other legislative initiatives related to Commission recommendations on rights. Additionally, DCH reports that it has been piloting the process of reviewing rights programming in licensed psychiatric hospitals.

● *Mental Illness and Justice Systems*

Michigan and the nation have not deinstitutionalized mental illness. Rather, the focus of institutionalization has switched from psychiatric hospitals to jails, prisons, and juvenile justice facilities. Meanwhile, the horrible circumstances and health consequences for Michigan prison inmates with mental illness (including multiple fatalities) have been widely publicized over the past two years by state and national media (e.g., “60 Minutes” coverage of the brutal death of a young adult with mental illness in the state prison at Jackson).

Since the Commission report, the state has begun the Michigan Prisoner Reentry Initiative (MPRI), which provides supports and services to increase chances for community success of released prisoners, both those with and without mental illness. The program was in its planning stages before the Mental Health Commission, but does relate to the Commission recommendation about the importance of pre-release planning. MPRI has been widely supported in the mental health community, but it is not exclusively a mental illness program; cannot and doesn’t serve all released prisoners with mental illness; and awaits reliable long-term evaluation data.

In 2007, two Michigan communities reportedly began attempts to initiate specialized Mental Health Courts. But our state government does not offer or provide assistance to communities with such interest, and legislation introduced early in 2007 to help enable Mental Health Court establishment has received no committee hearing or attention. Further, DCH has been under legislative directive in three consecutive budget bills (FY-06 through FY-08) to conduct a cost-benefit analysis, in conjunction with the State Court Administrative Office (SCAO), of specialized Mental Health Court programming. DCH has provided two related reports so far, the first issued April 2007 but dated April 2006, and the second issued at the end of 2007 but dated April ‘07.

Michigan has not deinstitutionalized mental illness. Rather, institutionalization has switched from psychiatric hospitals to jails, prisons, and juvenile justice facilities.

These reports were not done in conjunction with SCAO, and only the second one offered a partial cost-benefit analysis of specialized Mental Health Courts. SCAO is under a separate directive in the state's FY-08 judiciary budget to "evaluate various strategies for court systems to use to better respond to defendants with mental illnesses. Such strategies may include, but are not limited to, mental health treatment courts, dedicated probation caseloads for people with mental illnesses, specialized pretrial release programs, and court-based diversion programs."

Further, the legal burden for local mental health jail diversion programming still falls entirely on CMHSPs, even though community efforts cannot succeed fully without other units of local government also being involved. It is anticipated that legislation to spread legal requirements for jail diversion more fairly and appropriately will be introduced in 2008.

● *Funding for Public Mental Health Services*

State funding for CMHSP non-Medicaid services remains dangerously inadequate. Roughly half of statewide CMH clients (the vast majority of whom are adults or minors with mental illness) are not enrolled in or receiving Medicaid services. Yet less than 16% of basic CMH mental health treatment funding in FY-08 is designated by the Legislature for non-Medicaid service. There has been no improvement to this situation since the Mental Health Commission report, and none of the Commission's recommendations for increasing non-Medicaid funding without taking money away from other state budget areas (and without affecting mainstream state economy) has been implemented. Additionally, by bucking the overwhelming national trend and allowing private insurance to discriminate against coverage of mental illness, Michigan puts extra pressure and burdens on the publicly funded mental health sector. Everyone in Michigan winds up paying in multiple ways for the private sector not doing its fair share.

Conclusions

If mental health services in Michigan were "broken" in February 2004, they are surely still broken now, as our state government has done very little to implement Commission recommendations and significantly change dysfunctional systems.

As we enter 2008, some 39 months after the Commission report was delivered to the Governor (and she expressed agreement with "90 percent" of it), we are left looking at the following:

State funding for CMHSP non-Medicaid services remains dangerously inadequate.

- Michigan is one of only eight states that have taken no legal action to end or curtail vicious private sector insurance discrimination against individuals and families experiencing mental illness.
- Our state is woefully short on intermediate and long-term protective, intensive therapeutic care resources for those clinically requiring them, and we are no closer to piloting small, secure residential care programming than in 2004.
- Michigan’s justice systems are overflowing with persons experiencing mental illness, many of whom committed minor offenses that wouldn’t have happened if treatment had been available and accessible.
- Our state government doesn’t offer or provide assistance to local communities interested in establishing specialized Mental Health Courts.
- The legal burden for diverting people with mental illness from incarceration continues to rest with CMHSPs, even though multiple government resources are required for success.
- The number of CMHSPs has not been reduced.
- The publicly funded mental health system is still two-tiered, with non-Medicaid services greatly underfunded, and persons depending on them given the short end of the stick.
- CMHSPs remain too disparate in their practices and standards, and we still have the bureaucratic maze of some CMHSPs being responsible for both Medicaid and non-Medicaid service, while other CMHSPs are responsible only for the latter.
- What constitutes the most severe forms of mental illness and emotional disturbance remains legally undefined, even though the state’s Mental Health Code declares that this is one of the prime criteria for conferring priority service status upon a mental health consumer.
- Case-finding outreach, screening, and referrals are still not required adequately in law as activities for the public mental health system.
- The public mental health system remains judge and jury of almost all complaints filed against it.

Michigan’s justice systems are overflowing with persons experiencing mental illness, many of whom committed minor offenses that wouldn’t have happened if treatment had been available and accessible.

- Stigmatization of mental illnesses and persons experiencing them remains a major deterrent to progress in improving mental health services.

These were but some of the critical areas which the Mental Health Commission said required action. Through December 2007, our state government has failed in its response.

The Commission represented the most broadly based, comprehensive citizen review of mental health policy in a quarter-century. Do we have to wait another 25 years without meaningful change and then repeat the exercise of asking where and how mental health services have broken down? Or do we have the political will, with the Commission's recommendations still recent, to do something now about one of the most pressing problems of our time – untreated and inadequately treated mental illness?

About the Mental Health Association in Michigan (MHAM)

MHAM is the state's oldest advocacy organization for persons experiencing mental illness, having been incorporated in 1937. MHAM's main focus has been and remains policy analysis and governmental advocacy for state regulatory action benefiting adults and minors with mental illness. The Association believes it can achieve the greatest good for the greatest number through this approach, as there are two-million Michiganians experiencing some manner of mental disorder annually, with over 500,000 of these representing serious cases. MHAM was the leading statewide voice throughout 2003 on the need for establishment of a gubernatorial commission on mental health issues. The Association's President & CEO was one of the 29 voting members of the Commission, which was co-chaired by a current member of the MHAM Board of Directors. Affiliated with Mental Health America and partly funded by local United Ways, the Mental Health Association in Michigan is a 501(c)(3) non-profit corporation.

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APPENDIX

Summative Description of Each Commission Recommendation

Listed below are summary descriptions of each Mental Health Commission recommendation. As of December 2007, our assessment is that state government has fulfilled or demonstrated credible progress for 7½ of them. These would be #s 18, 30, 36, 37, 45, 58, and 61, along with the portion of #70 that deals with legally recognizing psychiatric advance directives.

1. Gubernatorial stimulation 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 step 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 state-sanctioned 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. *{A work group among state department directors exists regarding children's issues. DCH wrote at the close of 2007 that it "will (emphasis added) publish the findings and recommendations" of the group. Apparently, three-plus years haven't allowed sufficient time for this.}*
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, through multi-agency shared responsibility, including establishment 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. Require the position of medical director for mental health within Department of Community Health, to provide leadership on evidence-based practice.
37. Involve State Advisory Council on Mental Illness with implementation of Commission recommendations. *{The Council has developed three legislative proposals and done work on a fourth recommendation.}*
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 expansion of Housing Trust Fund in specific relation to needs of Community Mental Health clients.
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.