Michigan Mental Health Commission

established by Governor Jennifer Granholm's Executive Order 2003–24

MENTAL HEALTH COMMISSION MEETING SUMMARY

March 29, 2004
Holiday Inn South
Lansing, Michigan

Commissioners Present

Patrick Babcock and Waltraud Prechter, Co-chairs; Fran Amos, Beverly Blaney, Thomas Carli, Patricia Caruso, Nick Ciaramataro, Bill Gill, Beverly Hammerstrom, Rick Haverkate, Joan Jackson Johnson, Gilda Jacobs, Alexis Kaczynski, Sander Levin, Kate Lynnes, Milton Mack, Samir Mashni, Andy Meisner, Janet Olszewski, Donna Orrin, Jeff Patton, Brian Peppler, Michele Reid, Mark Reinstein, Roberta Sanders, Dave Sprey, Sara Stech, Maxine Thome, Marianne Udow, Tom Watkins

The meeting was convened at 8:30 AM. Patrick Babcock called the meeting to order and stated that the majority of the day's meeting would be spent in work groups, identifying key issues for which recommendations will need to be developed.

Approval of March 1 Meeting Summary

The summary of the commission's second meeting (March 1) was approved by a unanimous vote.

Action: Work Group Appointments

Recommended work group appointments were presented by co-chair Babcock. The recommended list was approved following the addition of individuals to address gaps in expertise, e.g., nursing.

The commission agreed on a process for contacting new members. PSC will provide information to work group chairs and/or lead staff so they may place phone calls to the individuals inviting their participation. Once they accept the offer to participate, a letter from Patrick Babcock and Wally Prechter will be mailed to them along with an information packet of commission materials. Work group chairs may schedule conference calls with their work group to bring the new participants up to speed.

The approved list of work group members is attached.

Update on Public Hearings

Geralyn Lasher provided an update on the four public hearings the Michigan Department of Community Health (MDCH) has arranged. They are scheduled as follows:

Grand Rapids
Wednesday, April 7, 2004
2:30–7:30 PM
The Conference Centers
Western Michigan University, Grand Hall
200 Ionia Ave., SW

Detroit
Wednesday, April 14, 2004
2:30–7:30 PM
Cobo Conference/Exhibition Center
O2-44, Oakland Hall (2nd floor, room 44)
One Washington Blvd.

Flint
Tuesday, April 20, 2004
2:30–7:30 PM
Mott Community College
Ballroom of the Prahl Conference Center
1402 E. Court St.

Marquette
Thursday, April 29, 2004
3:00–8:00 PM
Northern Michigan University
Great Lakes Room
1401 Presque Isle Ave.

Lasher asked commissioners to volunteer to attend a hearing and thanked those who already have volunteered. She also reported that public comment is now accepted online. She said that when the hearings are announced publicly, the announcement will include information about the commission website.

Signers for the deaf will be available at each of the public hearings. Commissioners also requested that translators be available for persons who speak Spanish or Arabic. Lasher said she would look into that possibility, and that written materials could be provided in multiple languages.

Each hearing will include a half-hour question and answer session at the beginning and end with time for testimony in between. Commissioners will welcome everyone to the hearings at the beginning and lay out the comment process for the afternoon. The commissioners requested that the department provide them with a consistent format to follow.

One commissioner inquired as to the plan for outreach in the Detroit area regarding the hearings. Geralyn said that she is working on comprehensive outreach plan with T. J. Bucholz, spokesperson for MDCH, and she agreed to provide the commission with an outline of that plan.

In response to a commissioner's request, Lasher said that she would invite the local community mental health agencies to attend the hearings and ask them to bring informational materials.

Updates

April 12 Seminar

Michael Ezzo (MDCH) provided an update on the April 12 seminar. The seminar is designed to give commissioners an understanding of the current Michigan mental health system and to identify experts who might present information directly to their work groups.

The seminar will begin at 8:30 AM and will consist of four 90-minute sessions on the Michigan mental health system:

- Structure and Financing
- Legal Mandates
- The Population Served, Underserved, and Not Served, and Service Array
- The Rights of People Served

The first 30 minutes of each session will consist of a presentation on the topic by MDCH staff; the second third will include a presentation from another group with expertise in the field; and the last half hour will be spent in group discussion.

New work group members will be invited to attend the seminar.

Commission members made the following requests/suggestions for information to be covered in the seminar:

- A "20,000-foot view" of the funding of the system
- Education on the intersection of departments and services (e.g., how does FIA intersect with MDCH or the Department of Corrections?)
- A basic overview of the evolution of the current mental health system
- Review of the contracts between the state and community mental health agencies

Michael Ezzo stated that as the presentations for the seminar are developed, they will be posted on the commission's website. He also said that further requests from commissioners would be helpful in developing the second seminar, which will address emerging and best practices.

National Schizophrenia Month

The commission co-chairs suggested that the commission recognize events that support increasing awareness of mental illness. For example, there has been a request that the commission recognize National Schizophrenia Month at its May meeting.

NAMI Meeting Attended by Commissioners

A number of commissioners attended a recent meeting of the National Alliance of the Mentally Ill (NAMI, Oakland County), to which they had been invited in order to hear the concerns of NAMI members. Tom Carli prepared notes from the meeting and shared them with the commissioners, who received a copy of his notes.

The commissioners then discussed the protocol for future events of this nature. It was decided that when commissioners are invited to hear public comment or to share information regarding the progress of the commission, they should notify Public Sector Consultants, who will post the opportunity on the commission listserv so that any commissioner who is interested may attend. Commissioners agree that when introducing themselves at such events, they will make it clear to attendees that they cannot make individual commitments on behalf of the commission. Commissioners that attend an advocacy meeting or other event will "appoint" one of themselves as a note taker. These notes will be summarized and provided to all commissioners for their information, not public distribution. The commission requested MDCH to post a list of the events attended on the Web page.

Action: Values and Work Groups

Patrick Babcock referred the commissioners to the final draft of the "Values and Work Group Structure" document in their meeting packets. With a few minor revisions, the commission unanimously approved the document. The final version of the document is attached.

Work Group Reports

The chair of each of the work groups reported to the full commission preliminary key issues and priority data and information needs of their work group. The summaries of each of the work group meetings are available.

Public Comment (morning)

Christine Riddlebaugh, Gratiot County CMH volunteer. She expressed her concern about funding disparities between urban and rural CMHSPs. She was unaware that there are two primary consumers on the commission She stated that rural areas are impacted more than urban areas with regard to funding cuts, etc. She concluded by thanking the commission for the chance to talk and asking if there are additional openings for other consumers within this process.

Bob Wernick. Gratiot County CMHSP. He had not planned on speaking until he saw the list of work groups and was concerned that there wasn't a work group on funding. He listed a number of general observations:

- What is the motivation of the commission? While he acknowledged that the public mental health system has some problems, he stated that he hopes that the commission is not on a "witch hunt." He shared his concern about the loss of institutional memory within the Department of Community Health and noted that staff levels within the department have been depleted because of early retirement.
- He asked if the commission is looking at problems at the local board level or the state or both? He stated that while all of the CMHSPs have their own distinct problems, there are some global problems, especially funding. The general fund dollars have been taken away and the Medicaid dollars are earmarked for designated types of individuals. He stated that the shift to Medicaid as the primary funding source "screwed up funding." He is concerned that there is a lack of understanding on how funding works. At Gratiot County CMHSP 86 percent of funding is Medicaid and 14

percent is general fund. Many community demands for services cannot be met because the majority of funding is dedicated and cannot be transferred. He compared separating people in need according to their eligibility for certain types of funding to the fight against separate drinking fountains and facilities that took place in the Civil Rights movement. This separate funding mechanism creates a severe problem statewide. He encouraged the commission to check this out and felt this would allow them to see why the CMHSPs cannot serve all the people.

- He urged the commission to look at the performance indicator system in place for the CMHSPs to see what is working and what is not working. What's causing these good and bad performances? He stated that he feels likes he's living in a house that is being dismantled. He urged the commission not to throw away the work done by the Greystone group. He stated that the messages from local CMHSPs were "diluted" when Governor Engler's executive order combined the Department of Mental Health with other departments.
- He stated that federal enforcement by CMS has become more aggressive and assertive in carrying out activities that have hogtied CMHSPs. Many different things (i.e., AIS decertification, capitation, etc.) have impacted the CMHSPs' ability to serve the population.
- He feels that changes occurring now will be attributed to Governor Granholm. Sees a gathering threat to rural boards. His board is looking at the possibility of declaring insolvency. Reports they are slated to have 25 percent of their budget cut. Also discussed impact on consumers who fear the reduction or elimination of services. Encourages the development and implementation of funding mechanisms based on consumer need and not geography.

Elmer Buese, ORR Advisory Committee. (Submitted written statement). He has read the governor's executive order and appreciates the commission's acceptance of the challenge. He is a volunteer advocate who started work in the mental health field in 1969 and has worked in a wide range of service areas. He was a unit director in Oakdale for five years and is currently a member of the ORR Advisory Committee and a member of the Appeals Committee.

He stated that someone once told him that if people were committed, challenged, and dedicated we wouldn't need a rights system. We're not living in an ideal world. Some CMHSPs look at rights system as an aid in providing services to consumers; others see rights as an infringement. Some see the Mental Health Code as applying only to state-operated institutions and not community settings. Advocates like Mr. Buese take the position that the rights system is for everyone, in order to ensure a high standard of recipient rights protection standards throughout the state.

Buese still hears that the rights system has no clout and no teeth. It was expected and hoped that the department would deal with enforcement issues in order to have high standards throughout the state. This is not the case. Discussed the problems with a particular CMHSP at a February 21 meeting. Relayed department staff comments that: 1) decertification would result in total defunding and death of the CMHSP service provider; 2) there needs to be a hierarchy of contract standards that are sufficient to motivate the CMHSPs to comply with higher standards; 3) DCH hands were tied and the only option

is to defund a service provider, recognizing the inability of another service provider to take over. This demonstrates that the state is incapable of enforcing the requirements.

Says that the public mental health system is at a crossroads. One parent told him that they went along with the request for a waiver, but that hasn't helped service provision. When the CMHSP director controls the recipient rights director the system isn't working because of the inherent conflict of interest. Why do we think that each county has to have a CMHSP? Maybe creating a multicounty board could have reduced this problem and addressed the funding problems.

He sees the recipient rights system as an aid to improve services, with its assessment and training session. Urges commission members to attend the recipient rights training conference (thinks this addresses numbers one and five of the commission's charge). Charge two addresses quality and effectiveness. When institutions closed, CMHSPs had to build staff levels. Many CMHSPs did not want to hire former institution workers, so they set up their own job criteria. These individuals' knowledge of the needs of the special group was not present. Need to look at upgrading the qualifications for working at a CMHSP as a mental health professional. Urges continuing education for staff in order to have a competent skilled staff, not just well-intended individuals. ORR is always offering training to rights staff, clients, and CMHSP staff. ORR also has an awards component.

Public Comment (afternoon)

Robert B. McReavy, parent from Macomb County. Shared a list of comments about his experiences at Macomb CMHSP. His son spent time in Clinton Valley. He credits the facility for savings his son's life. They taught his son life skills that continue to assist him today. Presently his son and his girlfriend live independently. Although they have done well five of the last eight years, the last three years have been a disaster. His son uses Macomb Hospital in Mt. Clemens for critical care. After his son's admission there, the hospital filed for a treatment order with the court. After the treatment order, McReavy found out that court orders aren't sufficient and that the hospital was already planned on releasing his son. The hospital proceeded with its "rapid release program," which ensures a quick return to the hospital and an increasing drain on public mental health funds.

McReavy expressed his frustration with Ventures, a mobile support system program used by his son. They told him budget cuts prevented them from doing the proper job. They have left his son in dangerous situations. His son's girlfriend was taken to St. Joseph Hospital. Her parents were escorted out of the hospital, and the next day she was released from the hospital without food or resources and returned to a squalid apartment. First Resources North staff members were told about the conditions at the apartment and they refused to do anything about it. She was only treated because Mr. McReavy turned in a complaint about her, which triggered a court order and hospitalization.

Urges commission to audit the offices of Macomb County. Feels they breached their contract and urges that their funds be pulled. Says that he is 62 years old and has paid thousands of dollars into the tax system. Says he is afraid to die for fear that his son will wind up in the street.

Judy K. McReavy, parent (wife of Robert McReavy). Her son has been in the system for 18 years. Clinton Valley Hospital provided services to him for nine years. He was stable for at least ten years after leaving. He tried to work, but could not manage it. She noted that the State received back ten stable years for the nine years they invested in her son.

Over the last three years her son has faced numerous problems. He and his girlfriend are not able to care for themselves. The CMHSP system is geared to making each person as independent as possible. Says not all mentally ill people can live independently, including her son and his girlfriend. Spoke about the resources her son has to live on and the fact that after paying rent, electricity, etc., there was only $34 remaining for food, clothing, medication, and recreation. Her son also receives $39 for food stamps. Says the system has not provided the basic services needed for living—no subsidized housing, and long waiting lists (three years).

Spoke about FIA in Macomb County and says you can't reach a human being by phone. If you visit the FIA offices you can wait for days until someone takes care of you. FIA says they have 45 days to respond but if a person needs food, they cannot wait 45 days. She has experienced unkind, belligerent, and accusatory treatment. Her family expects to receive everything they ask for: they have not asked for anything for five generations.

Hopes that all items necessary for persons with a mental illness would be provided, including housing subsidies, food subsidies, medication provision, support systems to teach how to live, as well as short-term and long-term hospital services. Federal government should provide minimal guidelines for all states to follow. Federal money should provide for services through Medicare and Medicaid. Treatment in hospitals should be based on need and not money. The state should provide minimum guidelines for each region to follow and money. Hospitals and group homes should be available, as well as shared apartment programs and in-home and in-office programs, transportation, housing, and food. The system needs to be reorganized.

Anne Yurcek, children's advocate. Yurcek placed a large basket filled with binders and papers on the podium as an illustration of the paperwork involved in obtaining services for her adopted daughter. Her family moved here from Minnesota. They have six biological children and adopted five siblings that had been in separate foster homes. When they adopted the children, they were told they could rely on the state for whatever was needed. Within 21 days they found they were in trouble. One of the adopted children tried to smother another child in the home and pushed Yurcek down the stairs. She took her daughter to the hospital, where she was admitted.

The family was referred to the local CMHSP in January 1999 and was told that the daughter's illness wasn't severe enough to qualify for services. In May 1999 she heard that there were respite funds available (her daughter finally had an open case). Yurcek said she slept outside of her daughter's door for six months to protect the other children in the home. Her daughter attacked a sibling and needed long-term residential care. She wound up in a crisis residential program followed by treatment in Hawthorn Center for 18 months. The CMH placed services in her daughter's person-centered plan so that two states could battle over the cost of care.

Yurcek was promised that public mental health system would take care of her daughter. She drafted a letter and forwarded it everywhere, but no assistance was provided. The end result was that the CMHSP worker said to bring her daughter home although the hospital said she needed residential care. CMS became involved; her daughter's person-centered plan included residential treatment, but the CMHSP denied it. An Administrative Tribunal Fair Hearing was requested. P&A assisted and the case was settled 18 hours before the hearing.

Yurcek is concerned about being placed on the state's Abuse and Neglect list and the loss of her husband's medical license because they adopted this child. She can't recommend that others adopt children. Her daughter is currently thriving but she may be the only one thriving and it took three and one-half years to get services. Her daughter is graduating in June but will continue to need help for the rest of her life.

Values and Work Group Structure

Approved 3/29/04

The commission approved values for transforming the Michigan mental health system and work groups for areas of deliberation. Each recommendation of the commission will strive to address these values.

VALUES FOR THE MICHIGAN MENTAL HEALTH SYSTEM

- ***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 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 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 disorders 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 acceptable to mental health professionals, mental health organizations, and the general public.

- ***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.

WORK GROUPS AND PROCESS

The commission approved the following work groups and identified the key questions to be addressed. At the completion of work group efforts, a reconciliation step will be taken to unify recommendations.

Work Groups

- Work Group I: Education, Rights, Outreach, and Advocacy
- Work Group II: Services and Supports for Children
- Work Group III: Services and Supports for Adults
- Work Group IV: Criminal Justice and Human Service Interface
- Work Group V: Governance, Structure, Finance, and Accountability of the Publicly Supported Mental Health System

Key Questions for Work Groups

Work Group I: Education, Rights, Outreach, and Advocacy

1. What are the key issues regarding mental health education, rights, outreach, and advocacy?
2. What are best and emerging practices for enhancing public awareness and understanding of mental illness by the general public, the media, the business community, educators, and the medical community?
3. What existing education, outreach, and advocacy practices can be strengthened?
4. What cross-cutting strategies for mental health promotion and outreach could be applied for adults and children?
5. Considering the values of a transformed Michigan mental health system, what should be done to eliminate rights abuses and reach out to the mentally ill so they can receive treatment and services?

Additional considerations (for all work groups):

- Model legislation, innovative solutions, and best practices
- Identify statutory implications of recommendations
- Identify funding implications of recommendations
- Systems coordination and integration among agencies (local, state, federal), with other systems (primary care, criminal justice, education), and among interventions (e.g., prevention, early intervention, disease management, and inpatient care)
- The role of technology
- Development of a road map for the optimal system
- What can we do within current constraints to optimize our system and lead it toward the optimal system in the future?

Work Group II: Services and Supports for Children

1. What are the needs and characteristics of children and families served by the publicly supported mental health system?

   - What is the prevalence/incidence of serious emotional disorders and mental illness in all children? In different age groups (youth, adolescent, young adult) and in each gender?
   - How are families affected by children with serious emotional disorders and mental illness?

2. What are the numbers of children and families with serious emotional disorders who are not served, inadequately served, and/or inappropriately served?

   - How many children receive services from the private system? How many from the public system?

- How many children are served/not served in different age groups (youth, adolescent, young adult)?
- What are the implications of a lack of service? What happens to children and families when disorders go untreated?

3. What are the key issues regarding services for children, e.g.:

- What is the system for delivery of services to children in the public mental health system?
- Gaps in service accessibility and availability, and in necessary ancillary support services (e.g., housing, transportation, medical care, schools, etc.)
  - What are the barriers to entering and leaving care and receiving services?
  - How are resources distributed throughout the state (e.g., child psychiatrists)?
  - What is the distribution of services/resources for youth and adolescents in transition?
  - How are wraparound services provided? Who is receiving wraparound services?
- The degree to which services are sensitive to cultural differences, sexual orientation, and consumer characteristics
- The extent to which evidence-based practices and service guidelines are used
- Do family physicians have proper training to appropriately prescribe psychotropic medication?

4. Considering the values of a transformed Michigan mental health system, what should be in place to meet the needs of children with serious mental illness?

Additional considerations (for all work groups):

- Model legislation, innovative solutions, and best practices
- Identify statutory implications of recommendations
- Identify funding implications of recommendations
- Systems coordination and integration among agencies (local, state, federal), with other systems (primary care, criminal justice, education), and among interventions (e.g., prevention, early intervention, disease management, and inpatient care)
- The role of technology
- Development of a road map for the optimal system
- What can we do within current constraints to optimize our system and lead it toward the optimal system in the future?

Work Group III: Services and Supports for Adults

1. What are the incidence and prevalence of mental illness and serious mental disorders among adults in Michigan?

2. What are the needs and characteristics of adults served by the publicly supported mental health system?

3. What services do they receive? What qualifies them to receive services?

4. What are the numbers of adults with serious mental disorders who are not served? What inferences can be drawn from available information regarding those adults that are inadequately served and/or inappropriately served?

5. What should constitute operationally defined criteria for uniform statewide application regarding: (a) qualification of an adult for publicly funded services and (b) symptomatic and functional circumstances meriting the highest priority attention?

6. What is best practice regarding services and supports that should be in place throughout the state? What are the elements of an effective, appropriate array of publicly funded services?

7. What are the key issues regarding services for adults, e.g.:

- Gaps in service accessibility, availability, and supply, and in coordination with necessary ancillary support services (e.g., employment, housing, transportation, medical care, etc.)
- The degree to which services are sensitive to cultural differences and consumer characteristics
- The extent to which evidence-based practices and service guidelines are used

8. Considering the values of a transformed Michigan mental health system, what should be in place to meet the needs of adults with serious mental illness?

Additional considerations (for all work groups):

- Model legislation, innovative solutions, and best practices
- Identify statutory implications of recommendations
- Identify funding implications of recommendations
- Systems coordination and integration among agencies (local, state, federal), with other systems (primary care, criminal justice, education), and among interventions (e.g., prevention, early intervention, disease management, and inpatient care)
- The role of technology
- Development of a road map for the optimal system
- What can we do within current constraints to optimize our system and lead it toward the optimal system in the future?

Work Group IV: Criminal Justice and Human Services Interface

9. What kinds of mental health treatment and services are currently given to people in jails, prisons, and the forensic center?

10. How many people currently incarcerated or detained in the juvenile justice system should be in the mental health system instead? How can we prevent inappropriate use of the criminal justice system? How do we get nonviolent (nuisance crimes,

misdemeanors, nonviolent felonies) offenders with mental illness out of the criminal justice system and into mental health treatment?

11. What are the services available for persons once they are discharged (not on parole)?

12. How do we make sure that people are placed appropriately initially?

13. How can we ensure that mental health treatment and service options are made known and available regardless of the manner in which an individual becomes involved with law enforcement or with human service agencies?

14. How can mutual understanding, information sharing, and cooperation among mental health agencies, corrections, and other human service agencies be promoted?

15. Which communities in Michigan have training programs in place for police and/or corrections officers? What types of training programs that are used in Michigan and other states have been the most effective in protecting the public safety and meeting the values adopted by the commission? How have communities in Michigan and other states funded these programs?

16. What types of pre-booking and post-booking diversion programs are in use in Michigan and in other jurisdictions and which have been most effective in protecting the public safety and meeting the values adopted by the commission?

Additional considerations (for all work groups):

- Model legislation, innovative solutions, and best practices
- Identify statutory implications of recommendations
- Identify funding implications of recommendations
- Systems coordination and integration among agencies (local, state, federal), with other systems (primary care, criminal justice, education), and among interventions (e.g., prevention, early intervention, disease management, and inpatient care)
- The role of technology
- Development of a road map for the optimal system
- What can we do within current constraints to optimize our system and lead it toward the optimal system in the future?

Work Group V: Governance, Structure, Finance, and Accountability of the Publicly Supported Mental Health System

17. What is the current structure of the publicly supported mental health system?

18. What are the key issues regarding the current organization and structure of publicly supported mental health system, e.g.:

    - Effectiveness of organization at the state, regional, and local levels
    - Coordination between mental health services and other human services, including primary care and criminal justice

- Effectiveness of state and county partnerships for planning, management, and delivery of services

19. What are the best and emerging practices regarding the structure and accountability of the mental health system?
20. What is the value of the current arrangement (legal, economic, and political)?
21. How can resources be maximized for treatment rather than administration?
22. What [funding] options are available to Michigan?
23. Considering the values of a transformed Michigan mental health system, how should the mental health system be structured?

Questions on finance, which were identified by the commission when considering a separate work group on finance:

- What is the effect of multiple payment sources (general funds, Medicaid, MiChild, Adult Benefit Waiver, consumer ability to pay determination, etc.) on the operation of the public mental health system?
- What are the administrative responsibilities and associated overhead costs of community mental health services programs (CMHSP) and network provider organizations?
- What is the degree of efficiency and consistency of CMHSP contracting arrangements with private providers?
- What are the financing options for expanding prevention and early intervention?
- Parity?
- Considering the values of a transformed Michigan mental health system, what should be done to maximize the use of financial and other resources?

Additional considerations (for all work groups):

- Model legislation, innovative solutions, and best practices
- Identify statutory implications of recommendations
- Identify funding implications of recommendations
- Systems coordination and integration among agencies (local, state, federal), with other systems (primary care, criminal justice, education), and across interventions (e.g., prevention, early intervention, disease management, and inpatient care)
- The role of technology
- Development of a road map for the optimal system
- What can we do within current constraints to optimize our system and lead it toward the optimal system in the future?

CROSSWALK BETWEEN EXECUTIVE ORDER AND WORK GROUPS

Executive Order 2003-24 (III A) is addressed by the work groups as follows:

Work Group I: Education, Rights, Outreach, and Advocacy

- Identify strategies and financing options for expanding prevention and early intervention (7)
- Identify methods to simplify access to care, promote effective service and support practices, improve care outcomes, and enhance consumer and family satisfaction (5)
- Provide recommendations on the best strategies to enhance public awareness and understanding of mental illness (8)
- Identify strategies that will increase collaboration among law enforcement, courts, corrections, CMH programs, and public and private hospitals (9)
- Develop a plan to determine the most appropriate strategy for achieving mental health parity (11)

Work Group II: Services and Supports for Children

- Assess the most appropriate organizational framework for delivery of services (B1)
- Identify and prioritize the most pressing issues and significant challenges in preserving and improving services for adults with mental illness (1)
- Identify methods to enhance state and county partnerships for planning, management, and delivery of services (3)
- Recommend options to improve organization (2)
- Assess opportunities for collaborative interagency and intergovernmental approaches (4)
- Recommend approaches to improve federal, state, county, and community collaboration while increasing efficiency and fiscal accountability (6)
- Identify strategies that will increase collaboration among law enforcement, courts, corrections, CMH programs, and public and private hospitals (9)

Work Group III: Services and Supports for Adults

- Identify and prioritize the most pressing issues and significant challenges in preserving and improving services for adults with mental illness (1)
- Identify methods to promote effective service and support practices, improve care outcomes, and enhance consumer and family satisfaction (5)
- Recommend options to improve quality and effectiveness (2)
- Identify strategies that will increase collaboration among law enforcement, courts, corrections, CMH programs, and public and private hospitals (9)
- Recommend policy and programs to improve and promote community-based services and integration for adults and children with serious mental illness or emotional disturbances (10)

Work Group IV: Criminal Justice and Human Service Interface

- Identify and prioritize the most pressing issues and significant challenges in preserving and improving services for adults and children with serious mental illness or emotional disturbances (1)
- Identify methods to enhance state and county partnerships for planning, management, and delivery of services (3)
- Recommend approaches to improve federal, state, county, and community collaboration while increasing efficiency and fiscal accountability (6)
- Identify strategies that will increase collaboration among law enforcement, courts, corrections, CMH programs, and public and private hospitals (9)
- Recommend policy and programs to improve and promote community-based services and integration for adults and children with serious mental illness or emotional disturbances (10)
- Identify strategies and financing options for expanding prevention and early intervention (7)
- Identify methods to promote effective service and support practices, improve care outcomes, and enhance consumer and family satisfaction (5)
- Recommend options to improve quality and effectiveness (2)
- Recommend policy and programs to improve and promote community-based services and integration for adults and children with serious mental illness or emotional disturbances (10)

Work Group V: Governance, Structure, Finance, and Accountability of the Publicly Supported Mental Health System

- Recommend the best strategies to enhance public awareness and understanding of mental illness (8)
- Recommend options to improve delivery (2)
- Identify methods to enhance state and county partnerships for planning, management, and delivery of services (3)
- Assess opportunities for collaborative interagency and intergovernmental approaches (4)
- Recommend approaches to improve federal, state, county, and community collaboration while increasing efficiency and fiscal accountability (6)
- Identify strategies and financing options for expanding prevention and early intervention (7)
- Identify strategies that will increase collaboration among law enforcement, courts, corrections, CMH programs, and public and private hospitals (9)
- Recommend policy and programs to improve and promote community-based services and integration for adults and children with serious mental illness or emotional disturbances (10)
- Develop a plan to determine the most appropriate strategy for achieving mental health parity (11)

WORK GROUP PROCESS

- Common process for each work group
  - Work groups are chaired by voting members
  - Work group chairs participate with the commission chairs in Project Management Team meetings
  - Work groups convene during commission meetings; work groups convene as necessary between commission meetings
  - Work groups follow a common schedule (preliminary recommendations by May 24)
  - Work groups do not exceed 15 members
  - At least two consumers of publicly supported mental health services per work group
  - Non-commissioners added to work groups as "resource members," according to the following criteria:
    - Balancing membership to assure participation of consumers, community mental health, judiciary/law enforcement, labor, legislators, local and state government, providers, and research
    - Providing needed expertise
  - Each work group updates the full commission during commission meetings
  - Decisions made consistent with commission policy on reaching consensus
  - Communication with stakeholders is handled by the commission
  - Staff support for each work group; each work group has a lead staff person who coordinates additional staff, as needed. Staff responsibilities are to
    - prepare meeting summaries for the Project Management Team, based on the work group chair's review and approval (if staff are unable to attend a work group meeting, the chair will assign this task to a work group member);
    - handle logistics, including meeting notification to work group members; and
    - help respond to data and information requests.

EXECUTIVE ORDER No. 2003-24

MICHIGAN MENTAL HEALTH COMMISSION

EXECUTIVE OFFICE OF THE GOVERNOR

WHEREAS, Section 1 of Article V of the Michigan Constitution of 1963 vests the executive power of the State of Michigan in the Governor;

WHEREAS, Section 1 of 1931 PA 195, MCL 10.51, authorizes and empowers the Governor, at such times and for such purposes as the Governor deems necessary or advisable, to create special advisory bodies consisting of as many members as the Governor deems appropriate;

WHEREAS, Michigan's publicly-supported mental health system must be committed to providing adequate and appropriate mental health care, treatment, and support in an efficient, effective, and fiscally accountable manner;

WHEREAS, the consumers and families involved with, and most affected by, publicly supported mental health programs and services must be included in the decision-making process;

WHEREAS, Michigan must move toward a more user-friendly mental health system that ensures timely access to care, fosters quality and excellence in service delivery, and promotes innovative and effective strategies to best serve adults and children with serious mental illness or emotional disturbances;

WHEREAS, the services provided by the publicly supported mental health system should be culturally competent and responsive to consumer needs and preferences;

WHEREAS, the publicly supported mental health system is currently at a crossroads, requiring the input of interested parties working together to address the challenges confronting the system;

NOW, THEREFORE, I, Jennifer M. Granholm, Governor of the State of Michigan, pursuant to the powers vested in me by the Michigan Constitution of 1963 and Michigan law, order the following:

I. DEFINITIONS

1. "Commission" means the Michigan Mental Health Commission created under this Order.

2. "Department of Community Health" means the principal department of state government created as the Department of Mental Health under Section 400 of the Executive Organization Act of 1965, 1965 PA 380, MCL 16.500, and renamed the "Department of Community Health" under Executive Order 1996-1, MCL 330.3101.

II. MICHIGAN MENTAL HEALTH COMMISSION

A. The Michigan Mental Health Commission ("Commission") is created as an advisory body within the Executive Office of the Governor.

B. The Governor shall appoint 29 members to the Commission to serve as members of the Commission at the pleasure of the Governor.

C. In addition to the 29 members appointed under Section II.B, the Directors of the Department of Community Health, the Family Independence Agency and the Department of Corrections, or their designated representatives, shall serve as ex officio, non-voting members of the Commission. The Governor may appoint additional persons as non-voting members.

D. A vacancy on the Commission shall be filled in the same manner as the original appointment.

E. The Governor shall designate one of the members of the Commission to serve as its Chairperson at the pleasure of the Governor.

III. CHARGE TO THE COMMISSION

A. The Commission is advisory in nature and shall:

1. Identify and prioritize pressing issues and significant challenges that must be addressed to preserve and improve services for adults and children with serious mental illness or emotional disturbances.

2. Recommend options to improve the organization, delivery, quality, and effectiveness of publicly supported mental health services.

3. Identify methods to enhance current state and county partnerships for planning, management, and delivery of mental health services

4. Assess opportunities for collaborative interagency and intergovernmental approaches to the provision of mental health care.

5. Identify methods designed to simplify access to care, promote effective service and support practices, improve care outcomes, and enhance consumer and family satisfaction.

6. Recommend approaches to improve federal, state, county, and community collaboration while increasing the efficiency and fiscal accountability of the publicly supported mental health system.

7. Identify strategies and financing options for expanding prevention and early intervention efforts within the publicly supported mental health system.

8. Provide recommendations on the best strategies to enhance public awareness and understanding of mental illness.

9. Identify strategies that will increase collaboration and communication between law enforcement, courts, corrections, community mental health programs, and public and private hospitals in most effectively meeting the needs of adults and children with serious mental illness or emotional disturbances.

10. Formulate policy and program recommendations to improve and promote community-based services and integration for adults and children with serious mental illness or emotional disturbances.

11. Develop a Michigan-specific plan to determine the most appropriate strategy for achieving mental health parity in this state.

B. In exercising its duties the Commission may:

1. Assess the most appropriate organizational framework for the delivery of publicly supported mental health services in Michigan.

2. Review model legislation and studies on the effective delivery of publicly-supported mental health services and collect information on states that have developed innovative solutions and best practices for similar challenges.

3. Identify training and technological assistance needs related to the efficient management and delivery of services provided through the publicly supported mental health system.

C. The Commission shall provide other information or advice as directed by the Governor or the Chairperson of the Commission.

D. The Commission shall complete its work and issue a final report and recommendations, including any proposed legislation, to the Governor not later than September 30, 2004.

IV. OPERATIONS OF THE COMMISSION

A. The Commission may promulgate bylaws, not inconsistent with Michigan law and this Order, governing its organization, operation, and procedures. The Commission may establish subcommittees as it deems advisable.

B. The Commission shall be staffed by personnel from and assisted by the Department of Community Health, as directed by the Governor or the Chairperson of the Commission.

C. The Chairperson of the Commission shall select from among the members of the Commission a Vice-Chairperson and a Secretary. Commission staff shall assist the Secretary with record-keeping responsibilities.

D. The Commission shall meet at the call of the Chairperson and as may be provided in procedures adopted by the Commission.

E. The Commission may establish committees and request public participation on advisory panels as it deems necessary. The Commission may adopt, reject, or modify recommendations made by committees or advisory panels.

F. The Commission shall act by majority vote of its serving members. A majority of the members of the Commission constitutes a quorum for the transaction business.

G. The Commission may, as appropriate, make inquiries, studies, investigations, hold hearings, and receive comments from the public. The Commission may consult with outside experts, consumers, and their families in order to perform its duties.

H. Members of the Commission shall serve without compensation. Members of the Commission may receive reimbursement for necessary travel and expenses according to relevant statutes and the rules and procedures of the Department of Management and Budget and the Civil Service Commission, subject to available appropriations.

I. The Commission may hire or retain contractors, sub-contractors, advisors, consultants and agents, and may make and enter into contracts necessary or incidental to the exercise of the powers of the Commission and the performance of its duties, as the Director of the Department of Community Health deems advisable and necessary in accordance with the relevant statutes, rules, and procedures of the Civil Service Commission and the Department of Management and Budget.

J. The Commission may accept donations of labor, services, or other things of value from any public or private agency or person.

K. Members of the Commission shall refer all legal, legislative, and media contacts to the Department of Community Health.

V. MISCELLANEOUS

A. All departments, committees, commissioners, or officers of this state or of any political subdivision of this state shall give to the Commission, or to any member or representative of the Commission, any necessary assistance required by the Commission, or any member or representative of the Commission, in the performance of the duties of the Commission so far as is compatible with its, his, or her duties. Free access shall also be given to any books, records, or documents in its, his, or her custody, relating to matters within the scope of inquiry, study, or investigation of the Commission.

B. The invalidity of any portion of this Order shall not affect the validity of the remainder the order.

This Order is effective upon filing.

Given under my hand and the Great Seal of the State of Michigan this 10th day of December, 2003.

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JENNIFER M. GRANHOLM
GOVERNOR

BY THE GOVERNOR:

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SECRETARY OF STATE