



# Michigan Association of **COMMUNITY MENTAL HEALTH**

## **Michigan's Publicly Funded Mental Health and Substance Use Disorders System**

The forty six (46) Community Mental Health Services Programs (CMHs) and the organizations with which they contract provide a comprehensive range of mental health services and supports to children, adolescents and adults with mental illnesses, developmental disabilities and substance use disorders in all 83 Michigan counties. The CMH network provides 24 hour emergency/crisis response services, screens admissions to state facilities, acts as the single point of entry into the public mental health system, and manages mental health benefits (for persons not eligible for Medicaid enrollment) funded through the state's general fund allocation.

While the general fund revenue represents approximately 12% of their annual operating budget, it is very important funding support to each CMH. Given the current rules regarding Medicaid eligibility, these general fund resources are the only ones available to support the increased demand for mental health services from persons without private health insurance coverage but are not poor enough or categorically eligible to qualify for Medicaid assistance. As the number of uninsured or underinsured continues to rise, these resources are important to provide access and early intervention services to persons with mental health and substance use disorders.

The eighteen (18) Prepaid Inpatient Health Plans (PIHPs) manage the services and supports for persons enrolled in the Medicaid, MIChild and Adult Benefit Waiver programs. Ten (10) of these PIHPs are made up of an affiliation of at least two, as many as five separate CMHs. These affiliations were created in order to realize administrative efficiencies in managing services and to provide a sufficiently large base of Medicaid enrollees to manage the risk-based, capitated funding system used to finance the system of care for Medicaid beneficiaries.

The substance use disorder system is managed by sixteen (16) Coordinating Agencies (CAs) which oversee the provision of substance use disorder services funded by Medicaid, federal adult block grant, and general funds. These CAs operate as the single point of entry into the publicly funded substance use disorder system. Eight (8) of these CAs are organized within the PIHP structures identified above. The other 8 CAs operate as independent entities.

Michigan's publicly funded mental health system has been nationally recognized for providing an innovative and comprehensive community based system of care that promotes independence through a person centered planning process.

## **Investing in community based services is the best way to protect the safety net.**

A principal strength of the current community-based mental health and substance use disorder system is that it is locally responsible and locally accountable.

- Local responsibility provides for a governance board and management structure that is familiar with the particular strengths, challenges, and resources of its own community, and the local people and partners with whom a local community based mental health system must work to build and sustain an effective system. This knowledge and these partnerships are critical to building an effective system of care. At a time when the Legislature is cutting support for public mental health and substance use disorder services, communication and partnerships across local community safety net service providers is especially needed to make optimum use of the resources available.

## Investing in behavioral health saves money.

Investing in the community-based mental health and substance use disorder system is a wise use of state resources because it ends up saving money in other areas.

- Over the course of the last 3 fiscal years mental health and substance use disorder services have been reduced by over \$55 million which is nearly a 20% reduction at a time when demand for services is steadily increasing. Reducing funding and limited access to care for behavioral health services does not mean that the persons in need will just go away. Jails and hospitals see additional cases of those with mental illness and substance abuse, and are less prepared to adequately handle them. This ends up being more costly for the state.

## Structural reform opportunities

### MORE EFFICIENT BUSINESS FUNCTIONS

- Eliminate multiple state administrative requirements and reporting functions that do not contribute to improved outcomes or improve the quality of care for persons receiving services.
- Simplification and standardization of enrollment information within and across state departments.

Many of the persons and families served access multiple publicly funded service and support systems - Standardize and simplify enrollment information across these system, increase the use of electronic enrollment, and distribute enrollment capabilities across departments of state and local government.

- National accreditation review in lieu of elements of state departmental reviews.

### ENHANCING SERVICES

- State leadership on facilitating greater use of electronic health records and electronic exchange of health information.
- Seek opportunities to use federal dollars as a way to pay for behavioral health services. Shifting the cost from the state general fund dollars to Medicaid would allow many unemployed or low income childless adults that do not have insurance and who currently do not qualify for Medicaid to receive much needed behavioral health services. More timely access to assessment and early intervention treatment services will prevent more costly treatment interventions later.
- Michigan is one of 8 states that do not have a mental health parity law. The proposed law is not a mandate; however, it states if a plan chooses to offer mental health coverage it must be at the same level as physical health coverage. Currently, most plans that offer mental health coverage do so with more restrictive caps on annual and lifetime benefits and considerably higher out-of-pocket costs. When polled, 83% of Michigan voters supported state legislation to establish mental health insurance parity.

Mental health/substance use disorder parity legislation would help offset state general fund reductions. Due to the inequities and limitations on behavioral health insurance coverage, individuals with private health insurance end up using general fund dollars for treatment because their insurance arbitrarily limits or prohibits payment for medically necessary behavioral health treatment services.



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

JENNIFER M. GRANHOLM  
GOVERNOR

JANET OLSZEWSKI  
DIRECTOR

December 15, 2010

**TO:** Executive Directors of Prepaid Inpatient Health Plans (PIHPs) and  
Community Mental Health Services Programs (CMHSPs)

**FROM:** Michael J. Head, Director  
Mental Health and Substance Abuse Administration

**SUBJECT:** Family-Driven and Youth-Guided Policy and Practice Guideline

Attached is the final version of the Family-Driven and Youth-Guided Policy and Practice Guideline that was forwarded for your review and comment in June 2010. We received comments from staff of seven CMHSPs, two advocacy organizations and one court staff person. We have reviewed all of the public comments and incorporated feedback and suggestions into this final version of the policy.

The purpose of this policy guideline is to provide guidance and support to PIHPs, CMHSPs and their contract agencies regarding the delivery of family-driven and youth-guided services and supports for children and their families. This guideline outlines essential elements of family-driven and youth-guided policy and practice at the child and family level, system level and peer-delivered level.

Family-driven means that families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community. Youth-guided means that young people have the right to be empowered, educated, and given a decision-making role in their own care as well as the policies and procedures governing the care of all youth in the community, state, and nation. A youth-guided approach views youth as experts and considers them equal partners in creating system change at the individual, state, and national level (SAMHSA).

It is the intent of the Michigan Department of Community Health (MDCH) to adopt a policy that promotes all publicly supported mental health agencies to engage in family-driven and youth-guided approaches to services with children and families. The attached policy is being issued as a technical advisory initially which MDCH encourages be used over the next year. MDCH does intend to incorporate this policy guideline/technical advisory into the Medicaid Provider Manual and into the contract negotiating process in the future. A technical companion guide will also be developed to assist in meeting the policy requirements.

If you have questions, please contact Connie Conklin at 517-241-5765 or at [conklinc@michigan.gov](mailto:conklinc@michigan.gov), or Sheri Falvay at 517-241-5762 or at [falvay@michigan.gov](mailto:falvay@michigan.gov).

Attachment

c: Irene Kazieczko  
Sheri Falvay  
Connie Conklin  
Mental Health and Substance Abuse Management Team

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH (MDCH)  
MENTAL HEALTH & SUBSTANCE ABUSE ADMINISTRATION  
FAMILY-DRIVEN AND YOUTH-GUIDED POLICY AND PRACTICE GUIDELINE**

**A. Summary/Background**

The purpose of this policy guideline is to establish standards for the Prepaid Inpatient Health Plans (PIHPs), Community Mental Health Services Programs (CMHSPs) and their contract agencies regarding the delivery of family-driven and youth-guided services and supports for children and their families. This policy guideline will outline essential elements of family-driven and youth-guided policy and practice at the child and family level, system level and peer-delivered level.

Person-centered planning is the method for individuals served by the community mental health system to plan how they will work toward and achieve personally defined outcomes in their own lives. The Michigan Mental Health Code establishes the right for all individuals to develop individual plans of services through a person-centered planning process regardless of disability or residential setting.

For children and families, the Person-Centered Planning Policy Practice Guideline states: "The Michigan Department of Community Health (MDCH) has advocated and supported a family-driven and youth-guided approach to service delivery for children and their families. A family-driven and youth-guided approach recognizes that services and supports impact the entire family; not just the identified youth receiving mental health services. In the case of minors, the child and family is the focus of service planning, and family members are integral to a successful planning process. The wants and needs of the child and his/her family are considered in the development of the Individual Plan of Service." As the child matures toward transition age, services and supports should become more youth-guided.

As a result of the effort to develop family-driven and youth-guided services, the Substance Abuse and Mental Health Services Administration (SAMSHA) in partnership with the Federation of Families for Children's Mental Health, has developed a set of principles (described in section C of this policy) which serve as the basis for the delivery of family-driven and youth-guided services. These principles comprise the standards which should guide the delivery of services to children and their families and are essential to development of an effective system of care.

This policy is consistent with the "Application for Renewal and Recommitment (ARR) to Quality and Community in the Michigan Public Mental Health System," as issued by MDCH on February 1, 2009. The ARR formally introduced new and enhanced expectations of performance and revitalized MDCH's commitment to excellence in partnership with PIHPs and CMHSPs.

While agencies are expected to collaborate, they are not intended to be the primary decision-makers on behalf of a child or family. It is important for systems to actively engage families in leading all decisions about the care of their child. Similarly, as appropriate, based on their age and functioning, youth should have opportunities to make decisions about their own care. Family and youth involvement is also important on a broader level, with an expectation that they are active participants in system-level governance and planning (Wilder Foundation, Snapshot: Mental Health Systems of Care for Children, August 2009).

## **B. Policy**

It is the policy of MDCH that all publicly-supported mental health agencies and their contract agencies shall engage in family-driven and youth-guided approaches to services with children and families and will engage family members and youth at the governance, evaluation, and service delivery levels as key stakeholders.

### **How this Policy will be supported:**

- MDCH staff in partnership with the family organizations will work with PIHPs, CMHSPs, and contract agencies to support successful implementation of the family-driven and youth-guided policy guideline.
- MDCH will work with other system partners at the state level to ensure PIHPs, CMHSPs and contract agencies can build an effective system of care.
- Through ARR progress reviews, updates and technical assistance. The different sections of the ARR have applicability to family-driven and youth-guided care, e.g., stakeholder involvement, developing an effective system of care, improving the quality of services and supports, assuring active engagement, etc.

## **C. Family-Driven and Youth-Guided Principles**

Family-driven and youth-guided principles should be measured at several different levels: the child and family level, the system level and the peer-to-peer level. These principles incorporate all levels, and will be detailed under section D: Essential Elements.

- Families and youth, providers and administrators share decision-making and responsibility for outcomes.
- Parents, caregivers and youth are given accurate, understandable, and complete information necessary to set goals and to make informed decisions and choices about the right services and supports for individual children and their family as a whole.
- All children, youth and families (parents) have a biological, adoptive, foster, or surrogate family voice advocating on their behalf.
- Families and family-run organizations engage in peer support activities to reduce isolation, gather and disseminate accurate information, and strengthen the family voice.
- Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports and advocate for families and youth to have choices.
- Providers take the initiative to change policy and practice from provider-driven to family-driven and youth-guided.
- Administrators allocate staff, training, support and resources to make family-driven and youth-guided practice work at the point where services and supports are delivered to children, youth, and families.

- Community attitude change efforts focus on removing barriers and discrimination created by stigma.
- Communities and public and private agencies embrace, value, and celebrate the diverse cultures of their children, youth, and families and work to eliminate mental health disparities.
- Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes so that the needs of diverse populations are appropriately addressed.

#### **D. Essential Elements for Family-Driven and Youth-Guided Care**

1. "Family-driven" means that families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community. This includes:
  - Being given the necessary information to make informed decisions regarding the care of their children
  - Choosing culturally and linguistically competent supports, services, and providers
  - Setting goals
  - Designing, implementing and evaluating programs
  - Monitoring outcomes
  - Partnering in funding decisions
2. "Youth-guided" means that young people have the right to be empowered, educated, and given a decision-making role in their own care as well as the policies and procedures governing the care of all youth in the community, state, and nation. A youth-guided approach views youth as experts and considers them equal partners in creating system change at the individual, state, and national level (SAMHSA).
3. "Family-run organization" means advocacy and support organizations that are led by family members with lived experience raising children with SED and/or DD thus creating a level of expertise. These organizations provide peer-to-peer support, education, advocacy, and information/referral services to reduce isolation for family members, gather and disseminate accurate information so families can partner with providers and make informed decisions, and strengthen the family voice at the child and family level, service delivery level, and systems level.
4. Child and Family-Level Action Strategies:
  - Strength and Culture Discovery - Children, youth and family strengths will be identified and linked to treatment strategies within the plan of service.
  - Cultural Preferences - The plan of service will incorporate the cultural preferences unique to each youth and family.
  - Access - Children, youth and families are provided usable information to make informed choices regarding services and supports and have a voice in determining the services they receive. Services and supports are delivered in the home and community whenever possible.

- Voice - Children, youth and families are active participants in the treatment process, their voice is solicited and respected, and their needs/wants are written into the plan in language that indicates their ownership.
- Ownership - The plan compliments the strengths, culture and prioritized needs of the child, youth and family.
- Outcome-based - Plans are developed to produce results that the youth and family identify. All services, supports and interventions support outcome achievement.
- Parent/Youth/Professional Partnerships - Parents and youth are recognized for having expertise, are engaged as partners in the treatment process, and share accountability for outcomes.
- Increase Confidence and Resiliency - The plan will identify specific interventions that maximize the strengths of the child, youth, and family, increase the skills of the youth to live independently and advocate for self, and equip the family with skills to successfully navigate systems and manage the needs of their child and family.
- Participation in Planning Meetings - Youth and families determine who participates in the planning meetings.
- Crisis and Safety Planning - Crisis and safety plans should be developed to decrease safety risks, increase confidence of the youth and family, and respect the needs/wants of the youth and family.

5. System-level Action Strategies:

- Agencies have policies that ensure that all providers of services to children, youth and families incorporate parent/caregivers and youth on decision-making groups, boards and committees that support family-driven and youth-guided practice.
- Agencies have policies that ensure training, support, and compensation for parents and youth who participate on decision-making groups, boards and committees and serve as co-facilitators/trainers.
- Policies are in place within the agency to support employment of youth and parents.
- Youth and parents are part of the program and service design, evaluation, and implementation of services and supports.
- Children, youth and families are provided opportunities to participate in and co-facilitate training and education opportunities.
- Services are delivered where the children, youth and family feel most comfortable and in a way that is relevant to the family culture.
- All stakeholder groups include diverse membership including youth and family members who represent the population the agency/community serves.

6. Peer-delivered Action Strategies:

- Parents/caregivers, youth who have first-hand experience with the public mental health system are recruited, trained and supported in their role as parent/peer support partners.
- Family Organizations are involved in the recruiting, supporting, and training of family members and youth peer-to-peer support partners. They may also serve as the contract employers of the parent support partners.
- Peer-to-peer support models approved by MDCH for parents and youth are available.

E. Biography

National Technical Assistance and Evaluation Center. A Closer Look: Family Involvement in Public Child Welfare Driven Systems of Care. February 2008

<http://www.childwelfare.gov/pubs/acloserlook/familyinvolvement/familyinvolvement.pdf>

<http://www.samsha.gov>

ACMH Youth Advisory Council Focus group (January 16, 2010)

ACMH Staff Retreat (December 14, 2009)



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

JENNIFER M. GRANHOLM  
GOVERNOR

JANET OLSZEWSKI  
DIRECTOR

November 10, 2010

**TO:** Executive Directors of Prepaid Inpatient Health Plans (PIHPs)  
and Community Mental Health Services Programs (CMHSPs)

**FROM:** Irene Kazieczko, Director  
Bureau of Community Mental Health Services

**SUBJECT:** Building a Trauma-Informed System for Children and Families Initiative

The Michigan Department of Community Health (MDCH) is supporting the training and implementation of a trauma-informed approach to screening, assessment, treatment, and parent education for children and families in the CMHSP system. MDCH is sponsoring a training initiative in collaboration with the Children's Trauma Assessment Center of Southwestern Michigan. Five cohorts have received training and are currently implementing this trauma-informed approach for children and their families in the CMHSP system.

At this time, MDCH is soliciting additional CMHSPs for their interest in participating in Cohort 6 of the Initiative. Cohort 6 will begin with a one day training on Wednesday, January 12, 2011 in Lansing. The initial training will include an overview of trauma and the Initiative as well as recommendations on how to develop a trauma-informed approach to your system's screening and intake process. A follow-up training will be held February 10-11, 2011 on "How to Implement Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)." There will be additional cohorts scheduled to begin later in FY11.

CMHSPs that are interested in applying for Cohort 6 must participate in an informational conference call for the CMHSP Contact Person and key staff (Program/Clinical/Children's Services Directors). The call is scheduled for **Wednesday, December 1, 2010 from 10:00 – 11:00 am**. The purpose of the call is to review the components of the Initiative and expectations for those participating in this initiative. The contact information for the call is:

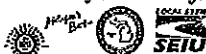
Dial-in Number: 1-215-861-0692  
Access Code: 9153059

To facilitate this discussion, two documents are attached to this email for your review prior to the call:

1. A description of the Trauma-Informed System Components with training activities delineated
2. A detailed outline of the Trauma-Informed System Initiative expectations

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The attached expectations are divided into the following categories:

- Pre-Training
- Training
- Coaching Calls
- Evaluation
- Expectations for completion of the initiative

CMHSPs who submit applications for participation in Cohort 6 need to be aware of the following expectations and requirements:

- A year-long commitment by all participants
- For Resource Parent Trainers:
  - Participate in the training of agency trainers and coaching calls
  - Conduct training in their respective CMHSPs/community.
- For Screening participants:
  - Participate in the training on January 12, 2011
  - Implement screening for trauma in the Agency's access/intake
- For TFCBT participants:
  - Individual and/or group clinical supervision provided to clinicians being trained in the TF-CBT model on a weekly basis
  - Supervisors complete TF-CBT with a minimum of 2 children/families
  - Clinicians complete TF-CBT with 3-5 children/families
  - Serving CMHSP children and families in a home-based or outpatient setting

The application for participation in Cohort 6 is attached. Following the conference call, interested CMHSPs are invited to fax completed applications to Mary Ludtke at 517-241-5777. **The deadline for applications to be submitted is Monday, December 13, 2010 by 5:00 pm.**

If you plan to participate in the December 1 conference call, please contact Wendy Walser at 517-241- 5774 or at walserw1@michigan.gov.

If you have additional questions, please contact Mary Ludtke at 517241-5769 or at ludtkem@michigan.gov, or Errin Skinner at 517-346-8004 or at skinnere@ceicmh.org.

Attachments

October 14, 2010

## *Michigan Autism Spectrum Disorders State Plan Development*

### **Opportunity for Public Input**

In 2009, the Michigan ASD State Plan Development Committee was approved to begin work on a Michigan State Plan for Autism Spectrum Disorders (ASD). At this time, the committee is prepared to submit the initial work for public comment in order to get feedback on the early development of the plan focus and direction.

The public may review the initial summaries for the state plan focus areas and provide feedback. Comments will be accepted through November 15, 2010. A draft of the final state plan document will be made available for public input in early spring 2011.

If you would like to review the focus area summaries and offer feedback, go to:  
[www.asdplan.cenmi.org](http://www.asdplan.cenmi.org)

#### **SURVEY**

While visiting the Michigan ASD State Plan Development website, please complete the Family Survey or School Professional Survey to contribute your knowledge, experience, and thoughts to the state plan development. Each survey will take approximately 8 minutes.