



UPDATES ON OUR LOCAL EARLY INTERVENTION PROGRAM FOR, MICHIGAN PREVENTS PRODROMAL PSYCHOSIS (M3P).

M3P has a mission to reduce the incidence of illnesses such as schizophrenia and bipolar disorder through early detection and intervention in those aged 12 to 25 who reside in Washtenaw County. Prevention services have not been included previously in the range of most mental health services. It is only recently with increased scientific knowledge of the brain, and improved information about the development of mental illnesses, that prevention services have even been explored. In 2007 Washtenaw County was selected by the Robert Wood Johnson Foundation as one of five sites nationally to receive funding to replicate a successful preven-

tion program established in Portland, Maine.

Initially, community partners are engaged in education about mental illness and early identification. This community-based education focuses on educating those who may be interacting with youth and young adults (e.g., teachers, church groups, family physicians, etc.) and could potentially observe early warning signs. We know the stigma of mental illness interferes with individuals and their support systems seeking, or encouraging, treatment at the first signs of potential problems, when intervention could make a difference. Now we are more likely to consider psychotic illnesses

chronic and persistent. These programs indicate a prolonged course of the illness may not necessarily be automatic, and could be interrupted with early detection and intervention. In addition to this broad-based community education, which includes a website (HYPERLINK "http://preventmentalillnessmi.org/" http://preventmentalillnessmi.org), customized direct services are also offered. These include evidence-based practices of family education, possible low-dose medication, supportive counseling, and education. Don't ignore the early warning signs!

WASHTENAW COMMUNITY HEALTH ORGANIZATION



ANNUAL REPORT

MICHIGAN PREVENTS PRODROMAL PROGRESSION

THE MICHIGAN IMPLEMENTATION OF MEDICATION ALGORITHMS (MIMA)

The Michigan Implementation of Medication Algorithms (MIMA) is a way to encourage prescribers to adopt evidence-based prescribing practices for the treatment of bipolar disorder, major depressive disorder, and schizophrenia. Previous studies have shown that consumers whose prescribers use disease management algorithms have a quicker reduction in their symptoms, compared to usual care. The goal is for prescribers to choose medications for which there is the most data confirming efficacy for a particular condition. The Flinn Foundation is funding six sites in Michigan to pilot the MIMA, including the WCHO.

Each guideline is broken down into 5 to 8 stages of treatment. The earliest stages focus on monotherapy treatment with FDA-approved medications. Middle stages utilize combinations of FDA-approved medications or combinations for which there is some evidence from open-label studies or case reports supporting their use. The final stages allow prescribers to be creative in prescribing novel, potentially useful combinations.

In addition to suggesting certain medications, these guidelines also recommend how often to follow up with a prescriber and when to change medications to try to find one that is more effective. This is done based on how long a consumer has been on a certain medication or combination, and how severe his/her symptoms are. Prescribers determine symptom severity by quantitatively assessing each important symptom associated with a disease. This is an example of a symptom scale item:

Encompass calculates the symptom severity score, and provides the prescriber with suggestions. The prescriber, working with the consumer, determines whether or not to follow the suggestion. If the suggestion is not followed, the prescriber has to document why. There is a dropdown list of reasons, like consumer preference, insurance issues, etc.

In order to assess the implementation of this system into Encompass, several features of the algorithms were analyzed:

Algorithms suggest certain medication for each stage (determined using data analysis)

Algorithms suggest when to in-

crease the dose or move to the next stage (depending on symptom severity and duration of treatment) and prescribers self-report whether they followed the recommendations. Algorithms suggest how soon to follow up after a medication change (to be determined using data analysis)

Data were gathered for medication reviews and psychiatric evaluations since January 24, 2007. Over 100,000 prescriptions were written for main symptom medications, half of which were for consumers whose diagnosis was MDD, bipolar, or schizophrenia/schizoaffective disorder.

Symptom scores were lower for consumers whose prescribers prescribed the medication or combination suggested by the algorithm. Symptom scores were lower for consumers whose prescribers followed the recommendations regarding dosing or moving to the next stage. We are still analyzing data addressing frequency of follow up. The data also suggested that 45%-66% of consumers had remission of symptoms during their last visit:

Percent of consumers with remitted symptoms at last visit (bipolar 3 or less, MDD 3 or less, Schizophrenia 6 or less)	
Bipolar Depression (N=236)	46%
Bipolar euphoric/mixed (N=539)	46%
MDD nonpsychotic (N=726)	45%
MDD psychotic (N=126)	48%
Schizophrenia/Schizoaffective (N=1545)	66%

The WCHO now has a benchmark that we can use to try and increase the number of consumers in symptom remission. Symptom remission is an important part of the recovery process.

In the future, there is an expectation that prescribers will include consumers in the rating process more, which will reduce the mystery associated with psychiatric practice. The more consumers, their families, and the public know about what psychiatrists ask, and why they ask, the less stigma will be attached to suffering from a psychiatric illness. Further, we want to incorporate this system in the clinics of our primary care partners, to improve the treatment of mood disorders in primary care.

Phase III of the MIMA project involves the creation of a website for all psychiatric prescribers across Michigan (private and public practitioners) to use guidelines. The Flinn Foundation has contracted with PCE, the vendor for Encompass, to design the new website, in part because of the success of the WCHO pilot. The use of guidelines is having a positive impact on consumer outcomes, with the hope that it will also improve the relationship between consumers and prescribers. Improving stakeholder understanding about what psychiatric illness is and how best to treat it will go a long way to reducing stigma and support recovery.

Dear Community Members,

This has been a busy year for the WCHO. First and foremost, we bid farewell to our long time Executive Director, Kathy Reynolds, who retired at the end of January. The Board appointed Patrick Barrie, who was on the WCHO staff, to be Interim Director beginning February 1, 2009. The Board launched a national search for an Executive Director, hiring a search firm from Maryland, The Meyers Group, to coordinate the search efforts. The Board is pleased to announce that on June 4, 2009 Patrick Barrie was appointed as the new Executive Director of the WCHO.

In addition to all the activity surrounding the search, several new initiatives have been undertaken. The Board approved a limited demonstration project, the Engagement Center, in order to fill a gap in community services for persons with alcohol and substance abuse histories who were unable to be served elsewhere in the community. The Engagement Center has involved the recovering community in a unique and positive way and to date served a large number of people who may otherwise have had no place else to go. Referrals have come from all segments of the community and the collaborative effort has been successful in finding treatment, housing, medical care and numerous other services for a significant number of people.

Approval has been received for a Chronic Disease Management project which will provide funding and support for our network of community clinics. Our vision states that "Individuals have universal access to and participation in high quality, integrated health-care" and this project will bring behavioral healthcare into our community clinic network so that we are able to address the chronic healthcare needs of our clients and their behavioral health care in the same location. Our goal is to help clients to live healthier lives and to live longer.

We finalized a Shared Governance document that outlines our strong working relationship with our partners in the other three counties of Livingston, Lenawee and Monroe. We continue to benefit from the mutual understanding and the recognition of the unique strengths of each affiliated county member.

We have received several large and prestigious grants that are allowing us to demonstrate the efficacy of our practices. SAMSHA awarded us a three year grant to utilize case management practices in substance abuse treatment.

If you don't already receive a copy of our newsletter, please contact Sally Amos O-Neal at 734-544-3000 to get on our mailing list. We'd love to provide you with quarterly updates on the incredible stories of recovery and skill building happening in our community. And, as always, we want to hear from you. We appreciate your feedback and value your input.

Sincerely,

Diane Davidson Board Chair

Patrick Barrie Executive Director

WASHTENAW COUNTY MICHIGAN- INTEGRATED HEALTH PROGRAMMING

The integration of physical and behavioral health care has been referred to as the "reunification of the body and mind." It is about bringing together fragmented systems to improve both access to care and health outcomes. In Washtenaw County, Michigan, our mission is to unify our entire community around the central issue of health care integration. Our efforts to accomplish this mission have occurred by focusing on partnership development with health care and non-health care partners alike.

In 2000, the Washtenaw Community Health Organization (WCHO) was created with the vision to construct a behavioral health system with the primary objective of integrating physical health care for vulnerable citizens of Washtenaw County. From this vision, a model of care has emerged that is made up of partnerships with primary care providers, housing shelter programs, public housing communities, and others who share the common belief that access to health care is central to their organizations' mis-

sions. In Washtenaw County we call this discovery and commitment to a common mission a "community of interest," in this case, an integrated health care community of interest.

Within this community of interest there are many integrated health programming elements and initiatives. Our primary model of health care integration is represented by our comprehensive integrated health sites. This comprehensive model was developed when the WCHO, the local community mental health provider (Community Support and Treatment Services, or CSTS), and a nonprofit safety net primary care clinic joined forces by embedding a full-time mental health professional and 4 hours of psychiatric consultation and treatment service time within the clinic. This staffing arrangement provides the primary care clinic an opportunity to improve their treatment of individuals needing mental health intervention, without fragmenting their overall care. In each of our five comprehen-

sive sites we have replicated this staffing model with great success, serving individuals of all ages with mental illnesses at varying degrees of severity.

This comprehensive model has evolved over time with lessons learned and challenges overcome along the way. Commitments to the shared vision, partnership collaboration and guidance from the leadership of the WCHO and other national partners have been the drivers of our continuous program improvement. The experience and knowledge that has been gained through these integration partnerships has been published in a field guide manual. This manual has been used in the development of our new local programs, as well as in assisting other organizations in their start-up of integrated health care activities.

Prevention is a core element in the continuum of health and wellness care. Through the evolution of our integrated health services, prevention has been an integral part. Prevention and early intervention are a natural blend of primary care and psychiatric

services because the interplay between many physical and mental health issues is inextricably linked. Signs of potential mental health and physical health issues can be recognized and treated in their early stages. The partnership involving the treatment of physical and mental health issues with prevention at its core, provides a holistic approach to health and wellness that recognizes all components of an individual's wellbeing including social, mental, physical, and environmental factors.

An important lesson learned through our journey has been the significance of perseverance. Bringing two different health care cultures together is a complex task, and should not be underestimated. It requires compromise from both partners along with the willingness to learn from each other and use that learning to expand on innovative ways of providing service. The journey thus far has been most rewarding thanks to the impact that the integrated health initiatives have had on many lives in our community.

OFFICE OF RECIPIENT RIGHTS

Did you know that the Office of Recipient Rights has three very important and distinct functions? The first of these functions involves looking into and resolving complaints filed by or on behalf of the people we serve. The ORR also works on prevention activities to ensure rights protection and prevent rights violations. Finally, they monitor service sites and services given, to address potential rights issues. The ORR seeks to be a visible and valuable resource while protecting consumer rights.

Have you noticed? If you have filed a rights complaint this past year, you may have no-

ticed that it was completed quickly. The law (Michigan Mental Health Code) actually gives the ORR 90 days to investigate complaints. Rights Officers in our affiliation believe that this is too long of a period of time and wanted to make the complaint process a more valuable service to stakeholders. They have been working on a Deadline Initiative, and are now almost always able to complete complaint cases in about 45 days!

During this past year, the Rights Office was awarded the Michigan Department of Community Health Office of Recipient Rights Director's Award for Innovation in Rights

Protection. To be considered for this award, a rights office had to have created a new and different way of enacting the vision of recipient rights or of a rights office. The Affiliate Rights Department developed a process that led to the creation of an electronic rights complaint system. Why is that important? It enables rights officers to work more efficiently, accurately, and quickly. It allows for the collection and analysis of very important rights data that is used to improve services and further protect consumer rights. The Affiliate Rights Department also shared these innovations with many rights offices in Michigan, helping them as well.

VISION:
Individuals of all ages will have universal access to high quality, integrated healthcare.

MISSION:
To provide leadership for the development and implementation of unique, effective models of integrated (mental health, substance abuse, physical health) healthcare that create medical homes for Medicaid and indigent consumers.

Annual Report 2007 & 2008



If you or someone you know would like more information about how to get started with Mental Health or Substance Abuse Services contact Health Services Access

(800) 440-7548 or (734) 544-3050



Washtenaw Community HEALTH ORGANIZATION

SUBSTANCE ABUSE

2008 was a year in which the community vision that grew out of the Blueprint to End Homelessness for Recovery Oriented substance abuse services became closer to reality. The Livingston-Washtenaw Substance Abuse Coordinating Agency was awarded a 1.2 million dollar grant by the Federal Substance Abuse Mental Health Services Administration (SAMHSA) for development of recovery based case management and recovery peer services for homeless individuals with substance use and co-occurring disorders. This program has a strengths based case management team that partners with peers in recovery to help clients engage in services and connecting with the recovery community. This program will be funded over a three year period. In addition to this grant, the Coordinating Agency also received a two year, \$200,000 grant

from the Michigan department of Mental Health and Office of Drug Control Policy to expand the existing community based case management team who will continue to work with clients who receive substance abuse services. Both programs work with clients, regardless of their treatment status.

Another initiative that was community driven was the decision by the WCHO Board to pilot an Engagement Center Program for the winter months in order to address the needs of individuals with substance use and co-occurring disorders and who frequent the emergency rooms when intoxicated. These clients do not need the high acuity of the ER and often leave without any discharge plans. The Engagement Center is a welcoming, hopeful environment where people can sober up in a safe setting, while meeting recov-

ery peers and case managers to help them obtain resources and develop plans for recovery.

On the prevention front, the coordinating agency utilized the Strategic Prevention Framework to award prevention contracts based upon collaboration; data focused community needs and a layered, social-ecological approach. Providers responded by joining together to implement a coordinated approach to prevention programs within identified geographical areas, and using evidence based practices.

During our second year of implementation on the Strategic Prevention Framework State Incentive Grant, we further strengthened the coalitions that began work in the Dexter and Pinckney Communities. Youth Photo Voice, an evidence based project was implemented in each community. This program

had high school youth use photography as a means of expressing their thoughts on underage drinking in their community. Youth took photographs around town, produced a presentation that included their interpretation of their photos and displayed them at a community venue. Discussion groups were formed to address the issue of underage drinking. The response from the community was very positive. The photos are on display in local businesses and schools. Other initiatives will be implemented in the coming months, as well as a bi-county survey on substance use, high risk behaviors, parenting practices and attitudes/opinions on related issues.

WASHTENAW COUNTY COMMUNITY SUPPORT AND TREATMENT SERVICES COMMUNITY CRISIS RESPONSE TEAM

What is the CCRT?

The CCRT is a vision for the greater Washtenaw County Community. The CCRT seeks to serve individuals in crisis in community based settings. The CCRT seeks to support individuals in crisis to mobilize natural, family and social supports as they recover from mental illness and substance abuse difficulties.

While our community possesses many elements of a comprehensive health care system, this system places too much reliance on inpatient psychiatric care for individuals in crisis that may better be served in community based settings. In Washtenaw County in 2007/2008, 2,314 inpatient days were authorized for out of county care at a total cost of \$1,222,008.

In-patient care accounted for over 9% of the WCHO local services budget as opposed to a range of 4% to 7% for our regional partners. Increasing reliance on out of county care directly impacts resources that could be reinvested in an effective local continuum.

What are the results of the current system?

Unfortunately, the results of this system can be termed as the "frequent user" phenomenon. Sixty percent of individuals accessing public inpatient psychiatric services in Washtenaw County do not qualify for CSTS services. Additionally, many also cycle up to three inpatient psychiatric hospitalizations in ninety days.

INTENTIONAL COMMUNITIES OF WASHTENAW (ICW)

Services are designed to facilitate families or guardians of someone with a developmental disability by providing them with membership benefits including but not exclusive to; mentoring relationships with other families, resource information on public mental health services and support, connections to community resources, right to have input and ownership over the direction of the organization, committee service, assessments and skills coaching for your loved one with a developmental disability.

Mission:

To promote community relationships among individuals with developmental disabilities

and their families to reduce isolation, develop skills for independent living and foster intentional supported housing communities. Purpose Statement: To lay the foundation for creating sustainable housing community for developmentally disabled individuals sharing the common bond of supportive living in a dignified, productive, and independent manner. ICW will strive to develop a range of housing options through partnerships for developmentally disabled adults based on their individual strengths, supportive needs and personal preference.

MEDICAID FUNDS INCREASED FOR CHILDREN'S MENTAL HEALTH SERVICES



In 2008/2009, the Michigan Department of Community Health made additional Medicaid funds available for increased services for high risk youth. At CSTS Youth and Family Services, we were able to increase services for Medicaid youth with serious emotional disturbances and youth with developmental disabilities.

Service expansion included:

- An additional half time Infant (ages 0-3) Mental Health Therapist
- An additional full time Home Based Therapist for youth ages 4-17

- A new half time Home Based assistant to work with families
- A Behavioral Psychologist contract for behavioral planning with youth and family training

An Occupational Therapist to work with youth and families on sensory integration and other developmental needs.

Specialized training for two therapists to work with families that have young persons (ages 0-6) with autism spectrum disorders

Additional child psychiatric hours to expand clinical

time for youth with developmental disabilities.

In addition, CSTS YF and the local Department of Human Services have developed a streamlined referral process for high risk Medicaid youth who are in foster care or protective services.

The highly skilled clinical staff members at Youth and Family are pleased to offer a more comprehensive array of services through the Family Centered planning process.

Fox News and Entertainment Industries Council Symposium on Stigma in the Media

Fox News Detroit and the Entertainment Industries Council teamed up for a symposium to reduce stigma about mental health issues by creating awareness and delivering a message of hope of recovery through various media. The EIC supports the work of the broadcast media who provide sensitive portrayals of psychiatric illness on TV and in the movies. Dr Bill Pozios from the University of Michigan invited doctors from all over Michigan to meet with representatives from TV, radio, and newspapers to generate stories that reflect the struggles of consumers with psychiatric illnesses. The symposium was broadcast on the My Fox Detroit website:

<http://media.myfoxdetroit.com/special/mental-health.html>

Fox News Detroit did an excellent job of balancing the heuristic value of stories with the entertainment value. A well-meaning story that no one watches is not as effective as a stylized story that captures the interest of the public. This is not to say that sensationalizing psychiatric illness is acceptable, but advocates must be aware of audience expectation from a 120 second segment on the news.

One idea that gained a lot of traction was to find a national spokesman for recovery from psychiatric ill-

nesses. A national spokesman could appear in various venues, and be associated with recovery. Increasing familiarity with psychiatric illness with consistent exposure (without making psychiatric illness the focus) may be preferable to educating the public with strident public service announcements.

Another good idea was the use of community partners to spread the word, particularly the religious community. Religious leaders can do a great deal to reduce stigma in their congregations, and have a level of respect and credibility that others in the community lack. Improving relationships among the media, the scientific community, and religious groups will lead to a reduction in stigma and an increase in the number of people who are willing to engage in treatment that facilitates recovery.

Each representative of the media was intent on matching a story with their particular medium. Print journalists have the latitude to explore stories in depth, while the TV reporters wanted stories with an obvious take-home message that could be covered in a short period of time. Radio personalities wanted segments that would provoke discussion from listeners who would call in. Using the internet to flesh out content was not addressed separately, but was subsumed under other discussions.

Dr Pozios was particularly excited about the anti-stigma DVD, "Believe In Me" currently being created by the WCHO and CSTS, and wants to encourage Fox News to use the DVD as a source for stories.

Daniel Healy, MD, represented the WCHO at this symposium, and came away with some specific suggestions about the future:

While a national spokesman would be ideal, there is value in developing lots of simple stories with positive outcomes that can reduce stigma little by little, normalizing and generalizing the experiences of those with psychiatric illness. Familiarize, rather than educate, which is a subtle, but valuable, distinction. Customer services at the WCHO is working with consumers to generate ideas like "Electroshock (ECT) saved my life;" "My kids are stealing and abusing my meds;" "My doctor prevented me from developing schizophrenia;" "I almost threw my social worker off of my balcony."

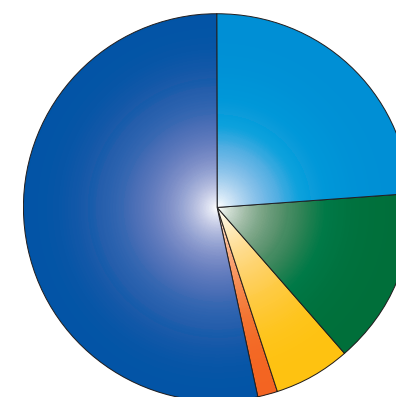
There was a focus on matching a particular story to a particular medium; perhaps a cross-platform approach can be used, as well. On TV, a reporter could interview a consumer who had a good experience with ECT, another reporter could be connected to a dummy ECT machine to see what is involved and riff

on the experience, a radio host could discuss depression and ECT on radio (call in if you've had ECT), a newspaper could do an in-depth analysis about controversies surrounding ECT and the proven benefits, and the Fox website could give away ring tones if folks answered questions about depression and ECT (with a pharmaceutical ad on the page, too). One story, lots of eyes.

Expand the definition of media when developing targets for stigma reduction. Twitter symptoms, to give a real-time flavor to the suffering; create video game avatars (World of Warcraft, Halo, Sims, Call of Duty) that develop psychiatric symptoms, requiring the use health points to heal; create pop up surveys with ring tone or I-tunes giveaways in exchange for answering questions (educate without being pedantic or shrill); create Facebook/MySpace pages with great incentives to visit/participate/learn.

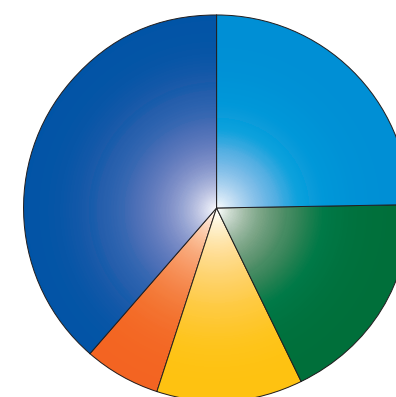
There is a great opportunity to align psychiatric illness with other medical problems, and use the media to mitigate stigma and encourage everyone to participate in recovery. A message of hope is always welcome during trying times; the WCHO is actively spreading this message.

SUBSTANCE ABUSE



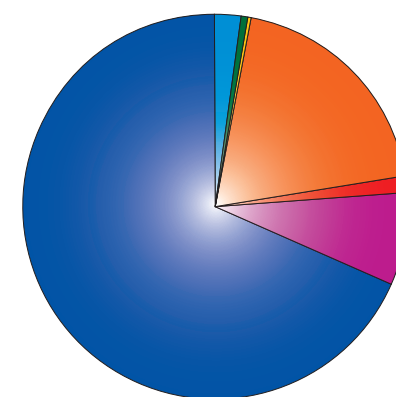
Substance Abuse FY 2008 Revenue:

- General Fund 53.45% \$2,932,943.48
- P.A.2 24.04% \$1,318,793.52
- Medicaid 14.73% \$808,081.00
- Local 6.39% \$350,655.00
- Other 1.39% \$76,438.00
- Total 100% \$5,486,911.00



Expenses Substance Abuse FY 2008

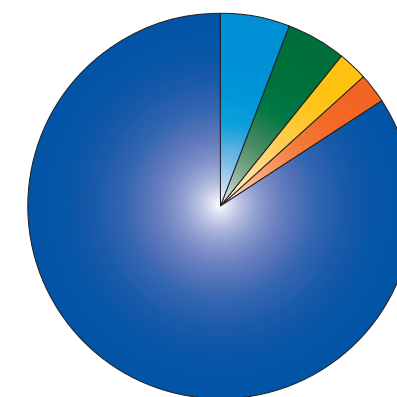
- Outpatient Treatment 38.86% \$2,132,284.00
- Local 24.75% \$1,358,089.00
- Prevention 18.04% \$989,610.00
- Residential 12.21% \$669,751.00
- Administration 6.15% \$337,177.00
- Total 100% \$5,486,911.00



Substance Abuse Demographics

- American Indian 19
- Asian 5
- Black/African America 451
- Other 32
- Unreported 185
- White/Caucasian 1598
- Hispanic 47

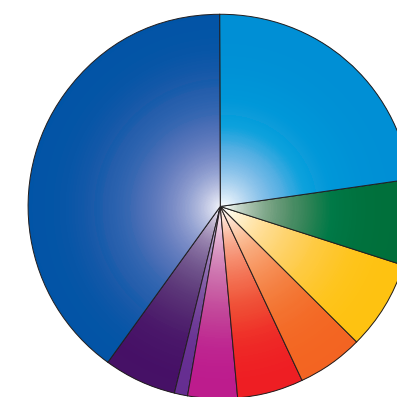
MENTAL HEALTH



Mental Health FY 2008 Revenue:

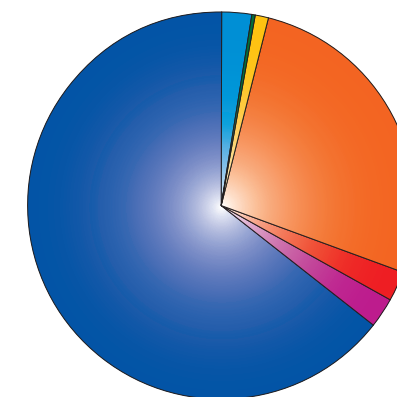
- Medicaid 84.17% \$94,754,403.00
- General Fund 6.05% \$6,815,268.00
- Other 4.89% \$5,504,866.00
- Local 2.48% \$2,790,648.00
- Inpatient State 2.41% \$2,711,413.00
- Total 100% \$112,576,598.00

Equals change in Net Assets per Audit report



Mental Health Expenses FY 2008

- Affiliate Agencies 40.48% \$45,551,303.00
- Outpatient Treatment 23.20% \$26,108,654.00
- Residential Services 7.32% \$8,241,874.00
- Supported Living 7.48% \$8,417,330.00
- Administration 5.68% \$6,393,778.00
- Inpatient Treatment 5.65% \$6,354,640.00
- Grants and Other 4.07% \$4,584,814.00
- Access 1.51% \$1,703,975.00
- Quality Assurance Assessment Tax 6.12% \$5,167,840.00
- Total 93.89% \$112,524,208.00



Mental Health Demographics

- American Indian 17
- Asian 36
- Black/African American 894
- Other 90
- Unreported 78
- White/Caucasian 2173
- Hispanic 82