MICHIGAN’S PUBLIC MENTAL HEALTH SYSTEM
OVERVIEW & CURRENT ISSUES

PREVENTION RESEARCH CENTER OF MICHIGAN BOARD MTG
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Mental Health & Substance Abuse Administration
Michigan Department of Community Health
MICHIGAN’S PUBLIC MENTAL HEALTH SYSTEM

- In FY 08, the public mental health system served ~235,000 of Michigan’s most vulnerable citizens
  - These individuals were persons with severe forms of mental illness, developmental disabilities, or children with severe emotional disturbances
  - Many require intensive care in residential settings, including inpatient hospital care
  - All need ongoing supports to be able to participate as members of their families and their communities, in work, daily activities, and

- By law, priority for services is given to those with the most severe forms of disability, and those in urgent or emergency situations
Legal Mandates/Directives

Michigan Constitution: Article VIII  Section 8—
“Institutions, programs, and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise seriously disabled shall always be fostered and supported.”

Michigan Mental Health Code--P.A. 258 of 1974 (as amended) charges the Department to:
“continually and diligently Endeavor to assure that adequate and appropriate mental health services are available throughout the state”

“Promote and maintain an adequate and appropriate system of community mental health services programs throughout the state”

“shift primary responsibility for direct delivery of services from the state to a community mental health services program…whenever there is demonstrated willingness and capacity to provide an adequate and appropriate system of mental health services to the citizens of that area”

Chapter 7 of the Code sets forth the rights of mental health services recipients, including:
“…mental health services shall be offered in the least restrictive setting that is appropriate and available.”
“that a person-centered planning process is used to develop a written plan of services in partnership with the recipient”
State Authority and Responsibility for Michigan’s Public Mental Health System is housed within the Department of Community Health in the Mental Health and Substance Abuse Administration.

The service system consists of:

**Community Mental Health Services** contracted by the state through:
- 46 Community Mental Health Services Programs covering all 83 counties, for general fund—financed services and certain Medicaid waiver programs
- 18 Medicaid Prepaid Inpatient Health Plans (PIHPs) under the Medicaid Specialty Mental Health Services program

**State Provided Services:**
- Psychiatric inpatient services through state psychiatric hospitals (3 Adult; 1 Children)
- Assessment & forensic mental health services at the Center for Forensic Psychiatry
- Mental Health Services to prison inmates under an interagency agreement with DOC
- NO Facility-based services for persons with developmental disabilities – last bed vacated on Nov 22, 2010
Mental Health: Evolution

- The 1974 Mental Health Code provides the basic framework; denotes state and county financial obligations; sets forth legal stipulations for involuntary treatment; assure protection of rights of recipients; provides for a system of county-based community mental health services programs; denotes structure to allow funds to follow the person.

- The late 1970’s saw policy changes to promote movement of care from large state-operated institutions to small community-based care settings.

- The 1980s saw the shift in governance of care from state-operated and contracted services, to governance through the system of Community Mental Health Services Programs.

- The 1990s continued the shift from state facility to community-based care, and the shift to Medicaid managed care as a method to enhance federal financial participation, as well as expand opportunity to those with the most severe needs. Significant changes in Mental Health Code provisions supporting evolution fo the current structure were enacted in 1996.
<table>
<thead>
<tr>
<th></th>
<th>1965</th>
<th>1991</th>
<th>2010</th>
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</thead>
<tbody>
<tr>
<td><strong>12 County</strong></td>
<td>County Community Mental Health Boards covering 16 counties; 7 in the</td>
<td>Community Mental Health Boards covering all 83 counties</td>
<td>Community Mental Health Services Programs covering 83 counties</td>
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<tr>
<td><strong>Mental Health</strong></td>
<td>planning process</td>
<td></td>
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<tr>
<td><strong>Boards</strong></td>
<td></td>
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<tr>
<td><strong>41 state</strong></td>
<td>state operated psychiatric hospitals and centers for persons with</td>
<td>state psychiatric hospitals and centers for persons with</td>
<td>state operated hospitals and centers with a resident census of 807</td>
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<tr>
<td><strong>operated</strong></td>
<td>developmental disabilities – about 29,000 residents (20,000 persons</td>
<td>developmental disabilities – total census: 3,054</td>
<td>on Nov. 11, 2009</td>
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<tr>
<td><strong>psychiatric</strong></td>
<td>w/ MR/DD)</td>
<td></td>
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<td><strong>hospitals</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>and centers</strong></td>
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## Changing Views of Persons with Disabilities

<table>
<thead>
<tr>
<th>Focal Question and Values</th>
<th>Institutional Era</th>
<th>Deinstitutionalization Era</th>
<th>Era of Community Living</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is Person of Concern?</td>
<td>Patient</td>
<td>Client</td>
<td>Person, Individual, Citizen</td>
</tr>
<tr>
<td>What is the Typical Setting?</td>
<td>Segregated Institutions</td>
<td>Group Home, Workshop, Clinics, Day Programs</td>
<td>Own Home, Neighborhood, Work, School, Community</td>
</tr>
<tr>
<td>How are Services Organized?</td>
<td>Regimented Facility Programming</td>
<td>Community Care Continuum Least Restrictive Setting</td>
<td>Supports for Living in the World According to One’s Preferences</td>
</tr>
<tr>
<td>What is the Model?</td>
<td>Custodial/Medical</td>
<td>Professionally-Driven Programmatically Oriented</td>
<td>Evidence-based, Peer-delivered, Best &amp; Promising Practices Informal Supports Self-Determination Arrangements</td>
</tr>
<tr>
<td>What are the Services?</td>
<td>Basic Needs Somatic Treatments</td>
<td>Professional Services Community-Based Programs</td>
<td>Treatment, Care Coordination And Supports for Living</td>
</tr>
<tr>
<td>How are Services Planned?</td>
<td>Professional Plan of Care</td>
<td>Individualized Treatment Plan</td>
<td>Person-Centered Planning</td>
</tr>
<tr>
<td>Who Controls the Planning Decisions?</td>
<td>A Professional (usually an M.D.)</td>
<td>An Interdisciplinary Team</td>
<td>Collaboration of Individual, Family, Allies &amp; Professionals</td>
</tr>
<tr>
<td>What is the Planning Context?</td>
<td>Standards of Professional Practice</td>
<td>Professional Standards and Team Consensus</td>
<td>Exploration of Preferences &amp; Desired Outcomes Treatment/Support Needs</td>
</tr>
<tr>
<td>What has the Highest Priority?</td>
<td>Protection and Provision of Basic Needs</td>
<td>Symptom Reduction Illness Remission Skill Development</td>
<td>Recovery, Supports for Living Illness Management Relationships</td>
</tr>
<tr>
<td>What is the Objective?</td>
<td>Control, Safety, Amelioration</td>
<td>Arrest Symptoms and Improve Functioning</td>
<td>Community Inclusion &amp; Participation, Independence &amp; Productivity</td>
</tr>
<tr>
<td>How are Services Funded?</td>
<td>Limited State Appropriation</td>
<td>General Funds &amp; Medicaid FFS To Support Programs</td>
<td>Medicaid &amp; General Funds for Individualized Supports &amp; Services</td>
</tr>
<tr>
<td>How is Quality Defined</td>
<td>By Professional Disciplines</td>
<td>Structure &amp; Process Measures</td>
<td>Quality of Life Person-defined Outcomes</td>
</tr>
</tbody>
</table>
COMMUNITY MENTAL HEALTH
SERVICE STRUCTURE

Community Mental Health Services Programs (CMHSPs) established under the mental health code as county entities or local authorities-administer state general fund-financed services, Adult Benefits Waiver, MI Child, Children's DD and Severely Emotionally Disturbed Waivers

Medicaid Prepaid Inpatient Health Plans (PIHPs) consisting of one or more CMHSPs administer the Medicaid Specialty Services Plan, under the provisions of the concurrent 1915(b) & 1915 (c) waiver program, functioning as managed care entities each with a minimum Medicaid population of 20,000 covered lives
46 CMHSP BOARDS; 18 PIHPs

CMHSP as Prepaid Inpatient Health Plans
Standalone and Affiliations

CMHSP Affiliations
- UP AFFILIATION
- NORTHERN ALLIANCE
- GL/WMNC AFFILIATION
- ACCESS ALLIANCE
- THUMB ALLIANCE
- AFFILIATION OF MID-MICHIGAN
- SOUTHWEST ALLIANCE
- VENTURE
- CMH PARTNERSHIP OF SE MICHIGAN
- LAKESHORE ALLIANCE
- UNAFFILIATED OVER 20,000
CMHSPs
Persons Served

Number of Individuals Served by Michigan's Public Mental Health System FY 2000 - 2009

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Individuals with Mental Illness</th>
<th>Individuals with a Developmental Disability</th>
<th>Dual Diagnosis DD/MI</th>
<th>Missing or Unknown</th>
<th>Total Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>2000</td>
<td>151,084</td>
<td>30,154</td>
<td>9,170</td>
<td>190,408</td>
<td>100%</td>
</tr>
<tr>
<td>2001</td>
<td>135,964</td>
<td>33,199</td>
<td>10,868</td>
<td>185,984</td>
<td>100%</td>
</tr>
<tr>
<td>2002</td>
<td>155,300</td>
<td>25,725</td>
<td>6,260</td>
<td>195,552</td>
<td>100%</td>
</tr>
<tr>
<td>2003</td>
<td>140,157</td>
<td>26,846</td>
<td>7,108</td>
<td>185,072</td>
<td>100%</td>
</tr>
<tr>
<td>2004</td>
<td>144,435</td>
<td>25,977</td>
<td>7,344</td>
<td>187,058</td>
<td>100%</td>
</tr>
<tr>
<td>2005</td>
<td>158,412</td>
<td>27,807</td>
<td>7,183</td>
<td>200,424</td>
<td>100%</td>
</tr>
<tr>
<td>2006</td>
<td>163,546</td>
<td>27,037</td>
<td>9,470</td>
<td>205,929</td>
<td>100%</td>
</tr>
<tr>
<td>2007</td>
<td>166,524</td>
<td>27,448</td>
<td>7,727</td>
<td>211,972</td>
<td>100%</td>
</tr>
<tr>
<td>2008</td>
<td>173,069</td>
<td>29,516</td>
<td>7,039</td>
<td>219,238</td>
<td>100%</td>
</tr>
<tr>
<td>2009*</td>
<td>185,839</td>
<td>28,965</td>
<td>7,619</td>
<td>233,654</td>
<td>100%</td>
</tr>
</tbody>
</table>

26.0% Increase in CHMSPs Persons Served FY 09 Compared to FY 03 - Due to Increase in Persons With Mental Illness Needs
Michigan Medicaid Caseload

*September 2010 (projected)
MDCH BUDGET BY MAJOR ADMINISTRATION

FY10 BUDGET: $13.08 B

- MEDICAID 69%
- MH & SA 22%
- HLTH POLICY & REG 1%
- PUBLIC HEALTH 6%
- AGING SERVICES 1%
- ADMIN & IT 1%
Federal Funds Far Outweigh State GF in DCH Budget
FY2010 Mental Health Budget By Revenue Source
$2,808,733.8 Gross

- **STATE RESTRICTED**: $21,805.7 (0.78%)
- **IDG’S**: $45,489.7 (1.62%)
- **PRIVATE**: $1,190.0 (0.04%)
- **LOCAL**: $164,619.5 (5.86%)
- **OTHER FEDERAL**: $49,952.2 (1.78%)
- **STATE RESTRICTED**: $21,805.7 (0.78%)
- **GENERAL FUND/GENERAL PURPOSE**: $1,112,208.8 (39.60%)
- **FEDERAL MEDICAID**: $1,413,467.9 (50.32%)
PIHP EXPENDITURES BY SERVICE TYPE
FY07 DATA (IN MILLIONS)

- $26.5M Substance Abuse
- $144.4M Therapies, Assessments
- $235.7M Supports Coordination & Case Management
- $104.6M Hosp/Crisis
- $28.2M Other
- $234.7M Supported Living, Private Duty Nursing
- $195.5M Support for community participation & integration
- $518M Support for people in group homes

Total: $518M
The Current Decade

- Continued evolution of community based services principles
  - Partnering with consumer/family member stakeholders
  - Supporting maximum consumer choice and control
  - Improving the Quality of supports and services
  - Improving the Culture of Systems of Care
  - Developing, Supporting and Maintaining a Competent Workforce

- Accountability
  - Achieving greater administrative efficiency
  - Evidence-based practices for effective treatment
  - Continuous quality improvement and quality monitoring

- New Constraints
  -- Equity in access and benefit
  -- Managing demand
  -- CMS oversight and adherence to revised regulatory interpretations has significantly increased administrative workload
Planning for the Future

- Reduce reliance on “legacy” programs
- Increase the use of evidence-based, peer-delivered, best and promising practices
- Increase connections to and collaboration with resources in the community
- Adopt a culture of gentleness
- Assure quality and sufficiency of residential care and community integration options for people with DD
The Right to Live In the World

“... many people with intellectual and psychiatric disabilities are being denied the right to live in the world in an even more basic sense—to receive services, they must submit to confinement in inappropriate institutional settings. America no longer has its Pennhursts—behemoth institutions that housed 3,000 or more people with intellectual disabilities at a time—but smaller institutions, nursing homes, and other care facilities continue to unnecessarily segregate people with intellectual disabilities from the community and deny them the right to live in the world.”

* REMARKS BY DEPUTY ASSISTANT ATTORNEY GENERAL SAMUEL R. BAGENSTOS OF THE CIVIL RIGHTS DIVISION AT THE ANNUAL CONVENTION OF THE ARC OF THE UNITED STATES, NOVEMBER 13, 2009
Planning for the Future

- Give people more control over their lives, their services, and their budgets
  - Assure that every service recipient is provided information about the costs of his/her services
  - Enhance opportunities for individuals to manage a capped amount of funds under self-determination arrangements
  - Evolve consumer-run options such as cooperative models
  - Listen constantly to consumer feedback
Planning for the Future

- Systems of Care to support children across CMH and other local systems
- Achieving a recovery orientation for all services for persons with mental illness
  - Must be actual, not nominal
  - Peer specialist involvement as service delivery partners
- Involving consumer/family stakeholders in design, development and evaluation of services
- Locally integrated service system arrangements
- Changing providers when progress is lagging
- Perceived fairness
CHALLENGES

- Improving the quality of services and supports
- Meeting increased demand within available funding
  - Pressures on GF-financed services mean fewer individuals being served through this mode each year, especially adults with mental illness
- Integrating physical health & mental health care
- Meeting mental health needs of children with SED in the child welfare system
- Refocusing on those with mental illness who are in the criminal justice system
CHANGES

- Election of new Governor and Legislature
- Change in Department leadership
- Early retirements
  - E.g., At Walter Reuther, almost 85% of RCA’s eligible
  - In hospitals, loss of docs, RNs, psychologists, O.T.s, etc., mean DCH will be scrambling to assure sufficient care
  - Central office: Departure of institutional knowledge and reductions to staffing capacity that follow will weaken capacity to meet federal and legislative requirements
- Health care reform opportunities and challenges require continuing attention
  - Continue to explore the potential of an Early Adopter option to bring in all childless adults at less than 35% of poverty
- FY 12 revenue projections indicate a 20% overall GF spending reduction
  - What that will mean for the mental health & substance abuse services system is unclear: Planning targets with 10% reductions due in January
  - Managing the change process requires increased communication with stakeholders