

## **MICHIGAN MENTAL HEALTH COMMISSION**

### **A BRIEF MODERN HISTORY OF MICHIGAN'S PUBLIC MENTAL HEALTH SYSTEM**

#### ***THE INSTITUTIONAL ERA***

Every society has grappled with the plight of individuals who manifest certain patterns of thinking, feeling and/or behavior that are considered signs of a serious mental disorder or condition. Michigan has long recognized a fundamental state obligation to assist those with serious mental disorders. Specific provisions in the state constitutions of 1850, 1908 and 1963 established the legal foundation for state involvement in the care and treatment of those with serious mental illness. The provisions in the 1850 and 1908 constitutions affirmed state support for institutions to serve those with mental illness (and other disabilities). In the 1963 constitution (Article VIII, § 8), state support was extended to include institutions, programs and services for the care, treatment, education or rehabilitation of the mentally disabled.

Initially, the state fulfilled its constitutional commitment through the establishment of state psychiatric asylums. In the mid-19<sup>th</sup> century, the development of mental asylums was considered enlightened and progressive public policy and a humane response to the plight of those with mental disorders. Michigan's first state institution for the mentally ill, the Kalamazoo Asylum for the Insane, began accepting patients in 1859, and over the next forty years, similar facilities were established in Pontiac, Traverse City and Newberry.

For much of the 19<sup>th</sup> century, public asylums in America generally housed a relatively modest proportion of long-term or chronically incapacitated patients, and these facilities had not yet assumed the role of custodial care institutions. Many patients entering public asylums during this period did not have prolonged lengths of stay at the facility, and they were eventually discharged back into the community. The circumstances that produced this diverse patient mix were complex, and involved legal issues, divided responsibilities among levels of government and certain financial liabilities and incentives.



By the end of the 19<sup>th</sup> century, however, these circumstances had changed, precipitating a steady increase in the proportion of chronically disabled, elderly, and disordered individuals with underlying somatic conditions among the population of state and county-operated psychiatric hospitals. This trend continued into the 20<sup>th</sup> century, and the average length of stay at public hospitals increased dramatically, with a concomitant decrease in discharge rates. The changing utilization patterns swelled the resident census at state facilities, necessitating the expansion of existing facilities, the establishment of additional state psychiatric hospitals, and a gradual shift in the role of the facilities from supportive and restorative treatment to custodial care.

The changing characteristics of the resident population (greater chronicity, more age-related psychiatric impairments, refractory symptomatology related to underlying physical causes) and the changing role of the public psychiatric hospital (provision of long-term custodial care) fostered an overly pessimistic perception of serious mental illness among the general public. Mental illness came to be regarded as a lifelong, gravely disabling, malady with little prospect for recovery or remediation of the illness. This gloomy perspective, in turn, diminished public support and legislative concern for state psychiatric facilities, and the hospitals steadily became more overcrowded, understaffed, regimented, bureaucratic, drab and impoverished. By the mid-1950s, there were over 559,000 individuals in publicly operated psychiatric hospitals across the United States. In that same period, over 20,000 Michigianians with mental illness were residing in state or county-operated psychiatric facilities.

### ***SEEDS OF CHANGE***

Despite prevailing negative stereotypes regarding mental illness and the seemingly pervasive indifference to the conditions in public institutions, there were other developments that were harbingers of new perspectives and treatment approaches for serious mental disorders. The National Mental Health Act of 1946 established the National Institute of Mental Health (NIMH) and authorized grants to states to support existing outpatient clinics that served the mentally ill, or to establish new clinics or programs for this purpose. In 1953, the American Medical Association and the American Psychiatric Association recommended a national study regarding the treatment of persons with mental illness. Congress adopted this recommendation and passed the Mental Health Study Act in 1955.

At the same time, scientific developments and psychosocial treatment modifications were changing institutional care for the seriously mentally ill. In 1952, the antipsychotic property of the drug chlorpromazine (Thorazine) was discovered, and the introduction of this medication (and other drugs of similar efficacy) into the treatment regimen at state facilities produced significant symptomatic improvement in many patients. Innovations in hospital milieu therapy were also being developed, reemphasizing the therapeutic (rather than custodial) orientation of state facilities.

With the widespread use of antipsychotic agents, improvements in the hospital milieu, and a growing professional recognition of the adverse effects of prolonged institutional care, the patient census at public institutions began to gradually recede, not just in Michigan but also across the United States. In Michigan, initially there was only modest flow of patients out of state facilities (the year-to-year census in Michigan's state-operated hospitals declined 16% from 1955 to 1965). Over time, however, this slow trickle became a mass exodus. While the advance in pharmacological treatment was not the sole factor responsible for the incremental census reduction, the new antipsychotic medications had clearly engendered a sense of hope regarding serious mental disorders and had altered public sentiments about these conditions.

As these changes were unfolding, the Joint Commission on Mental Illness and Health (operating under the auspices of the Mental Health Study Act of 1955) completed the study authorized by Congress and published its findings. The report, ***Action for Mental Health***, (1961), recommended changes in archaic state hospital systems (smaller facilities, better staffing) and suggested development of local centers to address the needs of the mentally ill returning to the community. The report stated that:

*“The objective of modern treatment of persons with major mental illness is to enable the person to maintain himself in the community in a normal manner. To do so, it is necessary (1) to save the patient from the debilitating effects of institutionalization as much as possible, (2) if the patient requires hospitalization, to return him to home and community life as soon as possible, and (3) thereafter to maintain him in the community as long as possible. Therefore, aftercare and rehabilitation are essential parts of all services to mental patients, and the various methods of achieving rehabilitation should be integrated into all forms of service.”*

In 1963, in response to this report, President Kennedy formed an interagency task force on mental illness to determine priorities for action and proposals for implementation. In 1963, reflecting the Joint Commission report and interagency task force recommendations, Congress passed, and President Kennedy signed, the Community Mental Health Centers (CMHC) Act. President Kennedy had previously (in a February 1963 address to Congress) called for 50% reduction in state hospital census over the next ten years, and the CMHC Act provided funds for the development of community-based care centers to help achieve this objective. The Act had some controversial aspects, however, since federal funding to establish CMHCs would bypass state government and go directly to grantees selected by the federal government. This created a split in authority and responsibility between the state hospital system and the new federally funded CMHCs.

The federal government went on to establish a number of ancillary social programs in the 1960s and early 1970s - medical assistance, income support, housing subsidies, and vocational rehabilitation services - that became instrumental in the successful transition of seriously mentally ill individuals from institutional care to community settings.

While Michigan had expanded institutional capacity during the first half of the 20<sup>th</sup> century, the state had also established a limited number of community-based programs to meet the needs of persons with mental illnesses. Community aftercare clinics had been established in various parts of the state under the auspices of nearby state psychiatric hospitals. Several child guidance centers had been founded by private organizations, and some of these later received state and/or local operating subsidies or contributions. In 1944, legislation was enacted to allow local county boards to appropriate funds for operation of child guidance centers and adult clinics.

In April 1963, (six months before the enactment of the federal CMHC Act), the Michigan Legislature passed **Public Act 54**. The intent of the legislation was to stimulate development of community mental health services throughout the state. Act 54 permitted counties – either singly or in combination – to form Community Mental Health Boards and to receive state matching funds for the operation of these agencies. In its original form, Act 54 allowed state match funds of 40% to 60% of the cost of an approved county program. The law was later amended to set the rate of state match for an approved program at 75%. By 1969, there were thirty-three (33) Act 54 boards, covering forty-nine (49) counties. State policy at that time promoted the gradual inclusion of other local publicly supported mental health services and clinics under the ambit of the Act 54 boards.

The federal CMHC grants and state support for community mental health boards spurred development of community programs and service capacity, consistent with the emerging perspective that serious mental illness was an enduring disorder with periodic exacerbation,

reoccurrence, and residual impairments (like other chronic disease states), but the condition was amenable to ameliorative, restorative and rehabilitative treatments and supports. Some individuals with serious mental illness might require episodic state hospital care during acute phases of the illness, but these individuals could (and should) be released back to their community and local "aftercare" programs, as soon as their condition stabilized and acute symptoms had receded.

Practice patterns in Michigan began to reflect this revised conception of mental illness, with the emphasis on more limited utilization of state facilities and greater reliance on community clinics and services. Between 1965 and 1975, the patient census at state psychiatric hospitals fell from 17,000 to roughly 5,000 patients. The national policy of deinstitutionalization had taken firm hold in Michigan.

In the early 1970s, changing societal views and perceptions regarding mental illness triggered numerous legal and advocacy challenges to existing civil commitment standards, inadequate hospital conditions, certain treatment methods, violations of constitutional rights and overly restrictive care arrangements. Complaints regarding inadequate community care emerged at the same time, with critics citing frequent readmissions (the "revolving door" phenomenon) among discharged patients, faulty coordination between the state and community agencies, insufficient community service capacity, and diffuse accountability for recipient care.

### ***THE SHIFT TO COMMUNITY-BASED CARE***

To address these issues and to provide a new framework for the organization and operation of Michigan's public mental health system, the Legislature passed **Public Act 258** in 1974. This statute - popularly known as the **Mental Health Code** - was a "tipping point" in the conversion from an institutional care system to a community-based treatment and supports model. The statute modernized civil commitment standards and due process procedures, clarified the roles and responsibilities of the state department and county-sponsored community mental health services programs (CMHSPs), designated priority populations for service and core program requirements, established the principle of "least restrictive setting" for care and treatment decisions, specified the rights of service recipients, and devised a monitoring and protection system. The legislation increased state match for approved county community mental health programs to 90% and stipulated that:

*"... it shall be the objective of the department to shift from the state to a county the primary responsibility for the direct delivery of public mental health services from the state to a community mental health services program whenever the county shall have demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of the county." (Section 116e)*

Despite passage of this landmark legislation and its sweeping prescription for change, implementation of many Code provisions lagged in the years following enactment of the statute. Coordination between hospital and community agencies continued to be problematic; discharge plans and community placement arrangements were often incomplete and haphazard; and local service capacity remained inadequate. To ensure more rapid transformation of the system, Governor Milliken established the "Governor's Committee on Unification of the Public Mental Health System" in 1979. In its final report, ***Into the 80s***, the Committee recommended:

*“...establishing a single point of responsibility for voluntary and involuntary entry into Michigan's public mental health system, for determination and oversight of the services it provides, for system exit, and for the resources that support service delivery. That single point of responsibility is to be located in the community. It is designated as a local mental health authority encompassing one or more counties.”*

Following publication of the report, the state assumed a more aggressive posture toward system restructuring and the pace of change accelerated. The Department of Mental Health (DMH) devised a new arrangement – referred to as “**full management**” - to affect the shift of responsibility, authority and fiscal resources for public mental health services from the department to the county-sponsored community mental health services programs. Under full management, the CMHSPs became the single entry/single exit point for the entire public mental health system. Funding related to utilization of state psychiatric hospitals and developmental centers (as well as funding for community-based services) were allocated to the CMHSPs, which in turn “purchased” inpatient services from state institutions as needed. If a CMHSP could reduce its utilization of the state hospital, it retained the savings (referred to as “**trade-off**” dollars) for expansion of community programs and capacity.

Beyond the structural, fiscal and contractual changes, DMH promoted the adoption of innovative community treatment and support programs for adults and children with serious mental illness and emotional disorders. The department provided expansion funding to CMHSPs to develop, implement or replicate service models such as the Fairweather Lodge Program, Assertive Community Treatment (ACT), Psychosocial Rehabilitation (PSR) Programs (Clubhouses), Home-Based Services for Children, Wraparound, Supportive Independent Housing and Supported Employment.

At the national level, federal policy on mental health shifted in the 1980s. In 1977, President Carter had established a Presidential Commission on Mental Health to review mental health care in America and make recommendations for improvement. The Commission's findings generated ambitious and far-reaching strategies for change and called for significant federal involvement in addressing the problem of serious mental illness. However, this approach was not pursued by the new administration, and federal involvement in mental health policy and funding gradually receded. Despite the more limited participation of the federal government in mental health policy, the National Institute of Mental Health continued its efforts to promote improved programs for adults with serious mental illness and children with serious emotional disturbances through the Community Support Program (CSP) and the Child and Adolescent Service System Program (CASSP).

By the end of the decade of the 1980s, the direction of Michigan's public mental health system (progressive deinstitutionalization, admission diversions, gradual facility downsizing, development of community-based alternatives and investment in programmatic innovations) was broadly accepted and generally enjoyed bipartisan legislative support. DMH policy emphasized continued reduction in state facility utilization and the establishment of a “continuum of care” (comprehensive service array) within each CMHSP. The “dollar follows the patient” concept (“trade-off”) encouraged community placement and reductions in facility utilization, and the funds retained by the CMHSPs were used to expand local service capacity and options.

However, during the 1980s, Michigan (similar to other states) began to increasingly rely on Medicaid coverages and federal reimbursement to support its community-based treatment services and rehabilitative programs. The establishment and gradual expansion of optional Medicaid services targeted to the needs of persons with serious mental illnesses provided additional revenue for the public system and increased the fiscal stability of community programs. However, the introduction and growth of Medicaid reimbursement also increased the complexity of funding arrangements, and encouraged certain budgetary adjustments that slowly compromised state-county collaboration on mental health care.

### ***PUBLIC MENTAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS***

Establishing a coherent public policy for children's mental health services posed persistent challenges for Michigan's mental health system throughout the 1970s and 1980s. Public institutional care had not been as frequently or extensively used for children as it had been for adults with serious mental illness, and hence the ability to finance increased community service capacity for children through the "trade-off" mechanism was much more limited. Most state psychiatric hospitals for children had been established adjacent to existing state adult facilities, and total bed capacity of these facilities was limited. In addition, Michigan had been an early pioneer and proponent of community-based child guidance clinics, which were supported by private donations, state funds, and/or local government allocations.

A number of national evaluations regarding the need for and the availability of mental health care for children and adolescents had estimated significant prevalence of mental disorders among this population, documented limited service capacity and availability, and revealed low rates of treatment and service utilization. The first of these reports emerged from the work of the Joint Commission on the Mental Health of Children, which published its report, ***Crisis in Child Mental Health***, in 1969. In 1978, the **Task Panel on Infants, Children and Adolescents**, a sub-committee of President Carter's Commission on Mental Health, found that children continued to receive inadequate mental health care, and noted that recommendations contained in the Joint Commission report of 1969 had never been implemented. In 1982, the Children's Defense Fund (CDF) published an extensive and highly unfavorable study of the provision of mental health care to children and adolescents in state mental health systems. The report, ***Unclaimed Children***, concluded that the vast majority of severely emotionally disturbed children and adolescents were not receiving adequate mental health care, and many received no treatment at all.

In Michigan, the ***Report of the Child Mental Health Study Group*** (1982) came to many of the same conclusions. Responding to these and other findings, Department of Mental Health policy and funding strategies in the 1980s emphasized the development and expansion of community mental health services for children and adolescents. Legislation passed in 1984 required the establishment of a "Children's Diagnostic and Treatment Services Program" within each CMHSP, to provide comprehensive evaluation, diagnosis and disposition arrangements for children in urgent or emergent need of mental health care. The Legislature also provided additional categorical funds to CMHSPs for expansion of intensive home-based services, therapeutic foster care, respite care programs and prevention initiatives. Finally, the state began to promote the development of local "systems of care" for children and adolescents, an approach first articulated through the federal CAASP initiative.

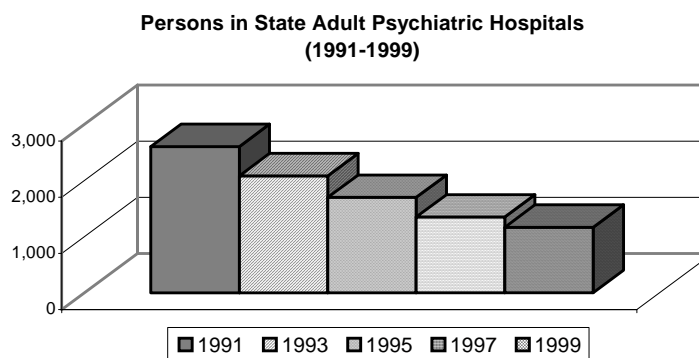
An enduring issue affecting the provision of mental health services to children and adolescents during the 1980s was the problem of coordinating service efforts and care responsibilities

among different child-serving agencies and systems. Many children in non-mental health systems (e.g., education, child welfare, juvenile justice, primary care settings, Head Start, etc.) exhibited signs of emotional disturbances and mental disorders. Determining service responsibilities, reconciling statutory mandates, and coordinating complicated funding arrangements often strained relations between agencies and drained energy and resources from service provision. Dissatisfaction with this state of affairs led to proposals for a state "superagency" for children's services, which would house and reconcile multiple programs directed toward the well being of children and families. However, these proposals were controversial and were never acted upon by the Legislature.

### ***ACCELERATING CHANGE AND NEW DIRECTIONS: 1991 TO 1996***

At the beginning of the decade of the 1990s, the transition of the public mental health system from institutional care to community-based service arrangements was significantly accelerated. Although the tension between institutional care and community-based services is not an either/or contest, resource limitations and funding constraints often press states to make choices regarding where to spend the bulk of their mental health budget. In Michigan, the recession of the early 1990s and ensuing shortfalls in state revenues precipitated an Executive Branch decision to close a number of state facilities, triggering a decisive shift in resources away from state hospitals and toward the community-based system.

The extent and pace of facility closures was controversial and strained the general consensus regarding state mental health policy that had characterized the 1970s and 1980s. Between 1991 and 1997, the state closed six (6) state psychiatric hospitals for adults with serious mental illnesses, and five (5) state psychiatric facilities for children with serious emotional disturbances. As the state withdrew from the provision of mental health care, county-sponsored CMHSPs assumed the lion's share of treatment and support obligations for persons with serious mental illnesses and children with serious emotional disturbances. While the county-sponsored CMHSPs received some additional funding during these years, much of this growth was attributable to facility closures ("trade-off"), the shift of responsibility from the state to the counties, and the assumption of new service obligations, rather than true economic increases or cost-related adjustments.



For CMHSPs located in less populated areas of the state, these changes generally did not produce any dramatic consequences. The number and needs of individuals with serious mental disorders within the catchment area of these CMHSPs was manageable, and many of these agencies had already significantly reduced their utilization of state institutions. However, certain CMHSPs in more populous areas of the state faced significant problems adapting to the closure of the institutions.

Beyond the closure of multiple state facilities and the transfer of care responsibilities to the CMHSPs, the public mental health system encountered other changes and challenges during the 1990s. The Department of Mental Health, which operated state facilities and directed, funded and monitored the CMHSP system, was abolished by Executive Order and subsumed within the Department of Community Health (DCH). Some feared that this development would eventually reduce visibility, interest and financial support for mental health services.

The creation of the Department of Community Health reflected a changing state posture and presence in the public mental health system. The system was becoming increasingly decentralized as more authority and responsibility devolved to county-sponsored community mental health services programs. In a decentralized system, community programs were now executing many of the functions and activities previously performed within the state bureaucracy.

Responding to these changing circumstances, the Legislature enacted major revisions to the state's Mental Health Code. Key provisions of the legislation (P.A. 290 of the Public Acts of 1995) included:

- (a) The establishment of a new type of CMHSP entity - the "Authority" - which had greater administrative independence and operational control than previous CMHSP organizational options;
- (b) A requirement that CMHSPs be "certified" by the Department, or achieve accreditation through a nationally recognized accreditation organization;
- (c) The inclusion of primary consumers and family members on CMHSP governing boards;
- (d) A new obligation for the CMHSPs to provide jail diversion services; and
- (e) The requirement that the individual plan of service for all recipients of the public mental health system be developed through a "person-centered" planning process.

The Legislature also pressed the Department (through boilerplate provisions in the Appropriations Act) to improve CMHSP data reporting and to establish a performance indicator system to assess CMHSP activity on key dimensions. The Department implemented its Mission Based Performance Indicator System in 1997.

In regard to mental health services for children, the Department promoted the expansion of multi-purpose collaborative bodies (MPCBs) throughout the state to encourage greater interagency collaboration, to promote a "systems of care" approach for seriously emotionally disturbed (SED) children, and to facilitate pooled funding arrangements for children and families involved with multiple public systems. Pilot projects (Michigan Interagency Family Preservation Initiative or MIFPI) were carried out in several communities within the state. However, funding for prevention and early intervention services declined, and many CMHSPs scaled back local initiatives.

### ***IMPLEMENTATION OF MANAGED PUBLIC MENTAL HEALTH CARE IN MICHIGAN***

Shortly after its creation, the new Department of Community Health announced major changes in the operation of Medicaid, the state-federal entitlement program that covers a wide array of specialty services for beneficiaries with serious mental illnesses. Medicaid reimbursement, introduced into the funding framework of the public mental health system during the 1980s,



played a major role in underwriting the cost of community services and programs. DCH indicated that it would move most Medicaid recipients and Medicaid benefits into capitated, risk-based "managed care" arrangements, and that it was proceeding with the submission of federal waivers to affect these changes. The state elected to "carve-out" Medicaid specialty mental health benefits and proposed that CMHSPs administer and deliver these benefits under a capitated, shared-risk, managed care program. DCH submitted a 1915(b) Medicaid managed specialty services waiver to the federal government in 1998, along with a request for an exemption from federal procurement requirements. The waiver and exemption were granted and the program was launched in October 1998.

Managing Medicaid specialty benefits under a federal waiver and on a shared-risk basis introduced additional complexities into the public mental health system. The CMHSPs had evolved and historically operated under the "community model" of organization and service provision. This model was predicated on geographic catchment areas, grant funding, priority populations for service provision, relational contracting between governmental units, and a stable non-competitive network of providers, responsive to governmental policies and priorities. Under Medicaid managed care, however, CMHSPs were forced to operate more like an insurance entity or health plan, with entitled beneficiaries, defined benefits and service obligations, medical necessity standards, stringent due process requirements, and increased administrative responsibilities.

These challenges were compounded by federal stipulations that the state develop a plan for moving to "open and full competition" for management of Medicaid specialty services. After tumultuous debate within the state, DCH submitted a revised plan to the federal government that successfully argued the "impracticality" of competition for management of these Medicaid services. The federal government accepted this argument and the state was allowed to continue sole-source contracting, albeit with some significant changes. CMHSPs in less densely populated areas of the state, with small numbers of Medicaid beneficiaries within the catchment areas, were required to affiliate as a condition of participation in the Medicaid managed specialty services program.

#### ***ADDITIONAL DEVELOPMENTS IN THE LATE 1990S***

In July 1990, President Bush proclaimed the 1990s as the "decade of the brain". Neuroscientific research over the course of the decade expanded our understanding of the etiology of mental disorders and pharmacological research produced a number of new medications to treat major mental illness. By the later part of the decade, these new therapeutic agents (atypical antipsychotics) were being widely used within the public mental health system and were rapidly replacing older medication regimens used to treat serious mental illness.

In 1996, Congress passed the Mental Health Parity Act, which prohibited (with certain exceptions) insurers and group health plans from placing annual or lifetime dollar limits on mental health benefits that are lower than annual or lifetime dollar limits for medical and surgical benefits offered under the plan.

Promotion of mental health issues and concerns were further bolstered in the late 1990s by the publication of ***Mental Health: A Report of the Surgeon General*** (1999). This landmark examination and study of mental illness established that mental disorders were pervasive, disabling, amenable to a range of effective treatments, and deserving of greater attention and consideration in national health policy.

Finally, during the late 1990s, the **recovery** concept of mental illness emerged as the guiding theme for mental health policy and practice. While defined in different ways by different parties, the recovery model emphasizes that persons with serious mental illnesses can regain control over significant aspects of their lives and develop a sense of identity and purpose, despite experiencing exacerbations and/or the persistence of symptoms and impairments. The recovery vision emphasizes both positive individual expectations (hope, empowerment, and self-directedness) and organized interventions (treatment, rehabilitation, and environmental supports). The concept looks beyond symptom alleviation to the kind of life experiences and situations - including social, vocational, educational, relational, and residential - needed and desired by a person with a serious mental illness.

### ***PUBLIC MENTAL HEALTH CARE IN THE NEW CENTURY***

The Surgeon General's 1999 Report indicated that roughly 20% of the U.S. adult population is affected by mental disorders during a given year. A sub-population of 5.4% of adults is identified as having a serious mental illness (SMI), applying a definition of SMI established in federal regulation. Roughly half (2.6%) of those with SMI are considered even more seriously impaired, and are described as having "severe and persistent" mental illness.

There are high rates of comorbidity (individuals with co-occurring mental illness and a substance abuse condition) among those with a mental illness. Individuals with co-occurring disorders typically utilize more services than those with a single disorder, and they are more likely to experience a chronic course in their illness.

Annual prevalence rates of mental disorders for children and adolescents have not been as well established or documented as those for adults. Current estimates are that 20% of children and adolescents experience a mental disorder in a given year, and approximately 5% to 9% of children and adolescents between the ages of 9 and 17 have a "serious emotional disturbance" (SED), again applying a definition of SED established in federal regulation.

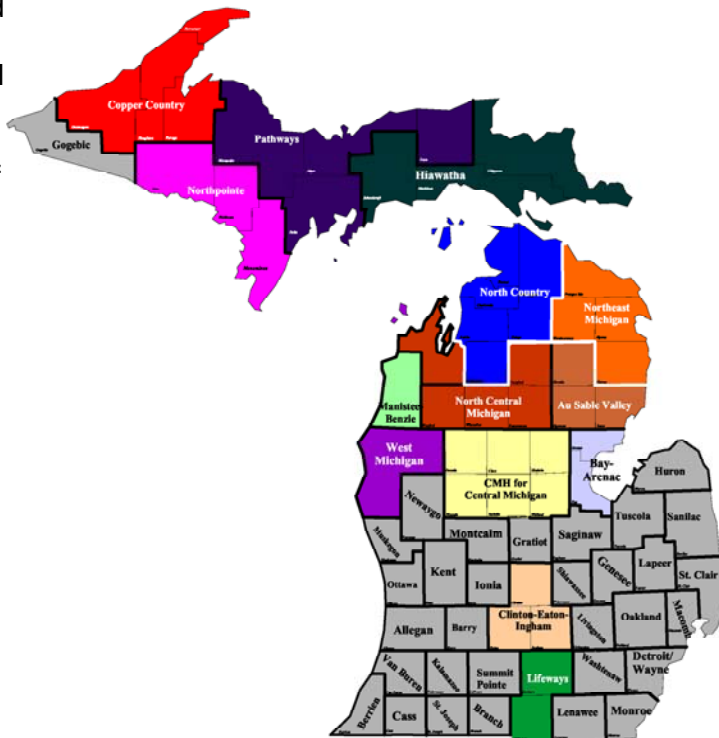
The Michigan Mental Health Code has a more circumscribed definition of serious mental illness (SMI) and serious emotional disturbance (SED) than those found in federal regulations. However, using the more liberal federal definition, the National Mental Health Information Center estimated that there were 403,930 adults with serious mental illness and 67,586 children and adolescents (ages 9-17) with serious emotional disturbance in Michigan in 2002.

Michigan has a relatively evolved public service system to address the needs of individuals with mental illness. However, by statutory intent and design, Michigan's public mental health system is configured to serve individuals with the most serious forms of mental illness and emotional disturbance, and those experiencing an acute psychiatric crisis. The Mental Health Code explicitly directs that priority for service be given to individuals with the most severe conditions and those in crisis.

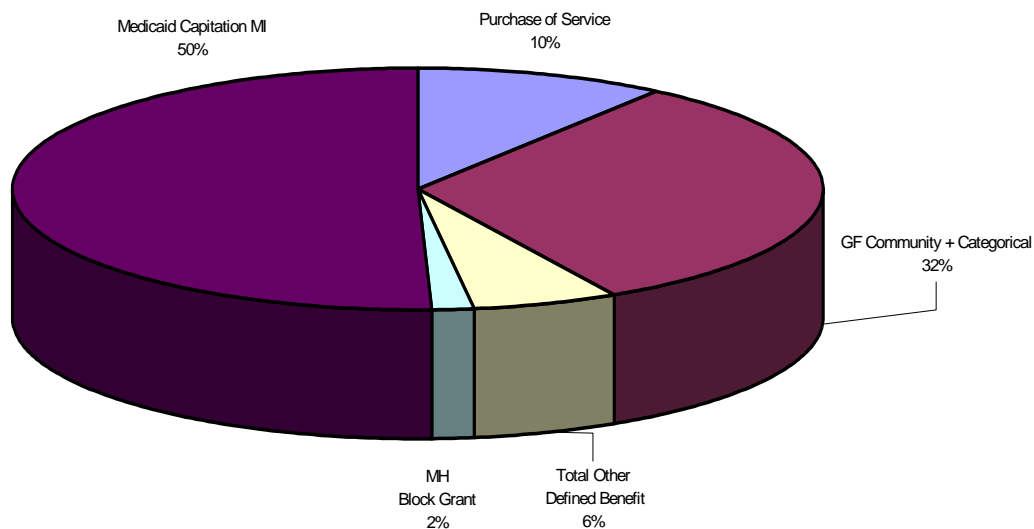
The state maintains three regional state psychiatric hospitals for adults (in Westland, Caro and Kalamazoo) and one state psychiatric facility for children and adolescents (Hawthorn Center in Northville). On any given day, there are roughly 600 adults in state regional hospitals and 80 children and adolescents at the Hawthorn Center. The state also operates the Center for Forensic Psychiatry in Ann Arbor, a 210-bed facility that provides both diagnostic services to the

criminal justice system and psychiatric treatment for criminal defendants adjudicated incompetent to stand trial and/or acquitted by reason of insanity.

Community-based mental health services are organized, administered, provided and arranged through 46 Community Mental Health Services Programs, which cover all 83 counties in the state. Forty CMHSPs have adopted the Authority form of CMHSP structure, five remain agencies of county government and one is formed under the Urban Cooperation Act as a CMHSP organization. CMHSPs are required by the Mental Health Code and through their participation in the Medicaid program to provide a comprehensive array of mental health services and supports, and they fulfill these requirements by providing these services directly, contracting with non-profit providers, or through a combination of these two approaches. Each CMHSP is required to have a pre-screening unit to assess individuals being considered for psychiatric hospitalization, and to provide alternatives to hospitalization whenever appropriate.



Community mental health services are funded through a complex mix of general fund allocations, purchase of service dollars (to pay for any utilization of state facilities), and capitated payments for the Medicaid Managed Mental Health Care Program, the Adult Benefit Waiver Program, and the MiChild program. According to the Senate Fiscal Agency, funding for community mental health has been tightly constrained over the past six years, with very limited adjustments. In fiscal year 2003-2004, roughly \$870,000,000 of state appropriations for community mental health was available to fund services to adults and children with serious mental illness.



The table below displays the number of children and adults with mental illness served by the CMHSPs over a four-year period (1999-2002).

Fiscal Year	Individuals with Mental Illness						Total
	Children		Adults		Age Not Reported		
	N	%	N	%	N	%	
1999	40,998	23.7%	125,814	72.9%	5,885	3.4%	172,697
2000	35,994	23.8%	110,826	73.4%	4,264	2.8%	151,084
2001	29,356	21.6%	101,799	74.9%	4,809	3.5%	135,964
2002	36,732	23.7%	117,174	75.5%	1,394	0.9%	155,300

**Source:** Community Mental Health Service Programs Demographic and Cost Data, FY1999 - FY2002, November 2003.

**Mental Illness:** An individual is determined to have mental illness if he/she has a DSM-IV diagnosis of mental illness, excluding mental retardation, developmental disability or substance abuse disorder.

**Children** are those consumers who are 18 years of age or younger during the fiscal year of reporting.

**Note:** Individuals who were dual eligible during FY '01 or FY '02 are not included in this table.

## **CURRENT CHALLENGES**

Public mental health systems across the nation are in distress. The title of a recent report by the Bazelon Center, *Disintegrating Systems: The State of Public Mental Health Systems*, aptly captures the mood of dissatisfaction and the sense of urgency. The President's New Freedom Commission on Mental Health has declared that "...the mental health delivery system is fragmented and in disarray".

Multiple funding streams now support public mental health care, each with varying eligibility standards, differential access policies, different service obligations and benefits, and sundry appeal processes. This has introduced tremendous complexity into the administration of mental health programs. In addition, mental health related activities are increasingly performed through many other agencies of state and local government, funded by sources outside the control of the formal public mental health system. This produces fragmentation in the state's efforts to address the mental health needs of its citizens. Finally, a significant number of individuals lack health insurance, and those with private coverage often discover that their mental health benefits do not adequately cover services needed by persons with serious mental illnesses.

Increasingly, individuals with significant mental health problems are showing up among the clientele served by other public systems (child welfare, juvenile justice, law enforcement, courts, corrections, education). These other agencies and entities are frequently ill-equipped to deal with such mental health needs, and these settings do not represent adequate or appropriate treatment venues for such conditions.

A recent analysis concluded that access to care for persons with serious mental illnesses has generally been maintained, but access and services for individuals with less severe conditions (which constitute a relatively large group) have declined considerably<sup>1</sup>. Prevention and early intervention services have also been greatly diminished. A key challenge over the next several years will be to devise financing strategies that can enhance access for individuals with less severe disorders and promote prevention and early intervention efforts.

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<sup>1</sup> "Treatment of People with Mental Illness: A Decade-Long Perspective"; David Mechanic and Scott Bilder, *Health Affairs*, July/August 2004