Testimony of Mental Health Association in Mich. to House DHHS Appropriations Subcommittee
10-30-19

Representative Whiteford and Members of the Subcommittee,

I'm Mark Reinstein, President & CEO of the Mental Health Association in Michigan, the state's oldest advocacy organization for persons experiencing mental illness. We have just begun our 84th year. I've been with the agency for almost 37 years, so I've seen and learned a lot.

I commend the subcommittee for the hearings you've been holding. Our publicly funded mental health system greatly needs repair. And when we talk about new ways of doing things, we have to be sure we're actually improving matters, and not accidentally making them worse.

There's been a lot of talk at your hearings about integration. Everyone is for improved behavioral-medical integration at the service delivery level. When it comes to integration at the appropriations level, that's a much more difficult and complicated matter, one that potentially threatens my agency's constituents.

It would appear financial integration can help our constituents with their other medical care needs, and that's important.

What is less clear is whether financial integration helps or hinders our constituents with their behavioral health needs. I found it interesting that the slides of last week's presenter only showed one mental health measurement, and that was a process objective, not one for outcome. Additionally, for a different picture on Arizona than what you heard last week, pleases see the Arizona Daily Star newspaper article I've linked:

https://tucson.com/news/local/tucson-mental-health-providers-owed-millions-in-unpaid-claims-after/article_87a91de8-258e-5275-ad05-734311af8cbf.html

If we turn over control of behavioral health services to for-profit entities with limited mental health experience and demonstrated poor performance in mental health, without even a readiness review of what they are and aren't capable of, are we risking the behavioral well-being of our population?

This is where we had been heading with section 298, now apparently defunct. The department, and undoubtedly some in the Legislature, now want to explore other options. We look forward to the dialogue that will take place.

Maybe in two, five or ten years, things will look a lot different in mental health. But I think we all need to be mindful of where we are right now, and could be for some time. Our Medicaid behavioral system is run through PIHPs and CMHSPs. I don't think we should omit working on making things better in our system right now because of the possibility that things will be structured differently down the road.

We have a lot to work on immediately, and many of these items will still be important whether we have financial integration or not.

Time will only allow me to address six items today. Some of these were endorsed by the department's Section 298 Workgroup and, more recently, seven statewide advocacy groups in a two-part report.

First, our system is too bureaucratic and duplicative. We don't need 10 PIHPs and 46 CMHSPs, all duplicating certain administrative expenditures.

Secondly, for as long as we have some PIHPs covering regions with multiple CMHSPs, we have to take ownership of the PIHPs from the CMHSPs. It is a totally illogical conflict-of-interest to have PIHPs attempting to regulate CMHSPs who own the PIHP. Ownership of PIHPs should rest with counties and/or the state.

Third, there is far too much variability in our system across the state. I call it unequal treatment under the law, simply based on where you happen to live. And there's no guarantee financial integration fixes this. I'll offer two examples today:

A. Section 409 of the Mental Health Code establishes no criteria for CMH preadmission screening units to utilize when assessing the possible need for hospitalization or Assisted Outpatient Treatment. Some people assume the same criteria are used as employed by courts. That is untrue. When we surveyed the CMHSPs six years ago and gave them the three criteria courts have to examine (only one of which has be present) and every possible combination of those criteria, we discovered that over 40% of respondents were not examining all three criteria. This lack of uniformity – this lack of equal treatment based on where you happen to live – can and should be easily remedied by state law.

B. There are three ways someone with serious mental illness can become a public mental health system priority client. The third way is to have one of the most severe forms of serious mental illness or serious emotional disorder. But what the "most severe forms" are has no definition, so every CMHSP must make that decision for itself. Going back to our CMH survey six years ago, when we asked how this is defined locally, there was considerable variability; there was disparate, unequal treatment under the law. Once again, this can and should be fixed by legislation.

Fourth, and this would remain critical under financial integration, how do we improve dispute resolution between a consumer and a service provider/manager? We have a new bill on formal, non-binding mediation moving through the Legislature. That's a good first step. But when it comes to recipient rights, most client action is at the CMH level, and local rights officers work for the CMHSPs – a clear conflict of interest. Lt. Gov. Calley's Mental Health & Wellness Commission recognized that problem six years ago and said we can't allow it to continue.

Fifth, we have to make sure that publicly funded overall health care is accountable and transparent. We have some degree of this in behavioral health because government agencies are involved. Will we have any transparency and accountability if matters are managed by for-profit entities under financial integration? And even within our current governmental structure, we have to do better. For example, we have to assure reporting to DHHS about deaths of behavioral health consumers who are or were receiving public services, and then related reporting and analysis from the department to the Legislature. That is irrespective of what we do with integration.

Lastly, we have to stop relying virtually entirely on private psychiatric hospital and psych units in community hospitals for inpatient stays. The number of these beds has decreased 27% in the last 25 years; these facilities often don't want our constituents; and the average length of stay they offer is less than a week. That is not enough time to effectively stabilize someone with acutely severe mental illness.

The only places that can offer intermediate or longer-term care are the state-operated psychiatric hospitals. We only have four of these – 3 for adults and one for youth. They have about 750 beds, but the adult hospitals are over half-filled with forensic patients and have lengthy waiting lists. In fact, the Treatment Advocacy Center says we're one of the five-worst states in the country for per capita availability of publicly operated adult psychiatric beds for mental illness. And the Treatment Advocacy Center analysis has nothing to do with developmental disability beds, correctional beds, or any other types of beds beyond those operated by states for adult mental illness.

I don't want anyone in a psych hospital who doesn't need to be there. That encompasses most people with mental illness. But with some of our constituents there is no other alternative – either because crisis stabilization didn't work or wasn't available. Are we better off giving someone 20-30 days in a hospital so that psychosocial rehabilitation begins and the consumer has a real shot at beginning recovery, or is it better to constantly shuttle highly disordered persons in and out of repeated short-term hospital stays of 3-6 days, where they're simply shot up with medications and then sent on their way while still partly psychotic, delusional, depressed, manic, or paranoid? That's cruel, unproductive, and ultimately costly.

Thank you.