House DHHS Subcommittee Testimony- Mental Health Funding

Good Morning,

My name is Mac Miller and I am here to provide a perspective on mental health funding and services in the State of Michigan. My perspective arises from my experience and from the experiences of hundreds of consumers in the public mental health system that I have had the privilege to serve. I worked in the public mental health system for 40 years. I began as a social worker at Kalamazoo State Hospital and finished my career as the Director of the Livingston County Community Mental Health Authority for 26 years.

In my career, I have seen good public mental health policy and I have seen bad mental health policy. Good policy improves services for mental health consumers, strengthens the system on which they depend and does no harm. Bad policy harms consumers by reducing access, services, or protections, weakens the system on which consumers depend and does harm whether it was intended or not.

For example, the State of Massachusetts attempted to privatize mental health services. Consumers lost access, services were reduced, providers had difficulty getting paid and the private management company left after 3 years with a 20% profit. Bad policy. Though the jury is still out, Arizona is experiencing similar and significant difficulties with access, delays in provider payments, and provider collapse.

Actions have consequences. The system will change to respond to the contingencies embedded the appropriations. How the system changes has real personal and dramatic consequences for those who depend on it. We need to act carefully and intentionally. **Do no harm!**

Michigan has developed an effective comprehensive community mental health system rooted in county government which provides a

broad range of services and supports to persons with severe and persistent mental illness, developmental disabilities, substance abuse issues, and children with emotional disturbance. Besides providing covered services, it leverages and integrates a huge number of other community resources and supports into consumers' care plans through case management and supports coordination to address the whole person which helps to ensure consumer success. It is integrated community based care and is perceived as best practice.

As the quote says, "Those who do not learn from history are doomed to repeat it." So what lessons has history taught us that must be remembered to avoid repeating costly mistakes?

1) **Measure the value of all ideas by the impact it will have on consumers, their goals and their care, not profit and loss.** The Michigan Constitution says that must be our purpose. When we lose that focus, bad things happen to the vulnerable human beings we are charged to care for and protect.
2) **The business of publicly funded services for the most vulnerable among us needs to be conducted in the open with plenty of light and fresh air.** Shame thrives on darkness and silence behind closed doors. The system has not always been kind to those who rely on it. Incidents of terrible abuse and neglect are part of our history. Don't believe that it can never happen again. Besides fresh air and bright light, recourse to a public political process which assures adequate representation is fundamental to the prevention of more shameful history.
3) **Don't deregulate when regulation protects important values.** To protect the most vulnerable among us, Michigan has developed a robust Recipient Rights system embedded in law designed to empower and protect consumers. It was developed because it

was necessary and it still is. The Rights system must follow the consumers, their services and the public funds wherever they go. Michigan has embedded Person Centered Planning (PCP) in law to assure that the consumer and their goals are at the heart of any plan. Listen to consumers and their families. They are the customers this system is meant to serve. Do not believe that professionals, Health Plans or politicians know what is best for consumers. Only they do: it is their lives we are talking about.

4) **Covered services alone are not enough to do the job for consumers.** While it is very important to appropriate enough to provide the necessary covered services, so much more is required for consumers to enjoy a full and meaningful life in their community as is their right. These services are social supports, not medical care. Case management and supports coordination rooted in each community can access, coordinate, and integrate community resources like housing, food, transportation, jobs, treatment courts, medical care and meaningful social supports. Without leveraging necessary community supports, paid services will fail. Such community systems take years to build. Once destroyed, there is no going back.
5) **Integrated payments do not create integrated care.** Integrated care is desirable but can only occur at the care planning and care delivery level where the consumer and their various care providers can create a team. This is a core competency of the CMH system. Anything else is simply administrative reorganization wearing sheep's clothing. By the way, medical systems are no good at integrated complex care and are famous for their fractured systems which don't talk to each other. You and I both know this from personal experience. We should be focused on pushing as much money down to consumer services as possible,

not recreating expensive and time consuming fee for service claims processing systems and contributing to corporate bottom lines.

6) **Integrated care can be accomplished without integrated payments.** As mentioned before, coordinating an extensive array of community supports to achieve consumer defined outcomes is a core competency of the CMH system. It is unnecessary to consolidate payments to do this and to try may, in fact, create turf wars which impede consumer access to necessary resources. There are administrative barriers to coordinating healthcare. All that is necessary to accomplish integrated care is to permit it, encourage it, incentivize it, and expect it. All else is merely quarreling over control of money.

Finally, a story to make my point. David M. is an actual mental health consumer who lives in Livingston County. If you met him at Starbucks, you would never guess that David spent most of his childhood and early adulthood in a state hospital. You would never guess that David cannot read or write. You would never guess that David has no family. David had his first taste of freedom when he was placed into a group home in Livingston County. His care and residency were eventually transferred to Livingston County. David began to flourish. He got a job and his own apartment. He made friends all over town. He got his own condo. He had significant dental issues and was helped to access dental care. He is on a first name basis with state level advocacy staff. Everybody knows David. He follows the politics of public mental health care with passionate interest. David's greatest fear is that something will happen to destabilize the system on which his sense of wellbeing depends. David is home and doesn't want anybody to rock his boat. David and thousands of others, friends and relatives, are watching.