Mental Health Funding and Services

BACKGROUND

History

The public responsibility for caring for people with mental illness and other mental disabilities was set out in Michigan more than 100 years ago, in the 1850 Michigan Constitution. The state's first mental health institution, the Kalamazoo Asylum for the Insane, received its first patients in 1859, and by 1983 there were others at Pontiac, Traverse City, and Newberry.

When they were established, these institutions were viewed as examples of enlightened public policy. Previously, care for the mentally ill and for people with mental disability had been a family responsibility and sometimes harshly discharged.

The most recent state constitution (1963) also identifies care for this population as an explicit responsibility of the state. Article VIII, section 8 says,

> Institutions, programs, and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise handicapped shall always be fostered and supported.

In practice, the state system for mental health care that has evolved over the years was designed to meet the needs of two very different client populations,

- the *developmentally disabled*—people with mental retardation, autism, cerebral palsy, or epilepsy, and
- the *mentally ill*—adults and children afflicted by such conditions such as schizophrenia, manic-depressive disorder, and serious depression.

For the first half of this century, the capacity of state institutions grew dramatically. Yet, even as the capacity of these institutions reached its peak, forces were at work that would diminish their importance. As a recent Michigan Senate Fiscal Agency analysis shows, in the mid-1960s there were more than 17,000 individuals in state facilities for the mentally ill and over 12,000 in state facilities for the developmentally disabled; by 1997 the populations had dropped to approximately 1,100 and 300, respectively—in total, a roughly 95 percent decline in the state's institutionalized population.

GLOSSARY

Community-based care
Care given mental health patients by community mental health service programs (CMHSPs) and located as near a patient's family as possible; the local program coordinates the diagnosis and treatment of patients and supervises the activities of group homes, adult foster care homes, and assertive community treatment (ACT) programs.

Developmental disability
A mental or physical incapacity, such as mental retardation, autism, or cerebral palsy, that arises before adulthood and usually lasts through life.

Managed care
The effort to "manage," or control, utilization and costs through alternative care-delivery systems and specific management techniques. Health maintenance organizations (HMOs) are a well-known managed-care delivery system; individual case management and utilization review are typical managed-care techniques.

Mental illness
Any mental or emotional disorder that substantially impairs normal life activity. Examples are schizophrenia, acute depression, and manic-depressive illness.

Parity
The proposition that limitations or restrictions on mental health benefits should be no greater than on insurance coverage for other medical services.

Utilization
Patient use of a service.

The decline has occurred not because fewer people are being afflicted or diagnosed but because of court rulings that limit involuntary commitments, dramatic improvements in treatment, and a significant change in how and where society thinks people with these illnesses and conditions should be treated.

Since the mid-1960s there has evolved a general consensus among practitioners and the public that the needs of most mental health patients best can be met in community programs located as close to a patient's family as possible. This treatment mode, broadly termed "community-based care," was incorporated into the Michigan Mental Health Code in 1974 (P.A. 258), with the intent being to allow patients to participate more fully in community life. Public Act 258 established the structure for community mental health boards (CMHBs) throughout the state, and paved the way for local government to play an increasingly important role in mental health care.

Today's Delivery System

As would be expected, deinstitutionalization of the mentally ill and the developmentally disabled has had a profound effect on the structure of the mental health delivery system, its budget, and state employment. Exhibit 1, produced by the Senate Fiscal Agency, summarizes important developments—appropriations, hospital population, staffing levels, and so on—over the past 11 fiscal years.

- From FY 1987–88 through FY 1997–98, gross state appropriations for mental health in Michigan rose by $850 million (current dollars), or 78 percent. General Fund/General Purpose appropriations (the best measure of the State of Michigan's contribution) rose by $287 million, or 38 percent. However, when the effects of inflation and accounting changes are factored in, the increase is much more modest in both cases: 15 percent for gross appropriations and just 2.5 percent for General Fund/General Purpose appropriations.
- By FY 1996–97 the state hospital census had dropped from more than 5,000 to fewer than 2,000, a decline of 62 percent.
- The number of state employees working in a mental health setting declined from over 11,000 full-time equivalents (FTEs) to slightly over 6,000—or 44 percent.
- General Fund/General Purpose appropriations to state institutions declined during the period by approximately 60 percent in real dollar terms.

The mental health delivery system in Michigan today is characterized by a greatly diminished state hospital system and a growing community system; responsibility has devolved from the state to the local level. At present, there are 50 CMHBs (now called community mental health service programs, or CMHSPs, in accordance with recent changes in law) serving the 83 Michigan counties. The CMHSPs coordinate the diagnosis and treatment of patients and supervise the activities of group homes, adult foster care homes, and assertive community treatment (ACT) programs.

Exhibit 2 demonstrates how the local CMHSPs spent their state allocation in FY 1995–96. More than half was expended for programs for developmentally disabled clients, more than a third for mentally ill adults, and less than 10 percent for mentally ill children. Per capita, mentally ill adults fare best, followed by developmentally disabled clients, and mentally ill children are again at the low end.

Facilities

Since 1980 the state has closed 34 state mental health institutions, 17 since 1990. Fiscal year 1996–97 alone saw closure of two facilities for mentally ill adults (Clinton Valley Center, in Pontiac, and Detroit Psychiatric Institute) and one for mentally ill children (Pheasant Ridge, in Kalamazoo), and services were terminated for the developmentally disabled at the Caro Center.

As of the beginning of FY 1997–98, the state roster of facilities was as follows:

- Serving mentally ill adults, with a total planned census of approximately 1,000: Caro Center, Kalamazoo Psychiatric Hospital, Walter Reuther

EXHIBIT 1. Mental Health Appropriations History, FY 1987–88 through FY 1997–98 (dollars in thousands)

	FY 1987–88	FY 1988–89	FY 1989–90	FY 1990–91	FY 1991–92	FY 1992–93	FY 1993–94	FY 1994–95	FY 1995–96	FY 1996–97	FY 1997–98	Adjusted[b] FY 1997–98
FULL-TIME EQUIVALENT POSITIONS	11,030.0	10,786.5	10,436.5	9,529.5	8,071.5	6,247.5	6,719.0	6,489.0	5,803.0	5,957.0	6,225.0	6,225.0
GROSS APPROPRIATION	$1,086,313	$1,160,169	$1,244,457	$1,281,025	$1,316,399	$1,330,512	$1,450,327	$1,524,798	$1,606,778	$1,600,882	$1,936,347	$1,676,347
INTERDEPARTMENTAL GRANTS	799	915	765	830	1,820	3,525	56,771	54,408	71,878	65,957	74,501	74,501
ADJUSTED GROSS APPROPRIATION	1,085,514	1,159,254	1,243,692	1,280,195	1,314,579	1,326,987	1,393,556	1,470,389	1,534,900	1,534,925	1,861,846	1,601,846
Federal	233,687	240,956	276,375	298,886	311,480	337,987	333,262	395,795	450,199	455,158	503,168	503,168
Local[a]	43,468	40,822	41,265	41,816	38,961	34,967	30,615	29,401	26,769	24,349	287,259	27,259
Private								2,200	2,310	2,200	2,200	2,200
State restricted	48,429	45,756	47,914	51,540	53,523	42,967	39,671	31,739	36,767	28,149	22,487	22,487
General Fund/General Purpose	$759,931	$831,720	$878,139	$887,954	$910,615	$911,066	$990,008	$1,011,254	$1,018,855	$1,025,068	$1,046,731	$1,046,731
HOSPITAL POPULATION AT END OF FISCAL YEAR	5,024	4,742	4,046	3,350	2,952	2,734	2,563	2,254	2,158	1,902	NA	NA
Mentally ill adult	2,979	2,838	2,478	2,050	1,933	1,790	1,571	1,286	1,173	952	NA	NA
Mentally ill child	345	391	302	268	252	256	181	117	117	115	NA	NA
Developmentally disabled	1,385	1,176	978	768	522	476	412	402	352	318	NA	NA
Other facilities (forensic, etc.)	315	337	288	264	245	212	399	449	516	517	NA	NA
GF/GP APPROPRIATION FOR INSTITUTIONS[c]	$380,756	$403,728	$438,406	$441,977	$433,600	$371,614	$333,936	$340,260	$290,832	$281,076	$202,198	$202,198
Percentage of total GF/GP budget	50.1%	48.5%	49.9%	49.8%	47.6%	40.8%	33.7%	33.6%	28.5%	27.4%	19.3%	19.3%
DETROIT CPI IN CALENDAR YEAR	114.7	120.8	126.5	131.1	133.4	135.2	138.7	143.6	147.3	150.7	154.0	154.0
GF/GP INSTITUTIONAL APPROPRIATIONS	$380,756	$383,341	$397,511	$386,687	$372,818	$315,267	$276,153	$271,781	$226,414	$213,899	$150,561	$150,598
GROSS APPROPRIATIONS IN 1988	1,086,313	1,101,584	1,128,373	1,120,774	1,131,866	1,128,770	1,199,369	1,217,927	1,250,886	1,218,275	1,441,844	1,248,552
GF/GP APPROPRIATIONS IN 1988	759,931	789,721	796,226	776,875	782,965	772,924	818,702	807,736	793,184	780,079	779,418	779,418

SOURCE: Senate Fiscal Agency, 1997.

[a] *Amount in "local" for FYs prior to FY 1994–95 combines both local and private.*

[b] *"Adjusted" means removing $260 million from the gross and local fund sources to keep the accounting for FY 1997–98 comparable to accounting in prior years.*

[c] *Due to declining census, GF/GP appropriation for institutions almost is always higher than the actual final spending; however, year-to-year comparisons usually are fairly accurate. This appropriation includes the Forensic Center.*

NA = Not available.

EXHIBIT 2. CMHSP Expenditures, by Client Category, FY 1995–96

Category	Expenditures (millions)	Percentage of Total	Per Capita Expenditures
Mentally ill adults	$485.6	39.9%	$69.18
Mentally ill children	102.3	8.4	40.60
Developmentally disabled	630.0	51.7	65.97
ALL CATEGORIES	1,218.0	100.0%	$127.54

SOURCE: Michigan Department of Community Health, 1997.

Psychiatric Hospital (Westland), and Northville Psychiatric Hospital

- Serving mentally ill children, with a total planned census of approximately 100: Hawthorn Center (Northville)
- Serving developmentally disabled clients, with a total planned census of approximately 300: Mt. Pleasant Center and Southgate Center

The state system is reinforced by a large system of private hospital care. As of May 1997, 127 private institutions in 38 counties offered a total of 5,100 hospital beds for psychiatric care. Just under 1,000 of these private beds were reserved for children.

DISCUSSION

Without question, in years to come the mid-1990s will be viewed as a watershed in the history of the Michigan mental health system. In addition to continued state hospital closures, five significant public policy events took place from 1995 to 1997, and their combined effect likely will influence state mental health policy debate for some time to come.

- During 1995 the first major revision of the state Mental Health Code in more than 20 years was completed. Public Act 290 of 1995 is a massive and complicated piece of legislation which, among its other accomplishments, moved the state even more vigorously in the direction of community-based care, set new treatment priorities, specified important new consumer rights, and established new accreditation requirements for CMHSPs.
- In 1996 all state mental health functions moved into the newly created Michigan Department of Community Health (MDCH). The new department subsumed health-related functions previously in the departments of Mental Health and Public Health as well as the Michigan Medicaid program.
- For FY 1996–97 the state employed a new funding formula for CMHSPs that uses sophisticated statistical projections to estimate the number of mentally ill, developmentally disabled, uninsured, and Medicaid patients in each CMHSP "catchment" area.
- Since 1995 Michigan state government has been embarked on an ambitious "managed-care program" for mentally ill and developmentally disabled Medicaid recipients. In the future, state officials plan to move toward an even more aggressive system in which the CMHSPs themselves will be forced to compete with other provider systems for management contracts.
- In 1996 Congress passed the Mental Health Parity Act, which prohibits health insurance plans from placing annual or lifetime limits on payments for mental health benefits if the limits are more stringent than those imposed on regular medical benefits.

Although the Mental Health Code revision and the reorganization of state departments were major issues during 1995 and 1996, they appear to have become less controversial with the passage of time. For instance, the fear, expressed by some advocacy groups, that mental health services would become the "neglected stepchild" of the newly created "super" department, seems not to have been borne out. Similarly, there appears to be broad agreement that the code revisions for the most part are working as intended.

The issue of continued state hospital closures remains contentious. The MDCH, Engler administration, and such supporters as the Michigan Association of Community Mental Health Boards view the recent closures as a difficult but necessary choice. They see the declining patient population as making closure a pru-

dent means of conserving resources and taxpayer dollars. Furthermore, the MDCH and its allies argued that private hospital beds are available to take up any slack created by state hospital closures.

The closings have been opposed by various advocacy groups, including the Michigan Association for Children with Emotional Disturbances and Alliance for the Mentally Ill in Michigan, both of which took the state to court over various aspects of the issue. The Michigan Psychiatric Society and the Mental Health Association in Michigan also opposed the 1997 round of closings, as did a committee of the Michigan House of Representatives.

These groups, individually and in combination, advance a number of arguments against closure. In the view of some, the declining census in state hospitals is more the creation of state budget cutters than of improved community-based treatment. They argue further that vulnerable populations, including children and adults with severe, long-term psychiatric problems are being deprived of services, and the private sector is not, in fact, positioned to meet these particular needs. Some closure opponents argue that patients who are denied adequate treatment through the state mental health system often became a state responsibility in another way—e.g., the criminal justice system; they point out that the *Detroit News* reports that from 1993 to 1997 the number of Michigan prison inmates who had been state mental-hospital patients grew by nearly 500, up 25 percent.

In September 1997, opponents of closure were temporarily gratified when a Wayne County Circuit Court judge issued a permanent injunction against closure of three state hospitals on the ground that it would violate state constitutional requirements that the state foster and support mental health institutions, programs, and services. The MDCH immediately appealed and was granted at least partial relief by the Michigan Court of Appeals, which allowed the department to proceed with the closures but agreed to rule on the constitutional issues at a later date. At this writing, the ruling has not been issued.

While the issue of hospital closure dominates much of the press coverage, the state's commitment to competitive managed care within the state mental health system may have greater long-term consequences. Although mental health advocate groups believe that managed care can, in principle, work well for low-income mental health patients, and although they are unaware of major problems with it now, they have three areas of general concern: whether (1) there are adequate data to properly evaluate the effects of managed care, (2) there is sufficient opportunity for consumer input into the system, and (3) the private companies who may be allowed to bid for management contracts have the experience necessary to deliver care to mental health patients.

It is, however, impossible to over-emphasize the fact that the long-term plan for a highly competitive system contains the seeds of more radical change. As the Citizens Research Council of Michigan recently noted, in an era of open competition, the continued success of CMHSPs will depend on their ability to compete, with a "substantial prospect" existing for the privatization of mental health service delivery in parts of the state.

Finally, the federal Mental Health Parity Act will affect state employers and is of great importance to mental health practitioners and to mental health patient advocate groups. Employers and insurers generally oppose health-insurance mandates of all sorts on the ground that they inevitably restrict choice and raise costs. Many also oppose mental health parity legislation because they are skeptical of their ability to control utilization and costs in a system characterized by rapid change and an explosive increase in the number of officially recognized diagnoses.

Proponents of parity argue that diagnosis and treatment of mental illness is every bit as precise and effective as that of other medical conditions. Where others see baffling change, parity supporters see the field as a maturing specialty and forecast more effective treatment. They argue that current arrangements often are blatantly discriminatory against mental

health services—a circumstance that they see as unfair to patients and practitioners and costly to society to the degree that treatable conditions are allowed to become worse.

The debate is likely to intensify in 1998 with introduction of a "mental health parity package." The bills, which are slated for introduction in May, would amend the state Insurance Code as well as laws governing the operations of HMOs and Blue Cross and Blue Shield of Michigan, to ensure that people with mental illness or substance abuse problems do not face a financial burden greater then those with traditional health problems. Another bill would amend the Michigan Handicapper Civil Rights Law to make discrimination illegal under that statute as well. The parity package is supported by the state's major mental health professional and advocacy groups.

See also Devolution; Domestic Violence; Health Care Costs and Managed Care; Special Education.

FOR ADDITIONAL INFORMATION

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