Michigan Department of Community Health

Mental Health and Substance Abuse Administration

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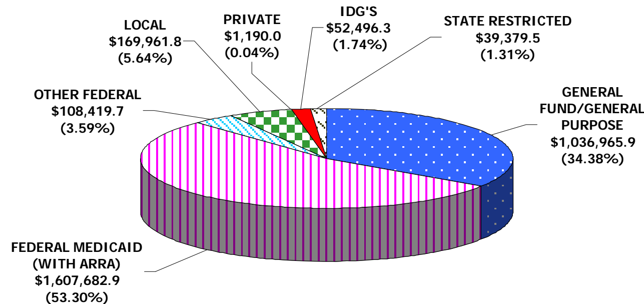
March 4, 2010

FY2011 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES EXECUTIVE RECOMMENDATION BY REVENUE SOURCE



TOTAL $3,016,096.1

2

Mission

Michigan's public mental health system will serve citizens by diminishing the impact and incidence of developmental disability, emotional disturbance and mental illness

Michigan's public substance abuse prevention and treatment system will promote wellness, strengthen communities and facilitate recovery for the people of Michigan

3

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." ..."treatment suited to condition"

-- "that a person-centered planning process is used to develop a written plan of services in partnership with the recipient"

4

Mental Health System Overview

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 Services and Supports Waiver for Mental Health and Substance Abuse Services

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
- Facility-based Intermediate Care (ICF) unit for persons with developmental disabilities at Caro
- Mental Health Services to prison inmates under an interagency agreement with DOC

5

Transition to Community Services

1965	1991	2010
12 County Community Mental Health Boards covering 16 counties; 7 in the planning process	55 Community Mental Health Boards covering all 83 counties	46 Community Mental Health Services Programs covering 83 counties
41 state operated psychiatric hospitals and centers for persons with developmental disabilities – about 29,000 residents	20 state psychiatric hospitals and centers for persons with developmental disabilities – total census: 3,054	5 state operated hospitals and centers; on Feb 24, 2010 with a resident census of 818

6

STATE-OPERATED SERVICES

7

Corrections Mental Health Program

- Provides mental health services to prisoners incarcerated in Department Of Corrections (DOC) facilities through an Interdepartmental Grant from DOC
- DOC retains responsibility for ensuring that these services are provided; DCH is their services provider
- The total average mental health caseload was over 6,000 prisoners in FY09
- Mental Health Department/Administration has provided services to inmates since 1992 under an interdepartmental agreement
- Prisoner re-entry support for individuals with mental illness issues is managed through this program

8

Hospitals and Centers

Adult Hospitals:

Caro (144)
Reuther (233)
Kalamazoo (174)

Forensic

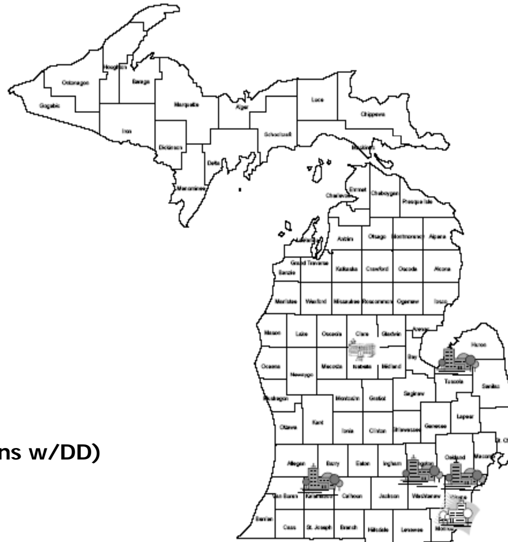
CFP (196)

Children

Hawthorn (58)

ICF Capacity **(Persons w/DD)**

Caro (13)



February 24, 2010

9

Hospital/Center Role

Primarily function as tertiary center of care for most challenging and difficult to treat clinical problems

- Psychiatric hospitals-high proportion of individuals with:
  history of justice involvement as IST, NGRI or probated NGRI
  40% resident population - 243 individuals - 9/30/2004
  49% resident population - 254 individuals - 9/30/2009
  (excludes Center for Forensic Psychiatry)
- Hawthorn- children's psychiatric facility which provides short term intensive diagnostic and clinical services and longer-term (~ 28 day average length of stay) 70-80% of utilization is by Wayne county residents
- Forensic Center-state's mental health treatment and diagnostic center for those charged with a crime and needing assessment, or treatment to be able to participate in their defense (IST), as well as initial care for those deemed NGRI
  - 3,700 forensic evaluations in 2009; daily ave census of 214

10

Challenges

Quality Standard of Practice

--maintaining accreditation and certification

--striving to maintain and improve clinical standards

Infrastructure

--seriously outdated technological infrastructure …paper record system; data systems dating to the 1970's

--aging physical plant not compatible with current patient population

Aging Work Force and Retirement Eligibility

--3 of the 4 hospital directors, and the head of the corrections program are eligible for retirement; similar %'s for clinical and hospital leadership

--overall, 18% of all hospital staff eligible to retire, but ranges from 10-29% depending on the hospital

Admissions Pressure

--Psych Hospital admissions were up 5% between FY08 and FY09—to 752

--Hawthorn admissions increased by 30% in FY09 while average weekly census was 56

11

FY09 Mt Pleasant Closure September 10, 2009

Employees

--406 at closure announcement

--100 retired

--157 accepted transfers within the state

--173 were laid off; of these 28 recalled to state employment (to date)

Physical Plant

--declared surplus on 9/30/2009

--winterization and complete shut down 1/29/2010

--24/7 site security will be provided until final disposition

12

Mt Pleasant Alternatives, ICF Capacity and Monitoring

- 120 residents were transitioned to the community beginning in 2007
- Today, 13 individuals reside at Caro in the ICF unit; all have community placement plans in varying degrees of development;
- The ICF unit at Caro will remain in place while CMHSPs develop an enhanced capacity to provide community-based care for individuals with developmental disabilities and complex care needs

13

Life in the Community

MPC discharge activities and post-discharge experiences confirmed what we knew:

- Success is dependent upon good transition planning where individual, family, the CMHSP and future caregivers are involved
- Small settings work best for people who have complex needs
- Keeping people engaged in activities reduces boredom and the drift toward behaviors
- Caregiver training and continuous support from CMHSP to the caregivers are essential
- Ongoing monitoring is necessary

14

Assuring Community Capacity

- DCH continues to monitor the care of the people who were discharged
- DCH provides training to caregivers in how to manage challenging behaviors through support, active engagement, and relationships rather than control and force. Almost 3,000 CMHSP and provider staff have received training, and more in-depth support such as Mentoring'
- The "safety net" services designed to respond to crises that the local CMHSP is unable to handle includes consultation and mobile crisis and a transition home that allows stays up to 45 days to analyze the needs of the person and train his/her caregivers.

Making a Difference: Stories

- Bobby moved in and out of institutions and group home settings for decades because of his distrust of staff and his violent behavior; since his discharge, he is able to get outside of his home and enjoy life. Bobby says that he is happy.
- Thomas spent 30 years in of Michigan's institutions. He needed constant surveillance because of Pica, seizures and aggression; and had stopped talking and walking. Since his discharge, he has begun walking; his seizures are under control and staff have helped him control the pica and eat real food. Thomas has formed relationships with the staff, his roommates, and his sister who says that she would have never believed it could happen, but Thomas is clearly happy now.
- Scott lived in a succession of institutions and group homes. He spent his days in bed, refused to eat with others, and wouldn't communicate. Since moving into a home where he is treated with gentleness, he's come out of his shell. He takes his naps in the living room, and while he is not talking, communicates with his caregivers. He is calm and appears content.

Community Mental Health

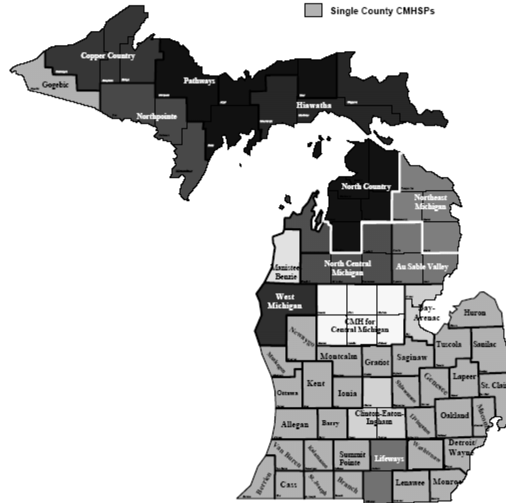
Community Mental Health Service Structure

Community Mental Health Services Programs (CMHSPs) established under the Mental Health Code as county entities or local authorities-administer state general fund-financed services, MI Child, Children's DD and Severely Emotionally Disturbed Waivers. The ABW waiver administration is planned to transition to PIHPs in FY10.

Medicaid Prepaid Inpatient Health Plans (PIHPs) consisting of one or more CMHSPs administer the concurrent 1915(b) (c) Medicaid Specialty Services and Supports Managed Care Waiver for Mental Health and Substance Abuse services functioning as managed care entities.

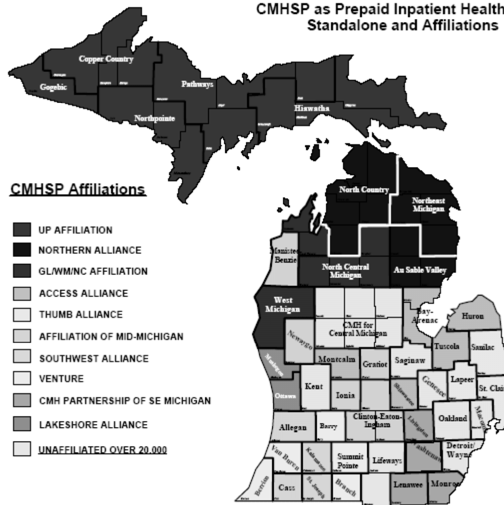
46 CMHSP Boards

Community Mental Health Services Programs

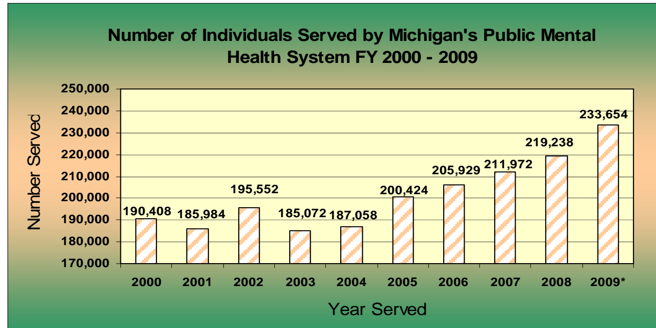


CMHSP Affiliations: 18 PIHPs

CMHSP as Prepaid Inpatient Health Plans
Standalone and Affiliations



CMHSPs
Persons Served



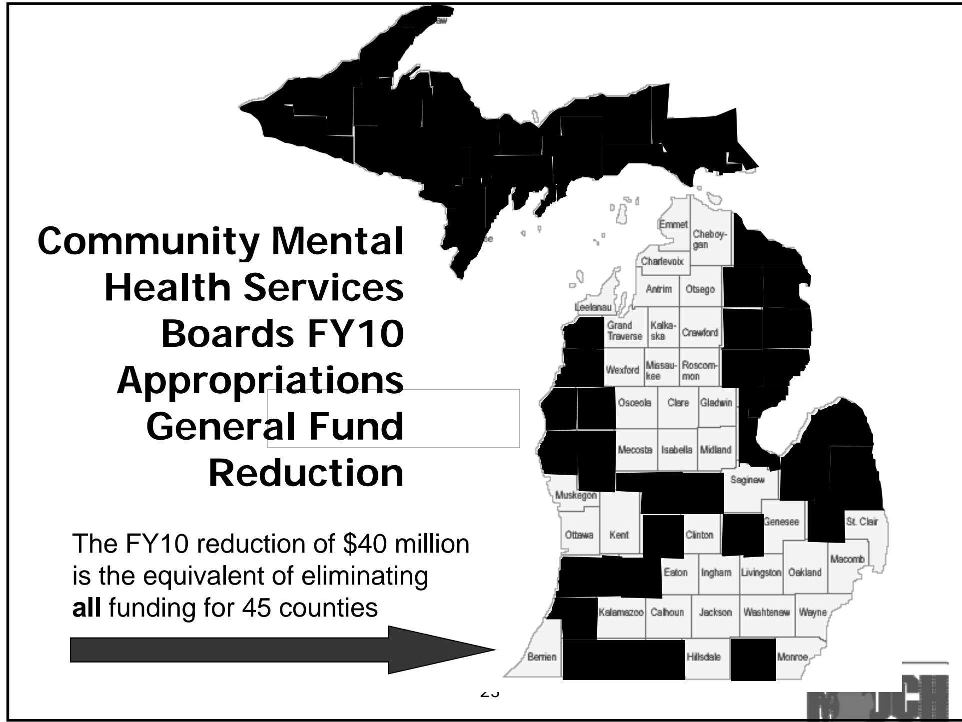
26.0% Increase in CHMSPs Persons Served FY 09 Compared to FY 03 - Due to Increase in Persons With Mental Illness Needs

Fiscal Year	Individuals with Mental Illness		Individuals with a Developmental Disability		Dual Diagnosis DD/MI		Missing or Unknown		Total Served	
	N	%	N	%	N	%	N	%	N	%
2000	151,084	79.3%	30,154	15.8%	----	----	9,170	4.8%	190,408	100%
2001	135,964	73.1%	33,199	17.9%	5,953	3.2%	10,868	5.8%	185,984	100%
2002	155,300	79.4%	25,725	13.2%	6,260	3.2%	8,267	4.2%	195,552	100%
2003	140,157	75.7%	26,846	14.5%	7,108	3.8%	10,961	5.9%	185,072	100%
2004	144,435	77.2%	25,977	13.9%	2,350	1.3%	7,344	3.9%	187,058	100%
2005	158,412	79.0%	27,807	13.9%	7,183	3.6%	5,031	2.5%	200,424	100%
2006	163,546	79.4%	27,037	13.1%	9,470	4.6%	5,876	2.9%	205,929	100%
2007	166,524	78.6%	27,448	12.9%	10,273	4.8%	7,727	3.6%	211,972	100%
2008	173,069	78.9%	29,516	13.5%	9,614	4.4%	7,039	3.2%	219,238	100%
2009*	185,839	79.6%	28,965	12.4%	11,231	4.8%	7,619	3.4%	233,654	100%

2009 figures are preliminary

Erosion of Service Capacity

- Inflation factored against flat GF funding over the years has eroded CMHSP capacity…by over $70M between FY04 and FY09
- Coupled with the FY10 reduction of $40M – this represents a 33% loss of service capacity in comparison to the FY04 appropriation



The Community Mental Health System as a Safety Net

CMHSPs provide services to:

- **13,000** who are reliant on the cmh system for at least 8 hours of care/per day…of these, 11,500 – 23 hrs;
- **19,100** receiving community psychiatric inpatient hospital services
- **5,400** persons a year who are homeless
- **20,000** persons who have some justice involvement-diverted from jail; awaiting trial, under court supervision, etc.

24

What CMHSPs "Must Do"

- The success of CMHSP services rest with the availability of a range of services that promote recovery and community membership; that support families and that are premised on effective models of practice.
- When demand overwhelms the system, or reductions eliminate those supportive services then expenditures are driven to toward emergency and crisis services
- Each CMHSP has GF costs associated with supporting Medicaid entitlements...these include: services during the spend down period; costs associated with delays in Medicaid eligibility determinations; Medicare coordination of benefit obligations for community inpatient services; and local match obligations within the Medicaid match agreement

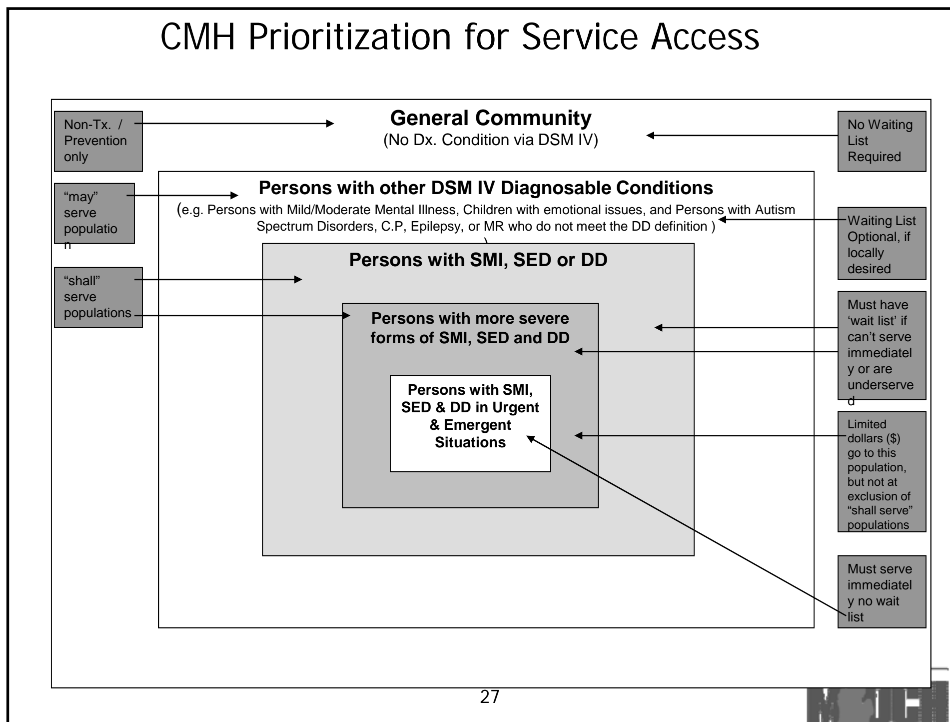
Waiting Lists and Service Priorities

- To develop consistency in the application of service priorities, waiting list standards have been developed
- The mental health code establishes service priorities..."priority" means preference for, and dedication of a major proportion of resources to specified populations or services 330.1100(c)(6)

  --that is: 1) persons in emergent (crisis situations) and 2) persons with more severe forms of SMI, SED, and DD

  --and, **if** funding exists: 3) persons with SMI, SED, DD 4) persons with other DSM IV Diagnosable conditions....e.g. mild/moderate mental illness, etc and 5) the general community including prevention

CMH Prioritization for Service Access



CMHSPs Cost Increases; Provider Reductions

GF Cost Increases

- increased community inpatient admissions and—in some parts of the state--community inpatient hospital rate increases as well
- rising residential costs
- reductions in SA services such as detox resulting in psychiatric crisis service utilization
- delays in both initial Medicaid eligibility determinations and in spend down determinations increasing CMHSP GF costs

New Costs

- Some CMHSPs are providing GF match to allow additional DHS eligibility determination workers dedicated to MH consumers

Provider Reductions

- frozen or reductions in rates;
- tightened consumer eligibility criteria reducing provider revenue
- non-renewal of contracts
- Provider-Layoffs, not filling vacancies; freezing staff pay

Changes in Eligibility Criteria and Limiting Services

- Reductions in the services that are provided (e.g. benefit plan)
- Significant increases in Waiting Lists
- Terminating services to current consumers except for individuals deemed to be most severe or with an emergency/urgent need
- Delayed and denied access to services

29

CMHSP Administrative Reductions

Administrative Reductions/Savings include:

- staff furloughs
- freeze on hiring;
- implementing training and contract monitoring reciprocity across PIHPs/CMHSPs
- implementing efficiencies such as electronic medical records
- increased shared services across CMHSPs

30

GF Reductions-Community Impact

- GF reductions have reduced the CMHSP capacity for local collaboration and partnerships such as:
- eliminating programs/services such as school based prevention;
- Eliminating CMHSP "match" for local grants/programs
- Closing drop in and peer support/outreach services
- Eliminating local funding support for multi-cultural programs
- Early termination of best practice initiatives such as integrating physical and mental health

31

Children's Services-Collaboration

- Collaboration with DHS Child Welfare Services
  - DHS is driven by the Children's Rights Lawsuit consent agreement
  - SED Waiver
    - Initially in five pilot Counties: Saginaw, Ingham, Oakland, Macomb, & Kalamazoo beginning in September
    - Expansion counties: Wayne, Genesee & Kent
    - Supports CW wards in out-of-home placements, to be supported in a home setting (natural or foster care) using wrap-around services
    - Child must be deemed to otherwise, in need of inpatient psychiatric hospital care
  - Examining the feasibility of utilizing ~ $1.50 M in DHS funds to expand wrap-around services outside of the SED waiver to support additional children, not at the threshold of needing hospital care, to move to a home setting
    - Lots of complications but the partners commitment to pursue this is strong
  - Discussions continue on modifying the DHS local services contracting process to support expanded contracting with CMHSPs for local DHS-funded counseling services

32

Substance Use Disorders

33

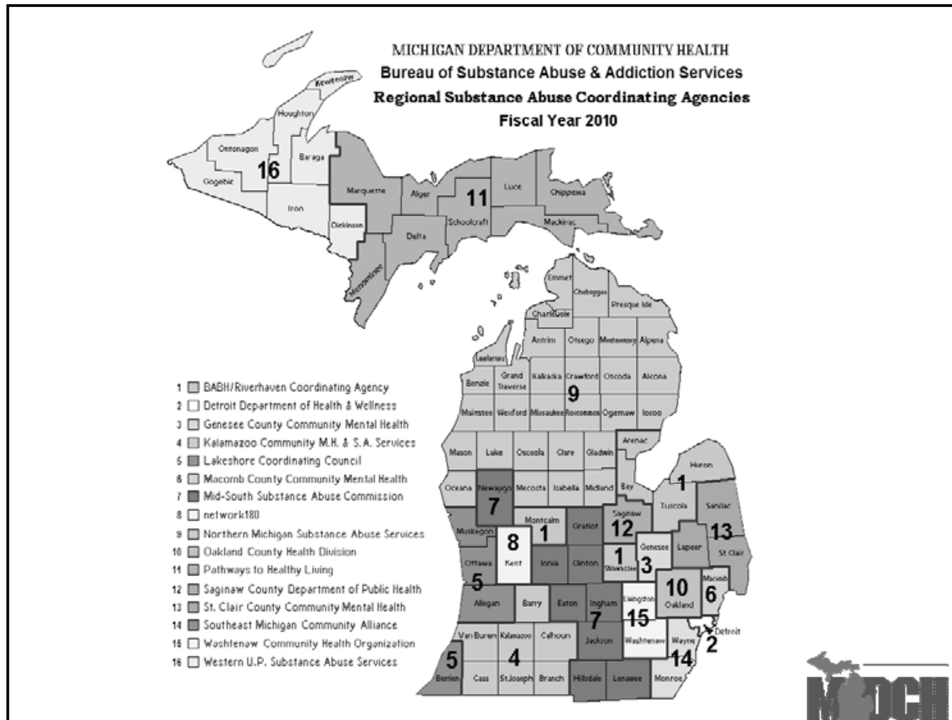
Substance Abuse Services

DCH is the state authority under Article 6 of the Public Health Code which governs the provision of Substance Abuse services and establishes the Substance Abuse Coordinating Agency and its responsibilities.

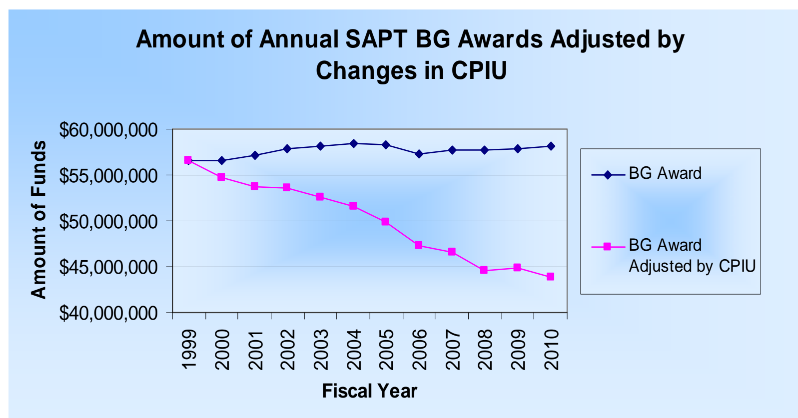
The Bureau of Substance Abuse and Addiction Services within the Mental Health and Substance Abuse Administration implements these responsibilities

Services are provided through the 16 Regional Substance Abuse Coordinating Agencies. Of these, Eight are community mental health agencies; Three are public health agencies and Five are free-standing, non-profit agencies

34



Erosion of Federal Spending Power



The inflation-adjusted value of the federal SAPT Block Grant funds decreased by $12.6 million between fiscal years 1999 and 2010.

36

Treatment Gap

- 744,000 Michigan residents are estimated to meet clinical criteria for substance use disorder treatment services, but have not received those services in the last year.
- Of those Michigan residents, 47,000 (6.3%) are estimated to feel that they are in need of substance use disorder treatment services.
- Of those, 30,000 (67%) are estimated to be eligible for, and would access services from, state funded programs.

Estimates are derived from the National Survey on Drug Use and Health for Michigan residents age 12 and above, and Michigan population estimates for 2006.

37

When Available, Treatment Works and Prevention Matters

- In FY09 567 women were pregnant at admission; 252 infants were born drug free. Using a conservative estimate of health care costs for substance exposed infants during their first year of life, these substance-free births resulted in a savings to Michigan of $12.6 million

- All 16 CAs show positive treatment outcomes in: Abstinence/Reduction in Use; Increased Employment; Reduced Homelessness; Reduction in Arrests and Increased Social Support via Self Help Groups like AA and NA

- In 2009, the Synar (tobacco sales to minors) survey rate of 14.1% was the lowest to date.

- Prevention services were provided to over 600,000 residents in Michigan during FY 2009

38

Funding and Service Statistics

- Total admissions in FY09 69,832--down from FY08.

  GF Reductions included 8% in FY09 and an additional 12% reduction in FY10 although state restricted funds offset about half the reduction. These state restricted funds have been exhausted.

- Since FY09 GF support for substance abuse programs including the SDA (room and board) program have been reduced from $19.9 M to $12.1 M
  - --Representing 3,800 treatment admissions and 93,000 days of room and board support
- Heroin and Other Opiates (including illicit methadone) have both seen persistent and steady increases over the last 10 years.

- Those Unemployed and receiving treatment have increased annually from 55% in 2005 to the current 62%.

39

MAJOR INITIATIVE: RECOVERY ORIENTED SYSTEM OF CARE

- Recovery oriented systems of care (ROSC) are networks of formal and informal services to sustain long-term recovery for individuals and families impacted by substance use disorders.
- Michigan has begun a process of transforming its SUD prevention and treatment network to foster recovery services and supports that:
-
  - Focus on building on individual and community assets, as well as making use of existing resources.
  - Integrate peer and community supports with treatment services.
  - Increase the importance of prevention as a means of sustaining community health.

40

RECOVERY ORIENTED SYSTEM OF CARE (continued)

- Partnership is crucial. We have established a ROSC Transformation Steering Committee with memberships of important stakeholder groups, including coordinating agencies, providers, mental health agencies, MDOC, courts, persons in recovery, and others.
- This initiative won't require additional funds, but it will require making very careful use of existing resources.

41

Integrated Treatment Initiatives

- **Accomplished through partnership with Mental Health.**
- **Established an Integrated Treatment Committee:**
  - Led by members of BSAAS, CMH Bureau, Coordinating Agencies, and PIHPs
  - Members from key state agencies and service providers throughout the state.
  - Assists regional authorities in developing and establishing integrated treatment services.
  - Provides a direct line of communication to and from the field

- **Pilot project to provide services to individuals with both a substance use disorder and a mental health disorder, which is not severe enough to receive priority treatment in the mental health system.**
  - Second and final year of the projects.
  - Requires CA and CMHSP partnership.
  - Over 500 clients served.
  - Largest need is access to psychiatric services for this population.

42

Problem Gambling in Michigan

- In FY2009, the problem gambling help-line provided referrals for problem gambling assistance to 2,041 callers.
- In FY 2009, treatment for gambling problems was provided for 472 persons.
- In FY2009, four coordinating agencies participated in two pilots to provide problem gambling prevention and treatment services using the substance abuse network. Service areas included mid-, northern-, and upper-Michigan counties, and provided problem gambling treatment services to 119 persons.

43

FY11 Executive Budget

Key Changes

- **Increase Psychiatric Hospital Rate Adjustor – PIHPs**
  - $16.0 million Gross Increase / $2.9 million GF/GP Savings
  - Savings achieved from Hospital QAAP retainer and Use Tax - GF/GP savings
- **Annualize FY2010 Mental Health Services to Corrections**
  - $2,168.8 IDG – 6 Outpatient Teams
  - $566.2 IDG – Residential Treatment Program
- **Recognize Transfer of ODCP to MSP and DOE**
  - $11,747.0 Gross
  - 10.0 FTEs
  - Will occur in FY2010

REDUCTIONS

- Eliminate Child Day Care Expulsion Program (Through DHS Child Care Development Fund)
  - $1,000.0 Gross
- Eliminate Transitional Medicaid Assistance Plus Program (950 Beneficiaries)
  - $164.3 GF/GP
- Freeze/Reduce Enrollment in Medicaid Mental Health HAB C Waiver (300 slots)
  - $8,634.6 Gross $2,320.1GF/GP
- Administrative Reduction - CMHSPs Non-Medicaid Mental Health Services
  - $3,797.9 GF/GP
- Reduce Mental Health Multicultural Services by 20%
  - $1,364.8 GF/GP
- Eliminate State Disability Assistance Program Substance Abuse Services
  - $2,243.1 GF/GP
  - Loss of 81,500 days of room/board support
- Reduce Substance Abuse Services GF by 12% (20% Administrative & 10% Services)
  - $1,636.1 GF/GP
  - Loss of service capacity for 920 clients