

Comments of Mark Reinstein, Mental Health Assn. in Mich.,  
to 2013 Mental Health Commission, April 23, 2013

I.t. Governor Calley and Members of the Commission,

Thank you for this opportunity to provide input.

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 are partly funded by local United Ways and affiliated with Mental Health America. I have worked in the mental health arena for over 30 years and served on the state's last mental health commission.

We have one treatment gap in Michigan that overshadows all others. There are thousands, if not tens of thousands, of persons with severe mental illness whom we can't identify and reach out to, or if we can, we're unable to get them to enter and stick with treatment that meets their clinical needs. Thus, we have an overflow of adults and minors with mental illness in justice systems; we have a significant portion of the homeless population coming from mental illness ranks; and we have too many with mental illness dying prematurely; winding up otherwise hurt; or, in a small minority of cases, hurting someone else.

There are multiple factors that have contributed to this situation. Below are some of them.

We have one of the country's five-lowest per capita ratios of state-operated psychiatric hospital beds, and these are the only hospital beds where someone can get longer than acute care. Additionally, most of our state beds are filled with forensic inpatients, which means for almost all of the non-criminalized public, their only shot at the highest level of intensive care is a stay of one week or less at a private or community hospital.

Often, our most serious constituents bounce around different systems and go in and out of varying manners of treatment. Many times, they do not believe or accept that they have a disorder of mood or thought. Our civil commitment laws aren't effective enough to meet the challenges of some cases, and our state doesn't currently make full use of all the tools that are in place. One example is assisted outpatient treatment law that took effect in 2005 but has never received appropriations to support its use. Oakland County officials report this mechanism has been a regularly used and beneficial tool, but no other county in the state consistently employs it.

We have a public mental health system that has become heavily dependent on Medicaid, and historically those with mental illness have qualified for Medicaid at significantly lower rates than those with developmental disabilities. (Medicaid expansion would help with that to some degree, but we don't know if Michigan will opt for expansion, nor the precise degree of relief it would bring.) This is one of the

reasons for the huge historical gap in what the public system has spent on these respective populations: over \$25,000 annually per developmental disability client and less than \$5,000 annually per mental illness client (with youth mental illness clients the lowest funded of all). This is not to suggest that developmental disability services are over-funded, or that the two populations should be funded at exactly the same proportions. I'm simply suggesting that \$5,000 annually per mental illness client is not sufficient if, as our public mental health system claims, it is only serving severe cases.

A 1990s study of 1,900 Wisconsin residents with serious mental illness found that the annual public mental health expenditure per client was \$11,000. That figure *would be considerably higher today. In fact, last year Virginia's Inspector General for Behavioral Health and Developmental Services projected that annual community costs for challenging mental illness cases should run between \$22,000-44,000 per person, after factoring out "federal subsidies."*

A critical issue becomes: Are we really only serving severe mental illness cases? The annual demographic reporting on diagnoses from the public mental health system suggests that we're some distance from doing so. This calls into question whether our highly decentralized public mental health system makes the same sense for the 21<sup>st</sup> century as it did 30 and 40 years ago. Do we need 46 Community Mental Health Programs, regardless of whether or not they're categorized as parts of regions? Should there be local variability, as there is now, of who does or doesn't get served – and how they're assessed and responded to – in a system that's almost entirely state-funded? Should recipient rights and second opinion mechanisms be controlled by the system's service managers, as they are now, or would independent mechanisms that are free from conflict-of-interest better serve consumers and families while also improving accountability?

Finally, our public mental health has been extra-burdened by the fact we're one of the few states without a mental health insurance parity law. The 2008 national parity law excluded too many otherwise privately insured people, and the parity implications of the Affordable Care Act's implementation are still being analyzed by many parties, including the Michigan Partners for Parity coalition, which hopes to soon have out recommendations on how Michigan should proceed.

These are just a few of the issues we hope you'll consider in your important work. I wish you the best and would welcome other opportunities to make additional comment.

Thank you.