CMHA Governance and Leadership Development Program

Boardworks Foundations
2. Public Policy

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Learning Objectives

1) Understand "policy" and its levels
2) Understand the history of mental health policy and/or answer the question, "How did we get to where we are today?"
3) Understand the role of the CMH Board in local policy setting
4) Understand the interplay between how we view consumers, funding and policy setting

Why we should be involved in Public Policy?

Mental Health America states:

"policy should ask people what they need to live the lives they want and support them in getting there.

...There is nothing more important than allowing everyone, and those they care about, the chance to live the life they want with meaningful roles in the community"

Unfortunately, that fight for true parity continues.

We need to be the voice for those often, voiceless to ensure that mental health is prioritized at the same level we prioritize physical health care.

Levels of Policy

Agency policy:	CMHSP/PIHP Boards
	Ex: Conflict of Interest
Local policy:	County commissions; Local municipalities
	Ex: Zoning
State Policy:	Governor, Legislature, Depts.
	Ex: Person Centered Planning
Federal Policy:	President, Legislature, Depts.
	Ex. Community Mental Health Act

Four Factors that Impact Policy

1. **Political Principles** – policy decision based on philosophy of proper role of government in society -
2. **Resources** – increasing or decreasing revenues; general vs. targeted -
3. **Knowledge/Research Data Base** – Evidence-based practices
4. **Implementation Expertise** – skills and operations of the care providers; provider networks

Dimensions of Policy

Level

1) Federal
2) State
3) Local

Areas of Impact

1) Consumer Perspective
2) Services Available
3) Funding Mechanisms
4) Governance/Policy Setting

Analysis of Policy Development in Michigan

- Looking at Policy-related issues across these dimensions on a decade-by-decade basis.
- What have been/are some of the major policy changes along these dimensions?
- How have these changes impacted consumers? Providers? CMH Boards?
- What do we think are/may be future trends?

The 1950s and 60s

	Federal Level	State Level	Local Level
Consumer Perspective	Mental Illness viewed as moral problem with incredible stigma (50s) Consumer as patient and we do for the consumer (60s)	Research subjects no civil rights (50s) Deinstitutionalization with very few services in the community (60s)	• Isolated from the community (50s) • Child Guidance Clinics developed • Psychoanalytic treatment (60s) • Lack of needed services • No or limited planning upon release
Services Available	Initiation of community based care model and advent of psychotropic medication (50s) Expectation that five then twelve services to be provided in states and local communities (60s)	State Facilities and psychotropic medication (50s) Inpatient Care with Preadmission and post discharge services (60s)	• Independent, private psychiatrists (50s) • Outpatient Services (60s) • Emergency Care ; Partial Hospitalization' Education and Consultation; Child/Adolescent Services; Elderly services; • Alcohol and Drug
Funding Mechanisms	Recommended five fold increase in funding for community care (50s) Large amounts of federal funding (60s)	State funds state hospitals (50s) State funding for hospitals and federal funding to develop CMHCs (60s)	• Virtually no local or private funding for mental health and substance abuse services (50s) • Federal dollars in a grant format that bypasses states and goes directly to local (CMHC grants) (60s)
Governance/ Policy Setting	Mental Health Study Act -1955 Mental Health Action Report -61 CMHC Act of 1963	Long term institutionalization and/or life in a group home (50s) State Plans for community based Services – Public Act 54 (1963)	• State run local services, if they existed in the community (50s) • Beginning of implementation of community services (60s)

The 1970s

	Federal Level	State Level	Local Level
Consumer Perspective	Civil Liberty Movement	Long-term stays in the state hospital Recipient Rights System Inter-dependence between system and patient	Recipient Rights Services Civil Rights in commitment proceedings Earlier intervention/less secondary disability
Services Available	Active policy direction setting, staffing help, assistance to local settings	Large State Hospital Settings State-run Residential Settings State Hospital Staff in the Community	Better medications Behavior Management Techniques
Funding Mechanisms	Federal anxiety about costs as health care costs increasing rapidly	Grant Based Funding with Global budgets	Full Management Boards Private insurance starts paying for mental health/sub abuse treatment
Governance/ Policy Setting	Expanded AOD attention, taking dollars from Mental Health Federal ADAMHA President's Commission on Mental Health – Carter 1977 – endorsed everything – no clear plan of action	Mental Health Code - 1974	Expanding CMHCs in the state in numbers, services and customers

The 1980s

	Federal Level	State Level	Local Level
Consumer Perspective	Emphasis on persons with serious and persistent mental illness NAMI begins and takes up advocacy role Case Management Emerges Community Support Program	State NAMI chapters evolve ACT develops in Wisconsin and Michigan	Reduced service criteria to SPMI in some places Increased homelessness due to lack of benefits Local NAMI develops
Services Available	Primarily research and demonstrations	State Facility Size Reductions State Community staff moving to local CMHs Reduction in available General Fund state support	Movement to restrict services to SPMI and most severe disabilities AIS Home Development Psychosocial rehab options
Funding Mechanisms	Increased emphasis on Medicaid, SSI, SSDI Reagan eliminates federal role in funding and block grants to states emerge Federal funding for case management in Medicaid Medicare expands to cover Mental Health	Block grants Emergence of Fee for Service to expand Medicaid Medicaid Expansion •Pros •Cons State Facility Trade Offs	Full Management Boards Increased finance staff for fee for service billing Continued expansion of services to Medicaid population State tradeoffs fund deinstitutionalization
Governance/ Policy Setting	Mental Health Systems Act (from Carter Commission) 1980 Federal Leadership role diminishes	State leadership role expands in policy setting, funding and direction of local CMHCs	Larger Budgets for Boards to manage More local risks emerge Different rates of movement to new funding mechanisms

The 1990s

	Federal Level	State Level	Local Level
Consumer Perspective	Emphasis on prevention Acceptance as a "disease"	Person Centered Planning Self Determination	Consumer involvement in Governance Expanded rights and grievance and appeals Stigma-busting activities Support for full integration into communities
Services Available	Emphasis on brain research rather than service research SAMHSA emerges	Reduction in State Hospital Usage	Community Hospital Expansion Clubhouse/Drop In Center Supported Community Living Movement from programs to services
Funding Mechanisms	Federal push back on the cost of federal participation in state Medicaid programs Creation of Waiver options	Medicaid Waivers •Habilitation Supports Waiver •Child Waiver •Combined B&C Waiver Medicaid Cost Containment and Managed Care -1998 Capitated Payments	Fundamental shift from fee for service to capitated system of care Entitlements and risk shift to local Continue loss of state general fund
Governance/ Policy Setting	Public Health Approach emerges Surgeon General's Report	Mental Health Code Revisions – Authority Status Regionalization	Consumers on Mental Health Boards Business approach to governance Shared governance models in affiliations

The 2000s

	Federal Level	State Level	Local Level
Consumer Perspective	Recovery Focus Integration of mind of body Choose in provider and services Consumer/family centered	Participation on MH Commission Recovery Council	Consumer involvement at all levels Self-directed lives Peer Supports
Services Available	Individualized plan of care Screening, Assessment, Referral School based services Co-occurring services Screening in primary care	Reduced number of state hospital beds Compliance monitoring	Consumer Run Services Micro-enterprises for consumers
Funding Mechanisms	Reductions in Medicaid Costs Discussion of Block Grants	Regional Medicaid funding Regional Rates for Service Standardization of Admin Costs Greater legislative involvement	Interdependence between affiliation partners Vouchers
Governance/ Policy Setting	Balanced Budget Act New Freedom Commission Institute of Medicine Report on Mental Health/Substance Use Regional Health Information Systems	Granholm's Mental Health Commission Report Recovery Emphasis Evidence Based Practices emphasis	Electronic Medical Records Full consumer integration in planning and providing care Primary Care Integration Strategies EBP Implementation locally

The 2010 and 2020s

	Federal Level	State Level	Local Level
Consumer Perspective	Self directed Recovery focused Home & Community Based Waiver Standards	Expectation of greater involvement in governance, policy, service development, and evaluation at all levels	Consumers /family members engaged as board members, in policy reviews, in service reviews, in community needs assessment and service design considerations.
Services Available	Integrated Care – 2703 Health Homes	Better integration of mental health and substance use disorder services Poleski Bills Expectation of better linkages with physical health care providers Section 298 Pilots	Co occurring Disorders (COD) competent care systems Monitoring population health conditions Partnering with local health care providers
Funding Mechanisms	Innovation grants to support policy direction Managed Care	Reduction in General Fund support Long expansion in Medicaid resources due to increased eligible – now plateauing	Loss of local fund support in many communities due to difficult Michigan economy; local tax base Mental Health Mileages
Governance/ Policy Setting	Affordable Care Act •Essential Health Benefits – •Medicaid Expansion – •Health Insurance Exchange Excellence In Mental Health Act –Certified Community Behavioral Health Clinics – CCBHCs	MI will have state/federal partnership exchange Medicaid expansion - Healthy Michigan State Innovation Model Mental Health and Wellness Commission/Diversion Council Governor's Budget-Section 298	PIHP regional system realigned – from 18 to 10 PIHP regions. New regional affiliations all formed as new regional entities .

Summary of Trends

- Cyclical nature of policy
- Michigan system leads in creating policy
- Increasing recognition of the role/control of consumer in their own treatment
- Limited use of research within the system below federal level
- Current federal legislative efforts related to behavioral health FQHCs and "look a likes"
- Expansion of Health Homes and Opioid Health Homes
- Integration – CCBHC, Section 298 Pilots
- BH Reform Bills in House and Senate SB 597 & 598
- Crisis Units/ Crisis Stabilization
- **Change is constant**

The Future

- Where do you see for the future of
  - Your CMH?
  - The Public Mental Health System?
- How can we influence that direction as individual boards, an association and as consumers?
- New challenges related to Medicaid Health Plans and State integration efforts?

Are we stronger as a bundle, or individual straws?