

# Mental Health in Michigan

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## INTRODUCTION

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This report analyzes and describes the existing system of mental health care in Michigan with a view to identifying its most important characteristics, gaps in the treatment of mental illness, and the policy issues that will most directly influence the development of the system in coming years.

The estimated prevalence of serious mental illness in the U.S. population during a 12-month period is 5.7 percent (11.4 million people), according to a group of technical experts working under the direction of the federal government. “Serious mental illness” includes schizophrenia, acute depression, bi-polar disorders, and any other condition that substantially impairs life activities. Based upon 1990 Census data, the state-level estimates range from 4.62 percent in South Dakota to 6.54 percent in the District of Columbia.

These federal estimates track very closely with those used by the Michigan Department of Community Health (DCH, which has subsumed the former Department of Mental Health). In a recent presentation to the Michigan legislature, the DCH estimated that approximately 5.2 percent of the adult population (400,000 Michigan adults) have serious mental illness. The DCH indicates that prevalence estimates for children are considerably less reliable, but as many as 320,500 may have some form of emotional disturbance.

The costs of mental illness to society are enormous. According to the U.S. Department of Health and Human Services (DHHS), the total direct cost nationwide was \$42.4 billion in 1990. Furthermore, the American Psychiatric Association estimates that the indirect costs—loss of productivity and function—may be three times higher. Mental illness is associated with the following social problems, each of which creates significant problems for society:

- loss of or exclusion from employment;
- lowered educational achievement;
- economic hardship;
- involvement with the criminal justice system;
- victimization by others;
- homelessness; and
- social isolation.

The last few years mark an important watershed in the history of Michigan mental health care. In 1995 the first major revision in more than twenty years was made in the state’s mental health code. In January 1996, Governor John Engler issued an executive order creating the DCH,

which for the first time combines state mental and public health functions with the Medicaid program. The effects of both these changes have yet to be fully evaluated.

The mental health professions are also in flux. In mental health as in other fields, efforts to control medical costs through managed care have altered patient-provider relations in ways that some view as unwelcome and others see as necessary. Also, recent scientific advances have made it clear that some mental problems have a biological and chemical basis, a development which has greatly altered the parameters of care. Therapeutic drugs are now routinely used to supplement therapy and sometimes supplant it altogether.

Although the mental health system in Michigan today is largely the product of the past three decades, it dates from 1859, when the Kalamazoo Asylum for the Insane received its first patients. Before that, care for the mentally ill was left to families, and it was sometimes harsh. A second asylum was established at Pontiac in 1873, followed by one at Traverse City in 1881 and one at Newberry in 1893.

These four institutions were designated state hospitals in 1911 and became the core of the Michigan system. During that same period, tremendous advances in treatment and diminished social stigma led to increased demand for institutional care. As a consequence, a private mental hospital system grew rapidly alongside the state network. A fifth state hospital was established in Ypsilanti in 1929. By the late 1950s, tuberculosis, a major killer during the early part of the century, was largely under control, and the sanitoriums at Howell, Hancock, and Gaylord were converted into hospitals for the mentally ill.

Even as the capacity of the state mental hospital system was reaching its peak, forces were at work that eventually would undermine its importance. From the 1960s to 1980s, the number of mentally ill persons in state institutions (those with schizophrenia, manic depression, and serious depression) dropped by 90 percent. The decline was not due to fewer people being afflicted or diagnosed but to court rulings limiting involuntary commitments, continued improvements in treatment, and a significant change in social attitudes about how and where such illnesses should be treated.

It is now believed that the needs of most patients can be met best in community programs located as close to their family as possible. This treatment mode, broadly termed *community placement*, was incorporated into the Michigan Mental Health Code in 1974 (P.A. 258). The intent was to allow patients to participate more fully in the life of the community. P.A. 258 established the structure for community mental health boards (CMHBs) throughout the state.

Serving the mentally ill requires institutions, organizations, trained mental health professionals, and money. These come together in a system of care that is extraordinarily complex. On the front line are about 14,500 licensed and registered professionals—the psychiatrists, psychologists, counselors, and psychiatric social workers who deal directly with patients. Since all nurses and social workers are available to the mental health system, the actual number of practitioners is no doubt much larger than can be readily identified through state licensing and professional organizations.

Many of these people are in private practice, while others work in an institutional setting. As of 1996, Michigan operated psychiatric hospitals with a capacity of more than 2,200 beds, and

the private system had a capacity of more than 5,600 beds in 76 institutions. Fifty-two CMHBS serve all 83 Michigan counties and coordinate the activities of group homes, adult foster care homes, and Assertive Community Treatment (ACT) programs.

Providing services to the mentally ill is an extremely expensive proposition, estimated at \$2.3 billion in Michigan in 1995. Blue Cross and Blue Shield of Michigan (BCBSM), which insures roughly half the private market, spent about \$145 million in 1995 to reimburse providers of psychiatric care, while DMH allotted approximately \$900 million of its \$1.5 billion appropriation to the treatment of mental illness. The state Medicaid program added another \$400 million in mental health care for the poor during that year. The remainder, perhaps as much as \$750 million, was in the form of private charitable contributions and out-of-pocket payments.

The following three chapters analyze the current system from the perspective of the three major entities: mental health professionals, the funders of mental health care, and mental health institutions and organizations. The concluding chapter identifies treatment gaps and summarizes the policy issues that emerge from the analysis.

## MENTAL HEALTH PROFESSIONALS

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The newly revised Michigan Mental Health Code defines “mental health professional” to mean any of the following:

- a physician who is licensed to practice medicine or osteopathic medicine in the state;
- a psychologist licensed to practice in the state;
- a registered professional nurse licensed to practice in the state;
- a certified social worker, a social worker, or a social worker technician *registered* in the state;
- a professional counsellor licensed to practice in the state; and
- a marriage and family therapist licensed to practice in the state.

The code also prohibits any of these professionals from performing an act, task, or function within the field of mental health that s/he has not been trained to perform unless acting under the direct supervision of an individual who has been so trained.

### Types of Mental Health Professionals

The categories listed here are broadly generic, whereas the underlying reality is more complex. For example, while psychologists, counsellors, and therapists are almost invariably engaged in providing mental health services, the same is not true of all physicians, registered nurses (RNs), or social workers.

The physicians most associated with the treatment of mental illness are, of course, psychiatrists. The new code grants considerable flexibility in how this subgroup is defined. The most highly trained are those who have completed a fully accredited residency program in psychiatry, but the category also includes physicians who have completed a twelve-month psychiatric rotation and are *enrolled* in a residency program; psychiatrists employed by or under contract to DCH or a CMHB program at the time of the code revisions; and any physician who devotes a substantial amount of time to the practice of psychiatry and who receives the approval of the DCH director.

Social workers and RNs need not, under the terms of the law, have specialty training in order to operate in a mental health setting. Those actively engaged in the treatment of the mentally ill, however, are generally experienced and consider themselves specialists. These professionals are commonly known as psychiatric nurses and clinical social workers.

Mental health professionals may be further stratified within each group in accordance with specialty training and education. A child and adolescent psychiatrist is a legally defined subgroup of psychiatrists. A certified social worker must have an MSW, while one needs only a BSW to practice as a registered social worker. A fully licensed psychologist must have completed doctoral work, although limited-practice licenses are available for those who have a master's degree in the field. Similarly, a licensed professional counsellor must have a master's or doctoral degree and a prescribed amount of professional experience. Limited- or restricted-practice licenses are available for less highly trained or experienced individuals.

To become fully licensed, psychologists and counsellors must sit for and pass written examinations administered by the state. The same is not true for social workers, who do not take a state exam and therefore are registered, not licensed. Michigan is the only state in the nation that allows this.

### The Practice of Mental Health Care

Although most members of these professions can practice individually, they often belong to a multidisciplinary team. In general, a psychiatrist assisted by RNs is responsible for the patient's overall medical condition, and s/he is the only mental health professional allowed to prescribe therapeutic drugs.

Psychologists, social workers, counsellors, and therapists can offer therapy, although the role of chief therapist is most often played by a psychologist or social worker. Only a psychologist is licensed to administer psychological testing. Social workers are often the case managers who link patients to appropriate community-based programs.

In Michigan in 1996, more than 14,500 mental health professionals were identifiable through state licensure or registration or through professional organizations. Exhibit 1.1 shows that more than 70 percent are either psychologists or counsellors. Therapists, social workers, and psychiatrists make up a much smaller proportion of the total.

While these figures are based upon the best available data, they are extremely conservative and to some degree misleading, since they greatly understate the importance to mental health care of nurses and social workers. The 114,000 nurses and 19,000 social workers licensed or registered in Michigan are available to the mental health system. Unfortunately, data on how many of these are actually employed in such a setting are not readily available.

Mental health professionals operate in all 52 Michigan CMHB districts. As Exhibit 1.2 demonstrates, however, there is considerable variation in the population-to-provider ratio (PPR) in the districts. The statewide average is 652 persons for each mental health professional, but this figure masks a considerable range. In Allegan County, the PPR is 2,500, compared to 220 in Washtenaw County, or more than a tenfold differential.

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#### EXHIBIT 1.1

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#### Mental Health Professionals in Michigan, 1996

Profession	Number	Percent
Psychologist	5,364	36.09
Counselor	5,219	35.80
Social worker	1,910	13.10
Therapist	1,096	7.50
Psychiatrist	973	6.70
Total	14,562	100.00

Sources: Michigan Department of Consumer and Industry Services; Michigan Psychiatric Association, Michigan Chapter;

## EXHIBIT I.2

## Mental Health Professionals in Community Mental Health Board Districts, 1996

CMHB	1994 Pop.	Psychologists	Counselors	Therapists	Social Workers	Psychiatrists	CMHB Total	Population per Provider
Alger/Marquette	80,503	35	48	7	16	12	118	682
Allegan County	96,087	9	16	0	6	7	38	2,529
Antrim/Kalkaska	34,065							
Ausable Valley	52,779	5	21	1	1	1	29	1,820
Barry County	52,232	16	23	3	3	0	45	1,161
Bay/Arenac	127,727	37	57	11	15	11	131	975
Berrien County	161,734	67	83	11	13	8	182	889
Branch County	41,990	16	11	0	3	1	31	1,355
Calhoun County	139,991	80	74	6	13	16	189	741
Woodland Behavioral Healthcare	48,921	7	15	0	2	1	25	1,957
Central Michigan	144,641	73	150	12	26	3	264	548
Clinton/Eaton/Ingham	436,130	355	305	59	148	45	912	478
Copper Country	54,990	19	10	2	10	2	43	1,279
Delta County	38,606	9	11	1	5	0	26	1,485
Detroit/Wayne/County	2,064,819	748	843	160	298	159	2,208	935
Eastern UP	47,501	16	15	1	7	1	40	1,188
Genesee County	433,297	125	177	37	63	17	419	1,034
Gogebic County	18,016	4	3	0	1	0	8	2,252
Grand Traverse/Leelanau	87,705	66	88	31	19	15	219	400
Gratiot County	39,785	15	29	4	3	2	53	751
Huron Behavioral Health Serv.	35,215	5	11	1	8	0	25	1,409
Ionia County	59,194	15	12	1	4	0	32	1,856
Jackson/Hillsdale	198,119	80	91	12	19	12	214	926
Kalamazoo County	228,798	352	261	38	61	26	738	310
Kent County	520,129	334	273	82	109	72	870	597
Lapeer County	81,242	24	15	1	11	1	52	1,562
Lenawee County	95,669	25	70	5	11	0	111	861
Livingston County	129,083	45	65	17	20	5	142	909

Continued on page 7

<b>CMHB</b>	<b>1994 Pop.</b>	<b>Psychologists</b>	<b>Counselors</b>	<b>Therapists</b>	<b>Social Workers</b>	<b>Psychiatrists</b>	<b>CMHB Total</b>	<b>Population per Provider</b>
Superior Behavioral Health	5,571	4	1	0	0	1	6	929
Macomb County	728,902	213	293	51	84	22	663	1,096
Manistee/Benzie	35,897	9	16	3	1	2	31	1,158
Midland/Gladwin	103,185	41	78	16	23	3	161	641
Monroe County	137,718	33	56	4	15	0	108	1,275
Montcalm Cent. for Behavioral Health	59,194	10	24	0	2	1	37	1,600
Muskegon County	163,436	61	47	15	17	4	144	1,135
Newaygo County	42,739	8	19	1	5	0	33	1,295
North Central	76,731	21	33	3	10	1	68	1,128
Northeast	64,744	13	27	0	4	3	47	1,378
Northern Michigan	92,442	43	60	10	13	9	135	685
Northpointe Behav. Healthcare	64,723	10	16	4	6	1	37	1,749
Oakland County	1,142,013	1,486	1,161	293	437	321	3,698	308
Ottawa County	205,338	110	100	29	26	0	265	775
Saginaw County	211,287	45	67	30	31	7	180	1,174
St. Clair County	152,413	44	74	14	30	6	168	907
St. Joseph County	60,000							
Sanilac County	41,568	4	14	1	3	0	22	1,889
Schoolcraft County	8,596	1	2	0	0	0	3	2,865
Shiawassee County	71,645	13	22	4	4	2	45	1,592
Tuscola County	57,018	16	20	2	8	0	46	1,240
Van Buren County	73,848	39	44	7	6	2	98	754
Washtenaw County	290,546	541	242	101	263	170	1,317	220
Western Michigan	60,324	17	26	5	7	1	56	1,077
Michigan	9,496,539	5,364	5,219	1,096	1,910	973	14,562	652

Sources: Michigan Department of Consumer and Industry Services; Michigan Department of Community Health; and Michigan Psychiatric Association.

While the calculation of such ratios is useful, the numbers should be approached with caution. A seemingly unfavorable PPR does not necessarily indicate poor access to care. The data for licensed and registered professionals are based on their mailing address, which may not be within the CMHB district where they do the majority of their work. For example, the Allegan County CMHB with its unfavorable ratio is next door to Kalamazoo County, where the PPR is 310; there is evidence that a number of professionals who live or have their office in the latter serve the Allegan population.

Exhibit 1.2 also suggests that access to specialized services such as psychiatry may vary considerably among CMHBs. For example, Oakland, Wayne, and Washtenaw counties have about 37 percent of the Michigan population and 66 percent of licensed psychiatrists, but 12 CMHBs have no such licensees within their borders. There are only 17 licensed psychiatrists in the entire Upper Peninsula, 12 of them in the Alger/Marquette CMHB.

There are reasons for the disparity. Psychiatrists tend to be most prevalent in the vicinity of public and private psychiatric hospitals and/or the state's medical schools. Still, the data suggest that people living in remote parts of the state may have greater difficulty obtaining psychiatric services than those residing in major population centers. The figures also raise the possibility that some CMHBs may have difficulty finding a fully qualified psychiatrist to serve as medical director, as is required under the revisions to the Michigan code.

In the vast field of mental health, professionals have long battled for turf, although officials in the Michigan Department of Consumer and Industry Services foresee few if any important "scope of practice" battles on the horizon. In mental health, however, as in the health system generally, changes in the way care is financed inevitably influence the way care is provided. In particular, the current emphasis on controlling costs creates the possibility of potential conflict.

Historically, psychiatrists and, to a lesser degree, psychologists have had the upper hand because state laws across the United States were much more likely to require insurance companies to cover their services. In today's cost-conscious environment, this may be changing. Some are beginning to think that the roles of social workers and psychiatric nurses, who offer relatively low-cost services, should be expanded. Others bristle at such suggestions and worry that cost-control strategies could damage the quality of care. Indications are that the current climate is seen as threatening, to varying degrees, by clinicians, who feel that their importance as a group has diminished in comparison to payors and administrators.

## **Types of Treatment and Patients**

The initial encounter between the patient and the mental health professional is the first step in a fairly predictable sequence. The professional's first job is assessment, that is, to diagnose what is wrong. Subsequent steps proceed through planning the treatment or intervention; providing care over a certain period; evaluating the results; and managing the client's mental health over a longer time to prevent relapse or the deterioration of his or her condition.

Four general kinds of therapy are usually provided.

- **Psychodynamic therapy** seeks to identify the conflicts and defense mechanisms that negatively affect adult behavior.
- **Interpersonal therapy** emphasizes the importance of enhancing relationships and improving communications skills.
- **Cognitive therapy** helps patients recognize and change distorted ways of thinking.
- **Behavioral therapy** provides patients with strategies for replacing harmful behaviors with more positive ones.

For years, drugs have been used to treat the mentally ill but often for purposes of sedation, whereas there has been increasing reliance over the past decade on therapeutic drugs. One of the best-known examples is Prozac, which is effective in treating depression and is much safer and easier to use than many of its predecessors.

In addition to scientific advances, another factor that affects the way mental health professionals practice is whether they work in a public or private setting. In general, private-sector patients have more resources, and they tend to have less severe conditions that can be treated by a single provider.

Since poverty, indigency, and unemployment are associated with severe forms of mental illness, patients with these conditions typically have fewer resources, and their care is more likely to become a public responsibility. In order to treat the more severe and chronic disorders found among public-sector patients, professionals working in that setting are likely to be involved in multidisciplinary teams or other forms of intensive and/or expensive intervention. The financing of these services is the topic of the next chapter.

## FUNDING

As is the case with health care generally, a complex and pluralistic system of funding pays for mental health services. A national study by DHHS produced the estimates by payment source shown in Exhibit 2.1. Three predominate: (1) private sources, which include out-of-pocket and philanthropic payments; (2) state and federal funding for the Medicaid program, which underwrites health care costs for the poor and elderly; and (3) the state and local expenditures that provide payments for those not otherwise covered.

In 1990, of the \$42.4 billion spent on mental health services nationwide, \$18.8 billion (44 percent) came from private sources. State and local financing provided an additional \$11.7 billion (27.5 percent). The Medicaid program paid slightly in excess of \$8 billion (19.1 percent), and the remaining \$3.8 billion (8.9 percent) came from Medicare, the Veterans Administration, and other federal programs.

### Insurance Coverage Nationwide

Exhibit 2.2 provides information on insurance coverage for the nonelderly. It reflects the well-publicized fact that the proportion of the population not covered by private health care insurance has risen in the last decade, from 15.9 percent in 1988 to 16.6 percent in 1991. This increase was accompanied by a decline in access to employer-sponsored private insurance over the same period, from 66.8 percent to 64.1 percent.

Since health insurance historically has discriminated against people with mental illness, the situation in this regard is almost certainly worse than the figures indicate. Not all pri-

**EXHIBIT 2.1**

**Estimated U.S. Mental Health Expenditures  
by Payment Source in 1990 (\$ in billions)**

Source	Payments	Percent
Private	\$18.8	44.3
State and Medicaid	11.7	27.5
Veteran Administration	8.1	9.1
Medicare	1.5	3.5
Other federal	1.5	3.5
Total	0.8	1.8
<b>Total</b>	<b>\$42.4</b>	<b>100<sup>a</sup></b>

Source: Center for Mental Health Services, U.S. Department of Health and Human Services, 1994.

<sup>a</sup> Does not equal 100 percent due to rounding.

**EXHIBIT 2.2**

**Insurance Coverage for the Nonelderly  
in the United State, 1988–1991**

	1988	1991
Any coverage	84.1%	83.4%
No coverage	15.9	16.6
Employer-sponsored private coverage	66.8	64.1
Other private	8.4	8.2
Public insurance	12.4	14.5

Sources: Center for Mental Health Services, U.S. Department of Health and Human Services, 1994; and Employee Benefits

vate plans cover mental health services, and the DHHS report claims that approximately 2 percent of the U.S. population falls in that category. If so, when the uninsured are added, then almost 19 percent of Americans have no mental health coverage at all.

Finally, coverage for mental health services is almost always more restrictive than health care benefits generally. Exhibit 2.3, based upon Bureau of Labor Statistics data, shows that between 1986 and 1991 the portion of medium and large private firms (employing 100 or more) offering plans with mental health benefits remained fairly constant at around 98 percent. But

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**EXHIBIT 2.3**

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**Percentage of Full-Time Participants in Plans with Mental Health Benefits  
by Extent of Benefits, Medium and Large Private Firms in the U.S., 1986, 1989, and 1991**

Benefits	Hospital Care			Outpatient Care		
	1986	1989	1991	1986	1989	1991
With coverage	99%	98%	99%	97%	95%	98%
Same as other illnesses	37	21	18	6	2	2
Separate limitations	61	77	81	91	92	95
Limit on days or visits	38	49	54	33	34	35
Limit on dollars	26	38	39	68	66	68
Coinsurance limited to 50%	2	4	10	48	43	56

Sources: Center for Mental Health Services, U.S. Department of Health and Human Services, 1994; and Bureau of Labor

the comprehensiveness of those benefits declined. For example, the proportion of firms covering hospital treatment for mental health identical to that offered for other illnesses dropped by more than half: from 37 percent to 18 percent. At the same time, the plans limiting hospital visits or stays for mental illness increased from 38 percent in 1986 to 54 percent in 1991.

Typical provisions might be 30 days of inpatient mental health care and 25 outpatient visits with 50 percent cost-sharing. For a number of people it is doubtful that such coverage is adequate. Data from the Mental Health Services Inventory of Mental Health Organizations suggest that 22 percent of inpatients stay longer than 30 days. No doubt many of them exceed the limitations of their coverage and are, for practical purposes, uninsured.

These developments have occurred during a period of growing budget constraints at all levels of government, and it is questionable whether the public is willing and/or able to respond to increases in the uninsured population. For example, the Medicaid program, which provides health care to a segment of the population that suffers from a high rate of mental illness, experienced annual growth rates in expenditures as high as 13 percent during the 1980s, a faster pace than private insurance and unsustainable in the long term.

### **Expenditures at the State Level**

State governments, exclusive of their contributions to Medicaid, have long recognized a responsibility to provide mental health services for the poor and for those with severe, chronic disease who are not served in other ways. States typically have assumed obligations for some combination of child and adult mental health, developmental disabilities, substance abuse, forensic services, and prisoners' mental health. Since different states offer various services and

administer them differently, the task of estimating state expenditures is complicated.

The National Association of State Mental Health Program Directors (NASMHPD) estimates that, in 1990, state mental health agencies oversaw expenditures in excess of \$12.3 billion. As a percentage of state spending on health and welfare, this represents a drop of about one percent from 1983 levels, but as a percentage of overall state budgets, the figure has remained fairly constant.

State per-capita spending on mental health varies widely, according to the NASMHPD data. In New York, the amount was \$118 in 1990, compared to \$17 in Iowa, approximately one-seventh as much. The national median was \$38. In general, high expenditure levels are associated with high state mental hospital expenditures, which likely explains at least some of the movement toward community-based services observable nationwide. States spent 67 percent of their mental health funds on hospital care and only 29 percent on community-based care in 1981, but by 1990 the figures were 58 percent and 38 percent, respectively.

### **The Situation in Michigan**

The foregoing discussion of national mental health costs and coverage issues provides a backdrop for analyzing the situation in Michigan. Although comprehensive cost analyses for the state are not available, it is possible to extrapolate estimates from national data. Admittedly, this involves an assumption that Michigan is not vastly different from the rest of the country.

As in other states, estimates of total mental health care spending in Michigan are difficult to obtain because paying for care is a joint public/private responsibility and because there are diverse funding sources within both sectors. In principle, a good deal of information would be available from private insurance carriers and individual mental health professionals, but in reality, and understandably, those data are considered confidential. Although information on public spending belongs to the taxpayers and is easier to obtain, Michigan's mental health programs long were housed in at least two state departments whose reports were not entirely consistent or compatible. For example, state psychiatric hospitals and CMHBs were the province of the former Department of Mental Health, while Medicaid spending was handled by the former Department of Social Services (DSS).

Executive reorganization in 1996 consolidated the vast majority of the state's public health and mental health functions into a single agency, the DCH, which also assumed the Medicaid program. The merger is intended to improve service coordination and provide more efficient management and administration of similar service providers. In the long term, the centralization may lead to better cost data as well.

In 1995, the last year for which adequate data are available, the best estimate is that nearly \$2.4 billion was spent on mental health services in Michigan. As Exhibit 2.4 shows, about \$1.3 billion came from public agencies. Since it is generally agreed that the public sector provides 55 percent of such spending nationally, that formula was used to arrive at the figure of \$2.4 billion. Of the private-sector amounts, only the \$57.8 million in BCBSM reimbursements for psychiatric care is based on hard data, the remainder on commonly accepted estimates.

### **State Appropriations**

From 1983-1996, gross state appropriations for the Michigan Department of Mental Health rose steadily in current dollars. As Exhibit 2.5 indicates, gross appropriations were \$672.1

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**EXHIBIT 2.4**

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**Estimated Gross Expenditures for Treatment of Mental Illness in Michigan, 1995**

	Dollars	Percentage of Total
Public expenditures		
Department of Mental Health <sup>a</sup>	\$ 891,504,523	37.6
Medicaid <sup>b</sup>	410,921,909	17.4
Subtotal	1,302,426,432	55.0
Private expenditures		
BCBSM Ins. <sup>c</sup>	57,785,682	2.4
BCBSM TPA <sup>d</sup>	86,678,523	3.7
Other private insurers <sup>e</sup>	144,464,205	6.1
Out-of-pocket & philanthropic	776,644,858	32.8
Subtotal	1,065,573,268	45.0
Total	\$ 2,367,999,700	100.0

Sources: Michigan Department of Community Health, 1996; Michigan Senate Fiscal Agency, 1996; Blue Cross/Blue Shield of Michigan, 1996; and Public Sector Consultants, 1996.

<sup>a</sup>Fiscal 1995, excluding developmental disability.

<sup>b</sup>State spending minus funds paid to CMHBs.

<sup>c</sup>Reimbursement for psychiatric services, calendar 1995, estimated to be 40 percent of total BCBSM business.

<sup>d</sup>Estimated psychiatric reimbursements in third-party administrator plans.

<sup>e</sup>Estimated at 50 percent of private insurance market.

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**EXHIBIT 2.5**

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**Michigan Department of Mental Health Appropriations, 1983 and 1986,  
in Millions of Dollars**

	1983	1996	Percentage Increase
Gross appropriation	\$672.1	\$1,606.8	139.0
General Fund/General Purpose	\$521.9	\$1,019.0	95.2

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**EXHIBIT 2.6**

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**Michigan Department of Mental Health CMH vs. Institutional Appropriations,  
FY 1980 and FY 1995, in Millions of Dollars**

	1980		1995	
	Dollars	% of Total	Dollars	% of Total
Gross appropriation	\$571.1	100.0	\$1,523.5	100.0
State-run institutions	\$361.1	63.2	\$354.2	23.2
Community mental health	\$165.8	29.0	\$1,054.9	69.2

million in 1983 and approximately \$1.7 billion in 1996. The contribution from the General Fund grew from \$521.9 million to around \$1 billion over that same period. It should be noted that gross appropriations include funding for developmental disabilities—a severe chronic mental and/or physical impairment, different from a mental illness, that results in substantial functional limitations.

As Exhibit 2.6 makes clear, over the past 15 years there has been a dramatic change in the allocation of state funds. In 1980, 63 percent went for the operation of state-run psychiatric facilities and only 29 percent to CHMBs. By 1995, the situation was completely reversed: 23 percent and 69 percent, respectively.

For fiscal 1997 there are already signs of significant retrenchment. The appropriations bill for the new DCH, which was signed by the governor in June 1996, is heavily contingent upon federal Medicaid reform and in any event is a reduction. If reform is achieved, the mental health portion of the \$8.03 billion DCH budget would be \$1.6 billion, all but about \$600 million from the General Fund. Absent reform, mental health programs would receive \$1.563 billion in total, with \$1.025 billion of that coming from the General Fund.

Under the best of circumstances, the mental health portion of the budget will be reduced by \$7 million over fiscal 1996 levels, with \$14 million less coming from the General Fund. If national Medicaid reform fails, the mental health appropriation will be \$44 million less, but the General Fund contribution will rise to avoid drastic cuts.

As will be discussed at greater length in the next chapter, recent revisions to the Michigan Mental Health Code will push the state even farther in the direction of community-based services and will save money, although officials insist that cost cutting was not the prime objective. The continued movement toward CMHBs is reflected in the 1997 budget, which cuts funding for state psychiatric hospitals both for adults and for children each by more than \$13 million over the previous year; state funding for community mental health will increase by more than \$30 million.

### ***The Uninsured and Managed Care for Medicaid***

Despite the enormous outlays over the years, it is apparent that many persons with psychological disorders do not have access to care. In a 1993 analysis of the 1990 Census data, the Michigan League for Human Services found that approximately 1.07 million Michiganders did not have public or private health care coverage and thus no mental health care benefits as well. Among the uninsured are:

- more than 158,000 children under age 15,
- more than 155,000 young men between age 12 and 18,
- more than 125,000 women between 45 and 65 years old,
- more than 540,000 low-income individuals, and
- more than 175,000 middle-income individuals.

Assuming that the prevalence of serious mental illness is the same in the uninsured population as in the public at large, then more than 55,000 seriously ill people lack insurance of any sort. Those with severe conditions likely will become a state responsibility and receive some care, particularly if they present a danger to themselves or others, but many people who would benefit from psychiatric help have no access to it.

Meanwhile, the state is trying to achieve efficiencies in various ways, chiefly by bringing the Medicaid program under managed care. Under the plan to be phased in from 1996-1999, mental health services reimbursed by Medicaid will be treated as a “service carve out,” managed by the DCH and the CMHBs and funded by block grants. In the early phases, the state intends to seek federal waivers and/or changes in state law necessary to allow Medicaid mental health dollars to be fully managed by the CMHBs. Later, an even more aggressive approach is contemplated, whereby the CMHBs will be forced to compete with other provider systems for management contracts.

While the plan can be justified as a way to conserve public dollars, it raises many of the same questions that have emerged in the private insurance market with the movement toward managed care. Among the most important are:

- How can quality of care for mental health patients in Medicaid managed care programs be assured?
- How will quality of care be measured and evaluated?
- How will it be possible to ensure that clinical judgment, not cost considerations or administrative convenience, dictates treatment?

### **Changing Attitudes and Approaches**

Of course, it is not possible to leave the subject of financing without touching briefly on the immense changes taking place nationally in mental health care. For years, mental illnesses took a back seat in health policy because of a widespread belief that they were not medical problems and not “real.” But during the 1980s and 1990s there was a sea change in public perceptions. To a large extent, any stigma associated with seeking care was alleviated as the public increasingly accepted what practitioners had been saying for years: Mental illnesses are genuine ailments that can be diagnosed and treated as effectively as those in the domain of physical medicine.

With this broader acceptance came a much greater willingness to seek treatment. Reflecting that trend, spending by employers for mental health and substance abuse services (so-called behavioral health) increased by 50 percent between 1986 and 1990, according to a report published in the *New England Journal of Medicine*. The most generous plans experienced the most dramatic cost increases. Characteristic of the period was an explosive growth in private, for-profit psychiatric hospitals.

Not surprisingly, the dramatic rise in costs inspired a vigorous effort to control them on the part of the companies paying the bill. More and more private as well as public insurers turned to managed care, which encompasses a wide range of organizational reforms and financial arrangements; all of these are based on the idea that financial resources are limited, and all of them can affect patient care. With regard to mental health, the following approaches may be used by health maintenance organizations (HMOs) and other systems.

- **Capitated Payment Arrangements:** Providers agree to cover care for a defined population in exchange for a predetermined fee for each enrollee. The risk to providers presumably creates an incentive for them to control costs.
- **Utilization Review Arrangements:** Individual episodes of treatment are reviewed by a third party unaffiliated with the patient or the practitioner, often an organization

that specializes in such reviews. Generally accepted guidelines or protocols are used to ensure that any recommended course of treatment is both appropriate and cost effective.

- **High-Cost Case Management:** Patients are linked to a professional case manager who acts as a gatekeeper for services and is at times authorized to seek treatment beyond that which is usually covered by the insurance plan. This brings focused managerial scrutiny to the cases that cost the plan the most money.

The empirical basis for managed care is found in studies which suggest that a great deal of hospitalization is unnecessary; that treatment varies widely for any number of psychiatric problems, and the most costly is not always best; and that a small proportion of cases can generate a high proportion of expense.

No one could argue that managed care has no basis in common sense or that it fails to control costs. Some businesses reported cutting mental health care costs by more than half after introducing aggressive managed care plans. Nevertheless, mental health professionals began voicing many of the same concerns that practitioners of traditional medicine had expressed when they were introduced to the concept.

### **The Practitioners' Perspective of Managed Care**

The main concern among mental health specialists is that the cornerstone of practice—the patient/professional relationship and the needs of the individual patient—may be damaged by managed care. It is feared that for too many patients the cost of care, not what is clinically appropriate, will be decisive. One area commonly cited is managed care and the use of drugs in treatment. Drugs are cheaper and faster acting than clinical therapy but are not always the best choice in the long run. It is argued that managed care will lead to a two-tiered system: therapy for the rich and drugs for the poor and uninsured. Another worry is that typical managed care restrictions on hospital stays and outpatient visits will deprive the chronically ill of necessary treatment.

Without in any way dismissing these concerns, it should be noted that clinicians find themselves in a situation very much of their own making. Although many changes in the profession have been positive and beneficial, many have not. Dr. Mary Jane England, president of the American Psychiatric Association, recently wrote that “sophisticated marketing campaigns targeting adolescents and substance abusers [resulted] in many unjustified and even harmful hospitalizations as well as sharply increased costs.” A leader of a major managed care company agrees, noting that mental health professionals “by not paying sufficient attention to or not caring about costs and length of treatment. . . killed or at least seriously wounded the goose that laid the golden egg.”

In the complex world of mental health care, however, nothing is static for long. As much as some practitioners dislike managed care, its demonstrated success may make possible something that mental health professionals and advocates have dreamed about: parity with other health coverage. In April 1996, the U.S. Senate passed a bill that prohibited all group, individual, or other health insurance plans from imposing on mental health services any treatment limits or cost-sharing restrictions that are not imposed upon other medical conditions. This amendment to the Kassebaum-Kennedy health insurance portability bill faced strong opposi-

tion not only in the House but also from businesses and HMOs concerned about escalating costs.

The senators were persuaded by testimony indicating that costs could be controlled and that in states like Maryland and Minnesota, which have similar legislation, costs and usage of mental health services did not rise. The bill was eventually passed by Congress without the mental health parity provision. A key supporter of the provision, Senator Pete V. Domenici (R-NM), said: “This is a very simple proposition of parity that is not going to cost very much, and says to the five million severely mentally ill Americans and their families that they are not going to be treated any longer as second-rate or even third-rate citizens.” It is ironic that managed care, so anathema to the mental health profession, may eventually prove the vehicle for realizing a cherished dream: equal status with the mainstream of U.S. medicine and the provision of more comprehensive services.

## MENTAL HEALTH CARE INSTITUTIONS AND ORGANIZATIONS IN MICHIGAN

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A good deal of mental health care in Michigan is provided in private offices and individual therapy sessions. Much is also delivered in hospitals, group homes, foster care homes, and similar settings. Institutions may be either public or private; the former often serve poorer clients at public expense, while the latter serve those with health insurance or sufficient income to pay out-of-pocket. Information on public institutions is more accessible for the obvious reason that no proprietary rights or interests are involved.

In both the public and private sectors, changes in the philosophy of care and methods of treatment as well as cost concerns have shifted the locus of care from institutional settings and into the community. That is, current practice is to provide care in the least restrictive setting permitted by the patient's condition. People who are hospitalized generally have the most severe disorders. As a result, while psychiatric hospitals still have a role to play, the system today is based more in the community than it was 30 years ago.

### **The Private Sector**

As of May 30, 1996, there were 76 private psychiatric hospitals and units in Michigan providing inpatient care. Many offer only partial hospitalization, while others do not offer full-time care. Overall, Michigan has 5,671 licensed beds in private psychiatric facilities, 1,049 of which are reserved for children, although the numbers fluctuate according to market conditions.

The distribution of facilities and beds reflects state population patterns. Wayne, Oakland, and Macomb counties have 33 of the hospitals, more than 40 percent of the total. Outstate, private hospitals are located in and around such major population centers as Grand Rapids, Muskegon, Flint, Saginaw, Bay City, Midland, Kalamazoo, and Battle Creek. Sixty-eight of the 76 facilities offering inpatient care, or 89 percent, are south of a line extending from Bay City to Muskegon. Two of the eight north of this line are located in the Upper Peninsula.

It is significant that all the beds are in 36 counties, that is, the other 47 do not have a private psychiatric facility. Obviously, patients who live in the more populated areas have more private hospitalization choices than do those who live outstate. While the statewide average may suggest sufficient beds, people in large areas of Michigan have no facility close by.

### **The Public Sector**

Public mental health institutions are comprised of two categories: (1) state-run psychiatric hospitals and (2) 52 CMHBs subject to state regulations but most directly accountable to local communities and county commissions. Over the past two decades there has been an important shift in emphasis from the state hospital system to community-based care. An analysis of the fiscal 1997 \$1.6 billion gross appropriation for the DCH demonstrates this clearly. More than \$950 million (about 60 percent) will be allocated to community mental health, while \$280 million (18 percent) will be spent on hospitals, treatment centers, and institutional services.

### **State Hospitals**

The State of Michigan operates nine psychiatric hospitals. Fairlawn and Hawthorn serve children exclusively. Kalamazoo Regional and Detroit Psychiatric accept both adults and children. Caro Regional, the Center for Forensic Psychiatry, Clinton Valley Center, Northville Regional, and Walter Reuther serve adults.

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#### **EXHIBIT 3.1**

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##### **Inpatient Psychiatric Capacity of State Mental Hospital in Michigan, 1994**

<b>Institution</b>	<b>Adult Beds</b>	<b>Child/Adolescent Beds</b>	<b>Total Beds</b>
Caro Regional	140	0	140
Center for Forensic Psychiatry	210	0	210
Clinton Valley Center	375	0	375
Detroit Psychiatric Institute	140	12	152
Fairlawn Center	0	125	125
Hawthorn Center	0	108	108
Kalamazoo Regional	290	16	306
Northville Regional	575	0	575
Walter Reuther	240	0	240
<b>Total</b>	<b>1,970</b>	<b>261</b>	<b>2,231</b>

Six of the hospitals are located in the tri-county region around Detroit, and the Center for Forensic Psychiatry is in nearby Washtenaw County. Only Caro Regional and Kalamazoo Regional lie in outstate areas. There are no state hospitals in the Upper Peninsula or in the northern Lower Peninsula. Only Caro Regional is situated in a county (Tuscola) that does not have a private facility. Exhibit 3.1 summarizes the capacity of the state system, which in 1996 has 2,231 beds, with 261 of these reserved for children.

Since the 1960s, as mentioned earlier, court decisions, changes in treatment philosophy, and advances in drug therapy have reduced the hospitalization rate, which is clear from recent admissions figures. Exhibit 3.2 shows that 8,247 mentally ill adults were admitted in 1990 but only 3,425 in 1995—a decline of

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#### **EXHIBIT 3.2**

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##### **Admissions to State Mental Hospitals in Michigan, 1990 and 1995**

	<b>1990</b>	<b>1995</b>	<b>Percentage Change</b>
Adults	8,247	3,425	-58.5
Children	233	146	-37.3

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**EXHIBIT 3.3**

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**Public Mental Health Facilities Closed in Michigan, 1972–1992**

<b>Facility</b>	<b>Location</b>	<b>Year Closed</b>
Fort Custer	Battle Creek	1972
Riverside Psychiatric Hospital	Ionia	1974
Metro Regional Psychiatric Center	Eloise	1980
Oakland Medical Center	Pontiac (Westland)	1980
Michigan Institute for Mental Health	Dimondale	1981
Alpine Center	Gaylord	1981
Hillcrest Center	Howell	1982
Northville Residential Training Center	Northville	1983
Clintonaire Nursing Home	Mt. Clemens	1983
Plymouth Center	Plymouth	1984
Ogemaw Valley Care Center	Rose City	1984
Oshtemo Care Center	Kalamazoo	1985
Coldwater Center	Coldwater	1985
Warren Village Nursing Home	Warren	1986
Traverse City Regional Psychiatric Hospital	Traverse City	1989
Macomb-Oakland Regional Center (Inpatient)	Mt. Clemens	1989
Beecher Manor	Flint	1990
Mt. Pleasant Total Living Center	Mt. Pleasant	1990
Ypsilanti Regional Psychiatric Hospital	Ypsilanti	1991
Oakdale Center	Lapeer	1991
Wayne Total Living Center	Wayne	1991
Arnell Engstrom	Traverse City	1991
York Woods Center	Ypsilanti	1991
Wayne Community Living Services	Wayne	1992
Coldwater Regional Mental Health Center	Coldwater	1992
Taylor Nursing Home	Taylor	1992
Newberry Regional Mental Health Center	Newberry	1992
Muskegon Regional Center	Muskegon	1992
SW Michigan Community Living Services	Coldwater	1992
Lafayette Clinic	Detroit	1992
<b>Total closures</b>	<b>30</b>	

Source: Michigan Department of Mental Health, 1995.

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nearly 60 percent. Over that period, admissions for mentally ill children dropped by 37.3 percent, from 233 in 1990 to 146 in 1995.

From 1980-1994, the decrease in Department of Mental Health employees closely tracked the declining number of state hospital patients. In 1980 the department had 15,800 workers, down to 6,400 by 1994.

Exhibit 3.3 shows the number of state mental health facilities and programs that were closed between 1972 and 1992. Thirteen of the 30 closures took place during the Engler administration.

In a more recent and highly controversial development, DCH director James Haveman informed the state legislature in January 1996 of plans to close the Fairlawn Center in Pontiac as of October 1, 1996. Pursuant to state law, the center's 194 employees were given 240 days notice. The proposal was made despite the fact that Fairlawn recently was upgraded with a \$6-million addition.

This move would eliminate 125 child/adolescent beds from the state system, nearly 50 percent of the total. It is possible, however, that moth-balled units at the Hawthorn Center in Northville Township will be reopened, which would restore some of that capacity. The DCH defended the proposal on the grounds that increased use of community-based services had reduced the Fairlawn population from 140 to 26 between 1991 and early 1996.

As with such closures in the past, the DCH decision proved controversial. Critics, including the director of the Michigan Association for Children with Emotional Disorders, claim that quality of care for Michigan youngsters is being compromised. Anecdotal evidence suggests that, at the very least, disturbed children may have trouble finding state hospital space close to home. Some people believe that the number of patients at Fairlawn was kept artificially low over the years to create high per-patient costs and thus a strong argument for closure.

### **Community Mental Health Boards**

Although the concept of community-based services was around much earlier, the legal mandate creating CMHBs was enacted in 1974. The Michigan Mental Health Code (P.A. 258) provides for the formation of CMHBs at the option of the county board of commissioners and directs the Department of Mental Health to “shift from the state to a county the primary responsibility for the direct delivery of public mental health services whenever the county shall have demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of the county.”

As of February 1996, there were 52 CMHBs serving all 83 Michigan counties. Exhibit 3.4 gives the name and location of these boards; a fuller description is included in Appendix A.

As the Senate Fiscal Agency recently pointed out, the movement toward community-based mental health care in Michigan was accompanied by a decrease in consistent, high-quality data on which to base decisions. When state mental health services centered on hospitals, the information was generally quite good. Now that data must be collected and transmitted by 52 separate organizations, problems with uniformity and completeness can be expected. The last two mental health appropriations bills, however, required the department to meet more stringent reporting standards, and it has made a credible effort to do so.

### **CMHB Demographics**

The DCH report published in 1996 is the basis for the statistical snapshot contained in Exhibit 3.5. In 1995, the last year for which fully comparable data are available, CMHB programs served 173,226 clients statewide, a number that had risen markedly in each of the last three years. The 1995 figure was a 43.7 percent increase over 1990, when 120,490 people were served.

More than half the clients of CMHBs (54.6 percent) are adults between the age of 27 and 64; approximately 23 percent are 18 years old and younger; seniors age 65 and older account for about 10 percent. Nearly two-thirds are white, and about one-quarter are African Americans (26.3 percent). Among the 5 percent of clients for whom race/ethnicity was not reported, it is likely that the vast majority fall into one of these categories. Roughly 3 percent of all clients are known to be incarcerated.

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**EXHIBIT 3.4**

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**Michigan Community Mental Health Boards, 1996**

<b>CMHB</b>	<b>County or Counties Served</b>
Alger/Marquette	Alger, Marquette
Allegan County	Allegan
Antrim/Kalkaska	Antrim, Kalkaska
AusableValley	Ogemaw, Oscoda, Iosco
Barry County	Barry
Bay/Arenac	Arenac, Bay
Berrien County	Berrien
Branch County	Branch
Calhoun County	Calhoun
Woodland Behavioral Healthcare	Cass
Central Michigan	Clare, Isabella, Mecosta, Osceola
Clinton/Eaton/Ingham	Clinton, Eaton, Ingham
Copper Country	Baraga, Houghton, Keweenaw, Ontonagon
Delta County	Delta
Detroit/Wayne County	Wayne
Eastern UP	Chippewa, Mackinac
Genesee County	Genesee
Gogebic County	Gogebic
Grand Traverse/Leelanau	Grand Traverse, Leelanau
Gratiot County	Gratiot
Huron Behavioral Health Serv.	Huron
Ionia County	Ionia
Jackson/Hillsdale	Hillsdale, Jackson
Kalamazoo County	Kalamazoo
Kent County	Kent
Lapeer County	Lapeer
Lenawee County	Lenawee
Livingston County	Livingston
Superior Behavioral Health	Luce
Macomb County	Macomb
Manistee/Benzie	Benzie, Manistee
Midland/Gladwin	Gladwin, Midland
Monroe County	Monroe
Montcalm Cent. for Behav. Health	Montcalm
Muskegon County	Muskegon
Newaygo County	Newaygo
North Central	Crawford, Missaukee, Roscommon, Wexford
Northeast	Alcona, Alpena, Montmorency, Presque Isle
Northern Michigan	Charlevoix, Cheboygan, Emmet, Otsego
Northpointe Behav. Healthcare	Dickinson, Menominee, Iron
Oakland County	Oakland
Ottawa County	Ottawa
Saginaw County	Saginaw
St. Clair County	St. Clair
St. Joseph County	St. Joseph
Sanilac County	Sanilac
Schoolcraft County CMH Serv.	Schoolcraft
Shiawassee County	Shiawassee
Tuscola County	Tuscola
Van Buren County	Van Buren
Washtenaw County	Washtenaw
Western Michigan CMH System	Lake, Mason, Oceana

Source: Michigan Department of Community Health, 1996.

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**EXHIBIT 3.5**

**Demographic Data on CMHB Clients, 1995**

	Number	Percent
Gender		
Male	83,134	48.0%
Female	86,701	50.1
Unrecorded	3,391	2
Age		
0 to 3	1,172	0.7%
4 to 12	18,511	10.7
13 to 18	19,674	11.4
19 to 26	19,361	11.2
27 to 64	94,583	54.6
65 and older	17,452	10.1
Unrecorded	2,473	1.4
Race/ethnicity		
Native American	1,306	0.8%
Asian or Pacific Islander	407	0.2
African American	45,619	26.3
White	111,994	64.7
Hispanic	2,857	1.6
Other	2,145	1.2
Unrecorded	8,898	5.1
Corrections status		
In prison	207	0.1%
In jail	4,496	2.6
Not incarcerated	134,369	77.6
Unrecorded	34,154	19.7
Income		
Below \$10,000	94,852	54.8%
\$10,000–\$15,000	13,746	7.9
\$15,001–20,000	7,189	4.2
\$20,001–25,000	4,730	2.7
\$25,001–30,000	2,756	1.6
\$30,001–\$40,000	2,318	1.3
More than \$40,000	3,511	2
Unrecorded	44,124	25.5
Payment source		
Personal resources	35,287	18.7%
Commercial health insurance	23,313	12.3
Service contract	2,427	1.3
Medicare	25,778	13.6
Medicaid-regular	72,713	38.4
Medicaid-HMO	5,646	3
Veterans Administration	168	0.1
CHAMPUS	296	0.2
Workers' compensation	182	0.1
Other public sources	5,625	3
Unrecorded	17,731	9.4
Employment status		
Part time	9,808	5.7%
Full time	14,893	8.6
Unemployed	109,015	62.9
Unrecorded	39,510	22.8
Education		
Less than high school	74,983	43.3%
High school or more	63,703	36.8
Unrecorded	34,540	19.9
Total	173,226	

Source: Michigan Department of Community Health, 1996.

**EXHIBIT 3.6**

**Percentage of the District Population Served by CMHBs, 1995**

CMHB	Percentage of District Population Served
Superior Behavioral Health	6.2
Manistee/Benzie	4.7
Schoolcraft County	4.3
Delta County	3.8
Huron Behavioral Health	3.8
Gogebic County	3.4
Woodland Behavioral	3.3
Northeast	3.2
Calhoun County	3.1
Northpointe Behav. Healthcare	3.1
Antrim/Kalkaska	3.1
Midland/Gladwin	3.0
Alger/Marquette	3.0
Newaygo County	2.9
Copper Country	2.9
Au Sable Valley	2.8
St. Joseph County	2.6
Detroit/Wayne County	2.6
Branch County	2.5
Van Buren County	2.5
Central Michigan	2.4
Grand Traverse/Leelanau	2.4
Berrien County	2.3
Eastern UP	2.2
North Central	2.2
Sanilac County	2.1
Muskegon County	2.1
St. Clair County	2.1
Saginaw County	2.0
Gratiot County	2.0
Lapeer County	2.0
Montcalm Center Behav. Health	2.0
Ionia County	2.0
Western Michigan	1.8
Tuscola County	1.8
Northern Michigan	1.8
Kalamazoo County	1.8
Bay/Arenac	1.7
Kent County	1.7
Barry County	1.7
Jackson/Hillsdale	1.5
Clinton/Eaton/Ingham	1.4
Livingston County	1.4
Genesee County	1.3
Shiawassee County	1.3
Lenawee County	1.2
Washtenaw County	1.2
Ottawa County	1.1
Monroe County	1.1
Allegan County	0.8
Macomb County	0.8
Oakland County	0.6
Percentage of Michigan population served	1.8

Source: Michigan Department of Community Health, 1996.

Compared to the population at large, the data suggest that CMHB clients are notably poorer—about 55 percent have an annual income of less than \$10,000. Nearly 60 percent have their care reimbursed by Medicaid, Medicare, or some other public payment source. At least 43.3 percent have no more than a high school education. Nearly two-thirds report being unemployed at the time of treatment, although that proportion is almost certainly low, since the work status of more than 20 percent was not ascertained.

Residents of every CMHB district used services during 1995, but as Exhibit 3.6 shows, they did so at vastly different rates. Approximately 6 percent of the population in Luce County received services from Superior Behavioral Health, in contrast to only .6 percent of the people in Oakland County who sought assistance from their CMHB. Part of the reason for this tenfold differential resides, no doubt, in the fact that Luce County has few if any alternatives, while Oakland County has what is arguably the most developed private mental health delivery system in the state. Eighteen of the top 20 CMHBs in the exhibit are rural and can fit this explanation.

Exhibit 3.7 suggests that poverty and indigency are predictors of who will use CMHB services. It is probably not accidental that counties such as Luce and Delta rank high in usage and high in the degree to which Medicaid is a funding source, while counties such as Oakland and Macomb rank low in Medicaid spending per capita and in CMHB usage.

Other points should be noted about these demographic data. First, at least some of the observable variation is cultural, that is, people in some counties may be averse to seeking mental health services for reasons other than income level or the availability of private treatment options. Second, if Medicaid spending is a fairly good predictor of CMHB

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**EXHIBIT 3.7**

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**Medicaid Spending per Capita  
by CMHBs, Fiscal 1995**

<b>CMHB</b>	<b>Medicaid per Capita</b>
Superior Behavioral Health	\$149.24
Kalamazoo County	79.10
Northeast	78.93
Copper Country	74.55
Gogebic County	73.18
Delta County	69.73
Muskegon County	64.08
Schoolcraft County	62.12
St. Clair County	61.29
Alger/Marquette	58.68
Tuscola County	57.77
Van Buren County	55.56
Huron Behavioral Health	53.06
Northpointe Behav. Healthcare	50.42
Manistee/Benzie	47.06
Allegan County	41.39
Lenawee County	40.57
Eastern UP	40.28
Bay/Arenac	40.11
North Central	39.22
Genesee County	38.97
Detroit/Wayne County	37.74
Midland/Gladwin	36.85
Au Sable Valley	36.42
Saginaw County	36.26
Jackson/Hillsdale	34.82
Kent County	33.90
Ottawa County	29.97
Monroe County	29.46
Sanilac County	28.16
St. Joseph County	27.94
Grand Traverse/Leelanau	26.94
Berrien County	26.56
Antrim/Kalkaska	25.27
Central Michigan	24.93
Washtenaw County	24.41
Livingston County	20.65
Lapeer County	19.53
Western Michigan	19.45
Clinton/Eaton/Ingham	16.85
Northern Michigan	16.42
Ionia County	16.08
Branch County	15.70
Calhoun County	15.19
Gratiot County	14.37
Newaygo County	14.31
Woodland Behavioral	13.42
Shiawassee County	12.52
Montcalm Cent. Behav. Health	11.51
Barry County	9.13
Oakland County	5.02
Macomb County	4.32

Sources: Michigan Senate Fiscal Agency; and Michigan Department of Community Health.

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**EXHIBIT 3.8**

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**State Authorization for CMHBs, Fiscal 1987 and 1994**

<b>CMHB</b>	<b>1987-89 (\$000s)</b>	<b>1994-95 (\$000s)</b>	<b>Percentage Change</b>
Alger/Marquette	\$4,822.3	\$6,974.1	44.6
Allegan County	1,626.2	6,888.4	323.6
Antrim/Kalkaska	813.1	2,770.0	240.6
Au Sable Valley	2,224.0	4,174.2	87.6
Barry County	995.3	2,606.9	161.9
Bay/Arenac	7,984.9	11,448.6	43.3
Berrien County	8,276.3	11,896.1	43.7
Branch County	662.4	3,075.1	364.2
Calhoun County	8,737.1	11,363.5	30.0
Woodland Behavioral Healthcare	1,053.6	3,354.8	218.4
Central Michigan	6,541.2	9,413.4	43.9
Clinton/Eaton/Ingham	21,730.9	27,565.7	26.8
Copper Country	3,884.7	6,512.1	67.6
Delta County	2,418.5	3,999.1	65.3
Detroit/Wayne County	69,251.8	301,618.1	335.5
Eastern UP	1,245.4	4,505.4	261.0
Genesee County	23,927.1	42,404.2	77.2
Gogebic County	1,616.5	2,569.6	58.9
Grand Traverse/Leelanau	5,252.5	9,341.6	77.8
Gratiot County	691.6	2,059.6	197.8
Huron Behavioral Health Serv.	1,855.2	2,474.9	33.4
Ionia County	2,401.5	3,565.4	48.4
Jackson/Hillsdale	4,396.5	14,598.2	232.0
Kalamazoo County	16,676.5	33,219.0	99.1
Kent County	22,956.4	35,276.7	53.6
Lapeer County	1,035.7	3,965.3	282.8
Lenawee County	4,274.6	6,225.0	46.3
Livingston County	1,237.9	8,202.3	562.6
Superior Behavioral Health	418.1	1,547.9	270.2
Macomb County	9,595.9	55,394.9	477.2
Manistee/Benzie	1,766.7	3,273.2	85.2
Midland/Gladwin	3,579.6	6,310.2	76.2
Monroe County	3,354.6	11,235.5	235
Montcalm Cent. for Behav. Health	1,608.9	2,552.9	58.7
Muskegon County	11,342.2	18,234.8	60.8
Newaygo County	1,997.1	2,304.9	15.4
North Central Michigan	2,765.4	6,542.1	136.6
Northeast Michigan	2,345.3	6,745.3	187.6
Northern Michigan	1,954.0	6,477.7	231.5
Northpointe Behav. Healthcare	3,857.3	6,749.1	75.0
Oakland County	16,384.2	90,177.8	450.4
Ottawa County	5,922.1	9,573.3	61.6
Saginaw County	4,509.1	18,616.9	312.8
St. Clair County	11,681.4	14,652.6	25.4
St. Joseph County	1,171.4	4,283.4	265.6
Sanilac County	877.4	2,940.7	255.1
Schoolcraft County CMH Serv.	532.5	1,434.3	169.3
Shiawassee County	1,253.5	4,361.4	247.9
Tuscola County	1,112.8	5,760.1	417.6
Van Buren County	3,599.0	5,010.0	39.2
Washtenaw County	12,582.2	19,383.0	54.1
Western Michigan CMH System	2,630.4	6,059.6	130.3
Michigan	\$335,422	\$891,689	165.8

Sources: Michigan Senate Fiscal Agency, 1996; and Michigan Department of Community Health.

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**EXHIBIT 3.9**

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**Gross Spending per Capita by CMHBs, Fiscal 1995**

<b>CMHB</b>	<b>1990 Census</b>	<b>Gross Spending</b>	<b>Per-capita Spending</b>
Schoolcraft County	8,302	\$2,634,163	\$317
Superior Behavioral Health	5,763	1,460,529	253
Gogebic County	18,052	4,173,859	231
Copper Country	53,955	12,280,701	228
Detroit/Wayne County	2,111,687	461,534,977	219
Delta County	37,780	7,701,417	204
Northeast Michigan	63,429	12,391,076	195
Manistee/Benzie	33,465	6,518,399	195
Kalamazoo County	223,411	43,047,213	193
Antrim/Kalkaska	31,682	6,096,680	192
Muskegon County	158,983	30,121,718	189
St. Clair County	145,607	25,984,726	178
Grand Traverse/Leelanau	80,800	14,121,590	175
Northpointe Behav. Healthcare	64,926	11,219,696	173
Tuscola County	55,498	9,313,640	168
Alger/Marquette	79,859	12,907,128	62
Western Michigan	56,574	8,912,401	158
Sanilac County	39,928	6,231,977	156
Huron Behavioral Health	34,951	5,392,765	154
Eastern UP	45,278	6,852,055	151
Van Buren County	70,060	10,278,991	147
Bay/Arenac	126,654	18,182,420	144
North Central Michigan	70,543	9,650,658	137
Genesee County	430,459	58,787,459	137
Allegan County	90,509	12,101,032	134
Berrien County	161,378	21,489,741	133
Calhoun County	135,982	17,771,206	131
Monroe County	133,600	17,418,144	130
Au Sable Valley	56,732	7,244,083	128
Woodland Behavioral Healthcare	49,477	6,227,689	126
Lenawee County	91,476	11,394,494	125
Kent County	500,631	62,335,856	125
Midland/Gladwin	97,547	11,960,116	123
Jackson/Hillsdale	193,187	23,246,088	120
Saginaw County	211,946	24,649,582	116
Northern Michigan	85,863	9,613,396	112
Newaygo County	38,202	4,199,191	10
Washtenaw County	282,937	30,829,241	109
St. Joseph County	69,770	7,556,108	108
Clinton/Eaton/Ingham	432,674	42,494,274	98
Oakland County	1,083,592	106,252,133	98
Livingston County	115,645	10,731,197	93
Gratiot County	38,982	3,609,948	93
Shiawassee County	58,913	5,353,628	91
Macomb County	717,400	65,015,292	91
Branch County	41,502	3,740,748	90
Ionia County	57,024	5,105,946	90
Ottawa County	187,768	16,442,608	88
Lapeer County	74,768	6,378,674	85
Montcalm Cent. Behav. Health	53,059	3,813,738	72
Barry County	50,057	2,645,332	53
Central Michigan	137,030	5,921,730	43
Michigan	9,295,297	\$1,331,528,864	\$143

Sources: Michigan Senate Fiscal Agency, 1996; and Michigan Department of Community Health.

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usage, the reverse is less apt to be true. Some counties, such as Kalamazoo, have low usage rates but high Medicaid spending per capita, most likely because the county does a relatively good job of obtaining Medicaid reimbursement for clients who qualify. The DCH has indicated that it would like for all CMHBs to be more aggressive in seeking Medicaid reimbursement.

### **CMHB Funding and Priorities**

Exhibit 3.8 gives information on state authorization for CMHB funding between fiscal 1986 and fiscal 1994. Over this period, the amount jumped from \$335 million to \$891 million, or by 165 percent. As the Senate Fiscal Agency noted in commenting on the data, the funding tripled during a time when the cumulative rate of inflation was just 33 percent. Furthermore, the rate of increase statewide masks considerable variation in the rate for individual CMHBs. The high was +562 percent in Livingston County, and the low was +15.4 percent in Newaygo County. Population factors explain a good deal of the variation.

Exhibit 3.9 provides data on gross per-capita spending in the 52 CMHBs for fiscal 1995. Whereas Exhibit 3.8 gave the original authorization, spending may be more or less than authorized depending on actual need. This exhibit shows total spending from all sources, including supplemental appropriations, private insurance, Medicaid, individual and local funds, and charitable donations.

As was apparent in earlier exhibits, the highest per-capita spending tends to be associated with northern lower Michigan and the Upper Peninsula. It seems reasonable to assume that a greater need for public assistance and a lack of lower cost treatment options in those areas provide an important part of the explanation, but other factors may include lack of choice in expensive treatment options, a greater willingness to serve the population, and demographic variables affecting “who shows up at the door.” Perhaps future improvements in data will make more detailed analysis possible.

Exhibits 3.10, 3.11, and 3.12 shed considerable light on differences in CMHB philosophy and approach to treatment, particularly the relative importance attached to adult mental illness, treatment for children, and programs for the developmentally disabled.

Exhibits 3.10 and 3.11 provide per-capita analysis using 1990 Census data for adults and children, respectively, to control for the demographic factor of a higher or lower proportion of young people in a district. As can readily be seen, considerable variation exists. With the exception of the Kalamazoo and the Detroit-Wayne CMHBs, gross and per-capita spending tend to be higher in northern Michigan and lower to the south, but there is no clear pattern.

The CMHBs serving Luce and Schoolcraft counties spend a good deal per capita on both mentally ill adults and children, while the Eastern UP CMHB, which adjoins that area to the east, spends only moderately on both groups. The Berrien County board spends fairly liberally on adults per capita but not on children; the Manistee-Benzie CMHB spends liberally on children but only moderately on adults; and the Central Michigan CMHB spends very little on either.

Exhibit 3.12 tracks spending for three client populations as a percentage of gross spending. Figures for the developmentally disabled are included because dollars expended on this group affect what a board has available for mentally ill adults and children. Thus, it becomes obvious

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**EXHIBIT 3.10**

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**Gross Spending per Capita by CMHBs on Mentally Ill Adults, Fiscal 1994**

<b>CMHB</b>	<b>Adult Census</b>	<b>Gross Spending</b>	<b>Per-capita Spending</b>
Superior Behavioral Health	4,195	\$551,867	\$132
Detroit/Wayne County	1,541,050	202,640,304	131
Schoolcraft County	6,172	797,470	129
Copper Country	41,459	4,779,425	115
Kalamazoo County	168,938	19,447,906	115
Grand Traverse/Leelanau	59,078	6,405,097	108
Delta County	27,606	2,386,582	86
Gogebic County	14,021	1,182,480	84
Van Buren County	49,664	3,866,771	78
St. Clair County	105,196	7,923,704	75
Berrien County	117,859	8,517,398	72
Washtenaw County	221,841	15,952,058	72
Northpointe Behav. Healthcare	48,435	3,476,295	72
Muskegon County	114,319	8,177,115	72
Bay/Arenac	93,285	6,635,571	71
Alger/Marquette	59,220	4,208,169	71
Eastern U P	34,432	2,393,972	70
Manistee/Benzie	25,408	1,750,398	69
Kent County	359,055	24,352,346	68
Huron Behavioral Health	25,574	1,691,522	66
Genesee County	309,796	19,641,185	63
Oakland County	815,534	51,095,408	63
Jackson/Hillsdale	142,364	8,473,600	60
North Central Michigan	52,001	3,066,128	59
Branch County	29,935	1,749,530	59
Western Michigan	41,166	2,400,748	58
Calhoun County	99,789	5,794,708	58
St. Joseph County	49,835	2,889,964	58
Monroe County	95,356	5,219,600	55
Northern Michigan	62,671	3,388,396	54
Midland/Gladwin	71,077	3,797,131	53
Woodland Behavioral Healthcare	36,112	1,913,100	53
Tuscola County	39,672	2,019,470	51
Macomb County	545,747	27,358,417	50
Antrim/Kalkaska	23,051	1,153,650	50
Lapeer County	52,659	2,635,062	50
Saginaw County	152,369	7,599,400	50
Allegan County	63,644	3,165,243	50
Northeast Michigan	47,618	2,316,455	49
Lenawee County	65,698	3,094,488	47
Newaygo County	26,910	1,259,071	47
Clinton/Eaton/Ingham	322,028	13,942,572	43
Sanilac County	28,635	1,237,656	43
Au Sable Valley	41,957	1,775,172	42
Livingston County	82,513	3,358,891	41
Montcalm Cent. Behav. Health	37,858	1,342,486	35
Ottawa County	132,690	4,504,716	34
Shiawassee County	41,935	1,393,363	33
Ionia County	40,920	1,309,655	32
Gratiot County	28,404	841,107	30
Barry County	36,068	948,504	26
Central Michigan	103,813	928,706	9
Michigan	6,836,532	\$518,758,032	\$76

Sources: Michigan Senate Fiscal Agency, 1996; and Michigan Department of Community Health.

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**EXHIBIT 3.11**

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**Gross Spending per Capita by CMHBs on Mentally Ill Children, Fiscal 1994**

<b>CMHB</b>	<b>Child Census</b>	<b>Gross Spending</b>	<b>Per-capita Spending</b>
Superior Behavioral Health	1,568	\$148,348	\$95
Schoolcraft County	2,130	161,856	76
Manistee/Benzie	8,057	608,556	76
Detroit/Wayne County	570,637	39,286,275	69
St. Clair County	40,411	2,644,257	65
Van Buren County	20,396	1,303,622	64
Grand Traverse/Leelanau	21,722	1,379,774	64
Alger/Marquette	20,639	1,230,654	60
Kalamazoo County	54,473	3,145,582	58
Delta County	10,174	567,769	56
Western Michigan	15,508	826,922	53
Northpointe Behav. Healthcare	16,491	854,391	52
Macomb County	171,653	8,476,945	49
Northeast Michigan	15,811	772,606	49
Branch County	11,567	542,788	47
Jackson/Hillsdale	50,823	2,343,683	46
North Central Michigan	268,058	11,911,889	44
Antrim/Kalkaska	8,631	359,167	42
Livingston County	33,132	1,368,849	41
Calhoun County	36,193	1,483,047	41
Copper Country	12,496	511,558	41
St. Joseph County	19,935	801,761	0
Ionia County	16,104	647,526	40
Lenawee County	25,778	1,002,527	39
Monroe County	38,244	1,469,580	38
Northern Michigan	23,192	824,714	36
Huron Behavioral Health	9,377	324,699	35
Au Sable Valley	14,775	509,206	34
Shiawassee County	16,978	570,943	34
Gogebic County	4,031	128,595	32
Genesee County	120,663	3,779,921	31
Washtenaw County	61,096	1,905,738	31
Lapeer County	22,109	676,559	31
Bay/Arenac	33,369	1,013,532	30
Eastern UP	10,846	322,840	30
Montcalm Cent. Behav. Health	15,201	450,383	30
Kent County	141,576	4,192,404	30
Newaygo County	11,292	331,398	29
Muskegon County	44,664	1,271,867	28
Saginaw County	59,577	1,617,193	27
Clinton/Eaton/Ingham	110,646	2,919,200	26
Barry County	13,989	349,876	25
Allegan County	26,865	588,935	22
Woodland Behavioral	13,365	276,239	21
Tuscola County	15,826	313,503	20
Midland/Gladwin	26,470	494,914	19
Central Michigan	33,217	590,212	18
Berrien County	43,519	769,462	18
Gratiot County	10,578	182,128	17
Ottawa County	55,078	720,477	13
Sanilac County	11,293	119,265	11
Michigan	2,458,765	\$109,944,307	\$45

Sources: Michigan Senate Fiscal Agency, 1996; and Michigan Department of Community Health.

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**EXHIBIT 3.12**

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**Percentage of Gross Spending per Client Category by CMHBs, Fiscal 1994**

<b>CMHB</b>	<b>Mentally Ill</b>		
	<b>Adults</b>	<b>Children</b>	<b>Dev. Disabled</b>
Alger/Marquette	32.6%	9.5%	44.3%
Allegan County	26.2	4.9	60.4
Antrim/Kalkaska	18.9	5.9	63.6
Au Sable Valley	24.5	7.0	49.1
Barry County	35.9	13.2	39.9
Bay/Arenac	36.5	5.6	52.0
Berrien County	39.6	3.6	51.0
Branch County	46.8	14.5	34.1
Calhoun County	32.6	8.3	43.3
Woodland Behavioral Healthcare	30.7	4.4	52.8
Central Michigan	15.7	10.0	69.2
Clinton/Eaton/Ingham	32.8	6.9	48.2
Copper Country	38.9	4.1	43.5
Delta County	31.0	7.4	55.0
Detroit/Wayne County	43.9	8.5	41.3
Eastern UP	34.9	4.7	45.1
Genesee County	33.4	6.4	57.7
Gogebic County	28.3	3.1	51.1
Grand Traverse/Leelanau	45.4	9.8	31.1
Gratiot County	23.3	5.0	61.2
Huron Behavioral Health Serv.	31.4	6.0	50.5
Ionia County	25.6	12.7	48.6
Jackson/Hillsdale	36.5	10.1	43.5
Kalamazoo County	45.2	7.0	40.7
Kent County	39.1	6.7	49.1
Lapeer County	41.3	10.6	43.2
Lenawee County	27.2	8.8	52.2
Livingston County	31.3	12.8	44.3
Superior Behavioral Health	37.8	10.2	31.8
Macomb County	42.1	13.0	34.5
Manistee/Benzie	26.9	9.3	63.8
Midland/Gladwin	31.7	4.1	54.0
Monroe County	30.0	8.4	52.8
Montcalm Cent. for Behav. Health	35.2	11.8	41.3
Muskegon County	27.1	4.2	56.4
Newaygo County	30.0	7.9	56.6
North Central	31.8	8.8	50.1
Northeast	18.7	6.2	66.1
Northern Michigan	35.2	8.6	48.0
Northpointe Behav. Healthcare	31.0	7.6	48.0
Oakland County	48.1	11.2	34.5
Ottawa County	27.4	4.4	56.9
Saginaw County	30.8	6.6	57.1
St. Clair County	30.5	10.2	50.6
St. Joseph County	38.2	10.6	43.4
Sanilac County	19.9	1.9	67.9
Schoolcraft County CMH Serv.	30.3	6.1	48.7
Shiawassee County	26.0	10.7	53.7
Tuscola County	21.7	3.4	66.4
Van Buren County	37.6	12.7	32.9
Washtenaw County	51.7	6.2	38.4
Western Michigan CMH System	22.5	9.3	48.0
Michigan	39.0	8.3	45.1

Sources: Michigan Senate Fiscal Agency, 1996; Michigan Department of Mental Health; and Public Sector Consultants.

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that outlays for mentally ill adults and children in the Central Michigan CMHB are small because most of the money goes to the developmentally disabled (nearly 70 percent in 1995). The Northeast Michigan and the Tuscola and Sanilac County CMHBs exhibit a similar if less extreme pattern. The data also make other useful comparisons possible. For example, Barry County spends comparatively little on the mentally ill per capita (Exhibit 3.9), but adults and children claim a high percentage of what is available, unlike the developmentally disabled.

Information on CMHB administrative expenses is available but not included here because state analysts do not consider it reliable. CMHBs across the state do not use a uniform definition of administrative costs, and some, such as the Detroit-Wayne CMHB, do not include the portion of contracts spent for administration. A similar problem of variation exists for information on client waiting lists, which is included as part of Appendix B.

### **Current Programs**

Although the move toward community-based care has been the policy of several Michigan governors, the commitment of the Engler administration is particularly strong. Today, people with mental illnesses may live in

- **foster care homes**, which are private, licensed residences for children and adults;
- **group homes**, in which six or fewer people live and which are managed by not-for-profit agencies or CMHBs responsible for the daily activities and maintenance of the homes;
- **supported independence programs**, which help individuals find homes, apartments, condominiums, or townhouses; and
- **residential treatment centers**, which provide crisis intervention and stabilization services as an alternative to hospitalization and which are especially important in rural areas.

In addition, the state and CMHBs have established a number of innovative services to help clients with independent living. These include

- **psychosocial rehabilitation**, a program for persons with long-term mental illness that provides an opportunity to develop social, occupational, and living skills;
- **wraparound services**, operated by clinicians in the community who coordinate support that “wraps around” the child and family in their day-to-day life; and
- **drop-in programs**, which provide a safe and supportive environment for individuals with mental illness living in the community, especially those who are isolated in society or reject participation in other mental health programs.

One of the most positive community-based initiatives to be developed in the last ten years is the Assertive Community Treatment (ACT) program. Based on a Wisconsin model, ACT began in Michigan in 1979 as a demonstration project called the Harbinger Alternative Treatment Program. The primary goal of this service is to eliminate unnecessary psychiatric hospital days of care and to increase the quality of life for patients. Its most distinguishing feature is mobile community treatment teams consisting of nurses, psychiatric social workers, psychiatrists, occupational therapists, and others. People are seen in the community, at home, and at work rather than in mental health clinics.

**EXHIBIT 3.13**

**CMHB Program Costs for Mentally Ill Adults, 1995**

Program	Number of Cases	Percentage of Total	Cost	Percentage of Total
Board-managed local inpatient	20,394	4.8	\$ 27,219,861	5.2
Board-managed state inpatient	1,822	0.4	158,571,338	30.2
Board-managed residential-local	9,645	2.3	87,944,071	16.8
Board-managed residential-state or other boards	349	0.08	12,000,023	2.3
Board-managed residential-supported independence	926	0.2	3,519,772	0.7
Partial hospitalization	521	0.1	2,220,341	0.4
Psychosocial rehabilitation	1,872	0.4	6,245,742	1.2
Other day programs	5,996	1.4	25,216,716	4.8
Outpatient clinic services	127,667	30.2	86,405,584	16.5
Emergency services	200,519	47.4	24,151,877	4.6
Assertive Community Treatment	5,735	1.4	34,900,732	6.7
Community treatment team	327	0.07	1,376,214	0.3
Client services management	40,657	9.6	47,221,990	9.0
Family supportive/home-based services	192	0.04	161,964	0
Integrated employment services	2,144	0.5	4,027,351	0.8
Community integration services	3,889	0.9	2,873,854	0.5
Respite residential services	151	0.03	292,899	0.1
Direct prevention services	0	0	0	0
Other prevention services	0	0	0	0
Board administration	0	0	0	0
<b>Total</b>	<b>422,806</b>	<b>100<sup>a</sup></b>	<b>\$524,350,330</b>	<b>100<sup>a</sup></b>

Source: Michigan Department of Community Health, 1996.

<sup>a</sup>May not add to 100 percent due to rounding.

Today, Michigan has 86 ACT programs, more than any other state, and they provide care to more than 3,400 people. Analysts with the DCH believe there is a direct correlation between the number of ACT teams and the decline in hospital days.

It should be noted that while the DCH is enthusiastic about the quality and efficacy of community-based programs, some of the major stakeholders are considerably more restrained in their assessment. The following observations are excerpted from remarks made by the executive director of the Michigan Psychiatric Society to the Senate Community Health Department Appropriations Subcommittee on February 21, 1996:

Our members have experience with young patients that would indicate that case workers and wrap-around specialists are not always adequately trained or prepared to deliver appropriate services, nor do they spend sufficient time with families to understand the needs of the child or to effectively intervene. The combination of philosophical and cost-driven reluctance to provide hospital or residential care with long waiting lists for services results in children being “on hold” for needed treatment. Blind adherence to the dictum that hospitalization is a treatment of last resort, to be avoided at all costs, can result in children cycling through a series of ineffective interventions, experiencing failure and becoming treatment-resistant or, worse, moving into the juvenile justice system.

Exhibits 3.13 and 3.14 present expenditure data by program category for mentally ill children and adults, respectively. The vast bulk of the clients are in the least restrictive programs, such as outpatient services. A disproportionate share of expenditures, however, is allocated to the most restrictive treatment setting—inpatient and residential care. For example, board-man-

**EXHIBIT 3.14**

**CMHB Program Costs for Mentally Ill Children, 1995**

Program	Number of Cases	Percentage of Total	Cost	Percentage of Total
Board-managed local inpatient	915	1.3	\$ 1,608,948	1.5
Board-managed state inpatient	209	0.3	16,626,004	15.2
Board-managed residential - local	908	1.3	14,382,409	13.1
Board-managed residential-state or other boards	117	0.2	4,771,631	4.4
Board - managed residential-supported independence	6	0.08	76,071	0.1
Partial hospitalization	100	0.1	512,429	0.5
Psychosocial rehabilitation	0	0	0	0
Other day programs	616	0.9	788,298	0.7
Outpatient clinic services	48,710	70.4	38,200,604	34.9
Emergency services	2,779	4.0	1,357,796	1.2
Assertive Community Treatment	143	0.2	506,314	0.5
Community treatment team	301	0.4	1,314,613	1.2
Client services management	7,004	10.1	11,569,675	10.6
Family supported services/home-based services	5,169	7.5	14,649,485	13.4
Integrated employment services	0	0	0	0
Community integration services	73	0.1	73,699	0.1
Respite residential services	2,137	3.0	3,078,556	2.8
Direct prevention services	0	0	0	0
Other prevention services	0	0	0	0
Board administration	0	0	0	0
<b>Total</b>	<b>69,187</b>	<b>100<sup>a</sup></b>	<b>\$109,516,532</b>	<b>100<sup>a</sup></b>

Source: Michigan Department of Community Health, 1996.

<sup>a</sup>May not add to 100 percent due to rounding.

aged state inpatient care is employed in only .3 percent of the cases involving children, yet it accounts for fully 15 percent of the CMHB dollars spent on mentally ill children. State officials may claim that they improve care by discouraging hospitalization, but there is absolutely no doubt that they save a great deal of money as well.

The CMHBs claim not to have spent any money on prevention or board administration during 1995. This is an obvious error contradicted by other sources. Actually, CMHBs spent about \$69.6 million on administration, or 5.2 percent of their total expenditures.

Furthermore, the DCH claims that of the approximately \$11 million spent each year on prevention services, \$1.5 million is for program development and \$9.5 million for a number of established programs, including those targeting infants, school-age children, and the children of mentally ill parents. This claim cannot be verified in available reports, but whatever the case, \$11 million would be less than one percent of CMHB spending. Since prevention is now a core responsibility for each board, and since better data on administrative costs are required by recent appropriations bills, both these spending categories may show dramatic increases in the future.

**New Directions**

The recent revisions to the Mental Health Code (P.A. 290 of 1995), effective in March 1996, are expected to shift even more responsibility for the delivery of care from the state to local

communities. The DCH views the legislation as the result of more than two years of negotiations among lawmakers, state agency officials, and interested parties.

Many believed that an overhaul of the code was long overdue. Breakthroughs in pharmacology have revolutionized the use of medications for many illnesses once thought to be untreatable. Therapy techniques also have changed, and community-based approaches successfully address the problems of many patients who previously would have been institutionalized.

There is little doubt, however, that the code revisions were largely engineered by the current administration. In 1992, three years before the legislation was enacted, DCH director James Haveman highlighted its essential goals:

- (1) complete the move to community-based services and end the dual system of care;
- (2) understand mental health services as health care, not merely social services;
- (3) focus the mission and functions of the department as a guarantor rather than provider of services;
- (4) strengthen capacity for local management by investing greater authority in community mental health agencies;
- (5) expand partnerships at all levels to provide better service to communities, consumers, and their families;
- (6) assume accountability, as measured by outcomes, throughout an enhanced system of management and services;
- (7) elevate priority status for programs “based on the earliest possible intervention and the preservation of the family”; and
- (8) involve consumers and families as extensively as possible in decision making at all levels, from designing treatment plans to considering statewide priorities.

P.A. 290 of 1995 is a complicated piece of legislation, and the enrolled text runs more than 70 pages. To a large extent, the desired goals listed above were embodied in the revisions.

Some of the major provisions of P.A. 290 are noted below.

- The DCH is required to shift primary responsibility for the direct delivery of public mental health services from the state to a community mental health services program (CMHSP), rather than the county, as specified in the previous law. A CMHSP is defined as an official county agency, a multicounty community health organization, or a CMH authority (CMHA), an entity newly created by the bill.
- The CMHA provisions in effect give localities a third option for structuring. Under previous law, CMHBs were either a single or a multicounty agency. An “authority” can be an independent government agency that can own property, reserve accounts, and otherwise be empowered to provide greater financial and program flexibility.
- Priority is to be given to the provision of services, with emphasis on the most serious cases of mental illness.
- The rights of consumers and their families are expanded by specifying that one-third of the membership of CMHBs, recipients’ rights committees, and the state advisory council be comprised of consumers and family members.

- CMHBs are given more financial flexibility by allowing them to carry forward 5 percent of their state funding from one fiscal year to the next.
- To assure consistent quality, all CMH programs are required to be certified by the state or else be accredited by one of three national agencies: the Joint Commission on Accreditation of Health Care Organizations; the Commission for the Accreditation of Rehabilitation Facilities; or the Council on Accreditation for Families and Children.
- To improve the quality of services, the DCH is required to present an annual needs assessment to the legislature, and each CMHB is required to review consumer outcomes.

P.A. 290 was supported by many in the medical and mental health communities, including the Michigan Association of Community Mental Health Boards, the Mental Health Association in Michigan, the Michigan Psychiatric Association, and the Michigan State Medical Society. This is not to say that each of these organizations was entirely satisfied with the legislation.

There also was significant opposition. The Alliance for the Mentally Ill in Michigan and the Michigan Association for Children with Emotional Disabilities (MACED) opposed the bill, as did a number of labor unions, who were concerned about possible effects on collective bargaining and other issues. The concerns expressed most often are highlighted below.

- Many important details of the bill were not well thought through, and the process moved too fast. It was known that the CMHB structure would be reviewed, but it was not generally known until fairly late that a rewrite of the code was under way. “A cut-and-paste job” is how one advocacy group described the changes. Other experienced observers warned that the many inconsistencies and the vague and confusing language are an invitation to confusion and litigation.
- A number of groups, including a few CMHBs, have repeatedly expressed grave reservations about creating CMHAs, particularly the fact that they would be granted governmental immunity from negligence, even intentional acts and gross negligence. Critics argue that this extends immunity far beyond the historical understanding of the concept.
- Targeting resources to those most seriously ill is rational but should not obscure the fact that persons with symptoms deemed less serious may have to wait for treatment, if indeed they qualify for it at all. The insured and those with financial resources will be fine, but the uninsured and/or low-income population may well go unserved.
- Some argue that the priority language is not adequately specific to ensure that the sickest people receive care. Of particular concern is the fate of children who need hospitalization at state institutions.
- The language dealing with involuntary civil commitment does not adequately protect patients, and that dealing with jail diversion is not nearly strong enough to ensure reform.

In the end, the legislature was not persuaded that any of these objections were sufficiently important to hold up passage of the revised code. It is possible, however, that some concerns will be addressed in the future.

Developments outside the legislative arena may have long-term consequences for the system. For example, MACED and a number of parents filed suit against the DCH and several CMHBs

on the grounds that their failure to provide psychiatric hospital care for some children is both harmful to the children and a violation of state law. The Michigan Psychiatric Society is considering filing an *amicus* brief in this suit and is preparing its own analysis of children's mental health issues. Finally, the Jail Diversion Subcommittee of the Michigan Bar Association is exploring the possibility of using court rules to remove some mentally ill prisoners from the criminal justice system and put them under the protection of the probate courts.

## FUTURE POLICY DIRECTIONS

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In Michigan and across the United States, the system for delivering mental health services is undergoing profound change. While it is impossible to say what will emerge in the next millennium, one thing is certain: The new system will be very different from the one developed over the past 30 years. A number of factors virtually guarantee it.

### What Lies Ahead

First, there is a general conviction that community-based care is superior to a hospital-based system in a majority of instances. Patients are to be treated in the least restrictive environment consistent with their diagnosis. Often, this is in a community setting close to their family.

Second, the development of effective drugs for the treatment of mental problems has contributed to and will continue to facilitate the move to a community-based system. Drug therapy has made outpatient treatment possible in many cases that once would have required hospitalization.

Third, the demand for mental health services will grow. There is much broader acceptance of the belief, long held by professionals, that mental health is one aspect of overall health and that mental illness is as real as any other. For many people, the stigma once associated with seeking mental health services has diminished or disappeared.

Fourth, as demand increases, so will cost, a matter of great concern to the businesses and public agencies that pay the bills. Community-based treatment and improved medication have been cost effective, but payors are seeking even more aggressive containment by introducing managed care, which includes HMOs, preferred provider organizations (PPOs), utilization review, and case management.

Fifth, although managed care saves money and has been vigorously defended on the ground that it deploys finite resources rationally, often it is unpopular with the mental health professionals who deliver care. They are concerned that

- treatment decisions may be made by administrators for financial reasons rather than by clinicians for medical reasons;
- patients in managed care plans may receive different, and quite possibly inferior, treatment compared to patients in traditional plans or those who pay out of personal resources; and

- the loss of provider autonomy may damage patient/provider relations, most seriously in the area of confidentiality.

Sixth, and paradoxically, while managed care is anathema to many professionals, its proven ability to control costs may make one of their dreams a realistic possibility: full equality as between mental and physical illnesses in health insurance plans. In spring 1996, the U.S. Senate approved legislation that would require precisely this.

To a large extent what happens in mental health care over the coming decade will result from the interplay of these six factors. As in any period of great change, both improvements and declines in the quality of care are possible. On the one hand, a greater percentage of people may have access to a more comprehensive array of benefits and a delivery system that is at once more flexible, localized, individualized, and cost effective. On the other hand, there may be fewer resources, demoralized and overworked professionals, and serious inequities in the quality of care.

The situation in Michigan may be especially dynamic owing to recent changes with far-reaching implications for care delivery. In 1996, the revisions in the Mental Health Code took effect. While they had strong support among some stakeholders and the legislature, other key groups opposed the changes. Furthermore, among supporters there are varying degrees of enthusiasm. Many believe that the full effects cannot be predicted, that certain issues must continue to be monitored, and that important work remains to be done.

Another important development occurred in January 1996, when Governor Engler issued an executive order that merged the former mental health and public health departments, along with the state Medicaid program, into the DCH. This was greeted with “cautious enthusiasm” by some in Michigan’s mental health community. On the positive side, the result may be care that is better coordinated and truly integrated, but there also are fears that mental health may become the neglected stepchild of a super-department. The fact that mental health, but not the public health component, was targeted for spending cuts in the 1997-1998 budget did nothing to allay these fears.

The following sections summarize some of the significant issues that must be analyzed and the questions that must be answered by those who seek to understand, participate in, and influence the upcoming policy debate.

## **Managed Care**

Already a reality, managed care is likely to become even more widespread and influential. Whether the payor is a private health insurance company or the Michigan Medicaid program, this cost-containment approach raises a number of questions.

- How can one best ensure that fully qualified clinicians, and not administrators, will determine the proper treatment and course of care?
- Can an adequate minimum benefit for managed care plans be defined? There are concerns that the proposed limitations on treatment will not meet the needs of chronically ill patients.

- Will patients in managed care plans receive inferior treatment? One fear is that they will receive pills because these are cheaper, while people in traditional plans may have access to more expensive therapies.

## **Mental Health Professionals**

There is considerable evidence that mental health professionals are demoralized as a result of managed care and other developments. One representative of a key group believes that many professionals are feeling beat up and left out of decision making. Many statewide conferences are dominated by administrators, and the agenda usually involves consortiums, affiliations, and funding but not clinical issues.

Mental health services may be improved if professionals along with mental health advocacy and consumer groups feel part of the debate. A supportive network of professionals and clinicians could help define the issues and solutions in Michigan.

## **State Psychiatric Hospitals for Children**

Few other mental health topics in recent years have inspired so much distrust and controversy as care for mentally ill children. Tensions were heightened when the Engler administration announced in spring 1996 that it would not seek funding for the Fairlawn Hospital in Pontiac, even though \$6 million recently had been spent on upgrading the facility.

State officials claimed that the number of patients at Fairlawn had declined, that the expenditure per patient was ruinous, and that private psychiatric hospitals and the state's Hawthorn facility were available for patients who needed hospitalization. Opponents believe these arguments conceal a narrow cost-cutting agenda and maintain that usage of state children's hospitals is being artificially constrained to make the case for closure. They also claim that private hospitals are by no means set up to accommodate children with the most serious, chronic emotional disturbances. In their view, children who require long-term hospitalization and their families are simply going to suffer.

The issue cannot be resolved here. Perhaps the report being prepared by the Michigan Psychiatric Association will shed light on the situation, although its preliminary finding is that the diversion of children from hospitals has not given rise to adequate alternatives. It also remains to be seen what may eventuate from the MACED suit.

Regardless of how those developments turn out, the subject is likely to remain front and center in the foreseeable future and is a major fault line in the ongoing debate. Different people looking at the same facts draw different conclusions about when hospitalization is appropriate, when adequate alternatives exist, and what the proper role of government and families should be.

Hospitalization for children touches on a larger question raised by the new Mental Health Code: whether the most seriously ill people will be given priority. On the surface, the law now appears to require it. But members of advocacy groups, including some that supported the revisions as a package, argue that the code's language still allows CMHBs too much discretion.

## **The Geographic Dimensions of Care**

Differences in population, financial resources, and access to institutions and professionals mean that people in various parts of the state have vastly different mental health care options. South-eastern Michigan has a mental health infrastructure that probably rivals any in the country. More than 40 percent of the state's private psychiatric hospitals and seven of the nine state hospitals are in that area, as are 66 percent of licensed psychiatrists.

At the other extreme, 47 counties have no private facility whatsoever (the two outlying state hospitals are in Kalamazoo and Tuscola counties), and there are only 17 licensed psychiatrists in the entire Upper Peninsula. To some extent variations are due to economics and cultural attitudes largely beyond the control of government, but public policy still needs to consider the issue of a basic floor of services.

A further complication is that different CMHBs give varying priority to serving mentally ill adults and children and developmentally disabled adults, as was discussed in chapter 3. Data limitations make it difficult to draw firm conclusions, but it seems reasonable to assume that demographics do not explain the variation. More likely, the different boards simply have different philosophies that may result in some populations being treated well, even generously, while others are underserved.

## **Prevention**

The revised Mental Health Code identifies prevention as a core responsibility of a community mental health services provider. Yet, spending information available from the DCH indicates that prevention efforts will have to start virtually from scratch. In fiscal 1995, the 52 CMHBs reported no expenditures in this category. The DCH claims that it spends approximately \$11 million on prevention services each year, or significantly less than one percent of total expenditures. This claim cannot be independently verified, however. The prevention pilot projects initiated by the department and boards in the past have not survived and apparently are among the very first casualties of budget cutbacks. For example, during initial budget discussions, the Engler administration proposed to reduce funding for new prevention programs from \$1.5 million to \$1.1 million, though the legislature restored the funds.

Cutting prevention dollars is probably short sighted, but Michigan is certainly not alone in this regard. Several recent national studies concluded that the efficacy of prevention is amply documented in the scientific literature. What has been lacking is the social will to put these programs in place. As the demonstrated ability of prevention models to reduce costs and alleviate suffering becomes more widely understood and appreciated, however, a preventive approach to mental illness is likely to gain in popularity—in Michigan and elsewhere.

## **Mental Illness and Crime**

There is a close link between the mental health and corrections systems because many criminals are mentally ill. One of the important social costs that investments in mental health services are designed to alleviate is the high cost of crime. Indeed, one economist has estimated public expenditures for alcohol and drug abuse and mental illness associated with the criminal justice system at nearly \$16 billion.

Several basic facts illustrate the interaction between crime and mental illness.

- According to the National Alliance for the Mentally Ill, approximately 7 percent of the people in the nation's jails (excluding prisons) have serious mental illness. The DCH and the American Psychiatric Association consider that estimate reasonable.
- The DCH confirms that CMHBs in 1995 provided mental health services for 4,496 persons in jail and another 207 in prison.
- The Michigan DSS reported in 1994 that 23.7 percent of the residents in its Delinquency Services program had previously been hospitalized in a psychiatric facility.
- A psychiatric profile of children and adolescents who commit murder found that nearly all had diagnosable mental disorders, though few ever received any mental health care. The study, published in the *Journal of the American Academy of Child and Adolescent Psychiatry* in 1995, suggests that, without rehabilitation, violent offenders may pose an even greater threat to the public upon release.

It should be noted that the number and percentage of persons with mental illness in the state's jails are at a 100-year high. In fact, the jailing of the mentally ill is ten times more prevalent today than it was in 1880. The state psychiatric hospital system was created in part because it was considered cruel and inhumane to treat sick people as criminals.

Jail diversion programs have not been politically popular of late, and the Alliance for the Mentally Ill of Michigan (AMIM) was unsuccessful in making it a priority issue during the recent debate over revisions to the Mental Health Code. The Jail Diversion Subcommittee of the State Bar Association is now studying the possibility of using court rules to turn certain mentally ill jail inmates over to the civil jurisdiction of the probate courts.

Whereas jail diversion for mentally ill adults may be considered an act of decency, diversion and treatment programs for adolescent offenders have even broader social implications, since experience suggests that when the young do not receive care they become an increasing problem as they age.

### **Governmental Accountability/Immunity**

In the recent discussion surrounding the Mental Health Code revisions, AMIM argued forcefully that existing governmental immunity in instances of negligence or malpractice should be revoked. This is unlikely to occur any time soon, however, because county governments are greatly in favor of limiting their liability exposure.

Nevertheless, AMIM believes that the revocation of immunity would be the single most important step government could take to improve the quality of its mental health operations and restore full accountability. The issue may be all the more important because the revised code allows the newly created CMHAs immunity while remaining beyond the control of directly elected county government. An important question is thus raised: If a CMHA is outside the governance of the county commission and cannot be forced to answer for its actions in a court of law, then how is it to be held accountable?

The concept of governmental immunity, which has its basis in common law, was effectively overturned by a court decision in 1961. The Michigan legislature enacted a law in 1964 that granted state government protection against suits with four exceptions: public highways, pub-

lic buildings, operation of motor vehicles, and proprietary functions. In 1986 a fifth exception was added—public hospitals and nursing homes—but curiously enough, an exception was made for state hospitals run by the Department of Mental Health. Why would the government not require the same accountability from those who treat the mentally ill as it does from those who maintain roads or treat all other types of medical conditions or diseases? Furthermore, why should a patient in a private psychiatric hospital be able to seek legal redress, whereas a patient in a public institution cannot?

The debate is not merely academic. Government-run psychiatric hospitals and mental health programs can and do make mistakes. In fact, after confronting a particularly horrendous set of facts, one judge on the Michigan Court of Appeals felt compelled to make the following observation: “I fail to see how summarily relieving the [government-run] hospital of responsibility for such obvious gross negligence, without requiring of it even the slightest explanation, serves any viable public interest or protects the people of our state.” He added that the time had come for the legislature to “preserve and promote justice” by modifying the doctrine of governmental immunity.

In the case under review, the police brought a woman to a state psychiatric hospital because she was threatening to kill someone. Nevertheless, and despite the fact she had previously been a patient at the institution, she was refused treatment. Four days later the woman went to the police and repeated her threats but was told to leave. Two days after that she fatally stabbed someone. The negligence case of the victim’s family against the hospital was dismissed on the grounds of governmental immunity.

The idea behind changing immunity rules is not to create new avenues for litigation but to afford patients of state hospitals the same access to justice as other patients and to provide some forum for establishing facts and assessing responsibility.

## **Data and Information Management**

Acquiring adequate mental health data from the private sector will always be problematic. Private corporations are reluctant to release information absent a compelling public reason, which is seldom present. Public sources are more accessible, but the Senate Fiscal Agency recently made clear that data on Michigan’s \$1 billion community mental health system is not of sufficient quality to allow the legislature to perform its oversight function properly or to keep the public fully informed.

Ideally, all 52 CMHBs would keep data that at a minimum includes the following:

- information on the client and the population category to which s/he belongs (mentally ill adult, mentally ill child, developmentally disabled adult);
- the diagnosis or diagnoses;
- the services plan;
- funding source;
- expenditures and expenditures per unit of service; and
- outcomes.

Needless to say, the definitions used for compiling these data would have to be uniform across the state. One of the worst possible outcomes would be for the different CMHBs to adopt management information systems that produce different and essentially incomparable data.

Uniform and high-quality data would permit interesting and important analyses to be made. It would be possible, for example, to know whether Medicaid patients typically are provided a certain kind of treatment with poorer results. Or one could determine whether some CMHBs spend excessively on patients with certain diagnoses without achieving improved outcomes.

The value of having such information is obvious. It would promote efficiency and accountability throughout the costly CMHB system. Equally important, it would allow the CMHBs to function as genuine laboratories of innovation—which is impossible without data to determine whether programs work effectively and efficiently.

No one familiar with the CMHB system seriously disputes this. The revised code and the last two appropriations bills require the DCH and CMHBs to provide more comprehensive reports and better data. And they have begun to do so. Whether the data/management information issue evolves in a way that is fully satisfactory remains to be seen. Good data inevitably expose program weaknesses and shortcomings, and this will always be a threat to someone.