Mental Health in Michigan

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Mental Health in Michigan

Project Manager	*Peter Pratt, Ph.D.*
Author	*Paul Smyth, Ph.D.*
Editor	*Ann Jacob*
Publication Specialist	*Dyan Iansiti*

Contents

INTRODUCTION **1**
MENTAL HEALTH PROFESSIONALS **4**
Types of Mental Health Professionals 4
The Practice of Mental Health Care 5
Types of Treatment and Patients *7*
FUNDING **10**
Insurance Coverage Nationwide 10
Expenditures at the State Level 12
The Situation in Michigan 12
State Appropriations *14*
The Uninsured and Managed Care for Medicaid 16
Medicaid Managed Care 17
A New CMHSP Distribution Formula 20
Changing Attitudes and Approaches 21
The Practitioners' Perspective of Managed Care 23
The Question of "Parity" 24
MENTAL HEALTH CARE INSTITUTIONS AND ORGANIZATIONS IN MICHIGAN **27**
The Private Sector 27
The Public Sector 28
State Hospitals *28*
Community Mental Health Boards *31*
CMHSP Demographics *31*
CMHSP Funding and Priorities *35*
Current Programs 38
New Directions 43
FUTURE POLICY DIRECTIONS **47**
What Lies Ahead 47
Managed Care 48
Mental Health Professionals 49
State Psychiatric Hospitals 49
The Geographic Dimensions of Care 50
Prevention 50
Mental Illness and Crime 50
Governmental Accountability/Immunity 51
Data and Information Management 52

PREFACE TO THE SECOND EDITION

This report on the mental health system in Michigan was first presented to the Flinn Foundation in August 1996. The system has not changed dramatically in the intervening 16 months, but there has been a shift in the relative importance of the issues under public discussion.

For much of 1996, the state, local mental health agencies, and the public were still adjusting to the effects of significant changes to the mental health laws and to the state agencies that execute them.

- In 1995, the Michigan legislature completed a massive revision to the mental health code—the first such major revision in 20 years.
- In 1996, an executive order of the governor merged all state health-related functions—including those found in the departments of Public Health and Mental Health and the Michigan Medicaid Program—into a newly created Department of Community Health (DCH).

While both these changes, and especially the code revisions, were controversial at the time, little of the controversy lingers today. Many observers believe that the new arrangements are generally working well.

On the other hand, the issue of hospital closures became much more explosive in 1997 following the Engler administration's announced plans to close the Pheasant Ridge, Clinton Valley, and Detroit Psychiatric Institute facilities. The proposed closures spawned heightened rhetoric on all sides and at least three lawsuits.

The administration and its allies argued that the declining patient census in these facilities made closure necessary as a way to conserve public resources and taxpayer dollars. They argued, further, that the state's large private hospital system was available to fill any gaps in treatment caused by the closures.

Opponents of closure, including many state practitioner and patient advocacy groups and a committee of the Michigan House of Representatives, argued that the decline in the state hospital census was the result of cost, not treatment considerations. They also argued that the closure of public facilities would create a gap in the mental health "continuum of care" which the state's private hospitals could not be expected to fill.

In September 1997, a judge of the Wayne County Circuit Court permanently enjoined the state from proceeding with closure on the grounds that to do so would violate the Michigan Constitution. That same month, the Michigan Court of Appeals issued a brief order staying the circuit court's injunction, while denying the state's request for a peremptory reversal. In so doing, the Appeals Court allowed the hospital closures to take place, while agreeing to rule on the constitutional issues at a later date. The case, which is being argued on an expedited basis, may be decided as early as January 1998.

Although not nearly as well publicized, developments of another sort may alter enormously the structure for the delivery of mental health services on the local level. Since 1995, the state has been operating a limited behavioral health managed care program for state Medicaid recipients. Beginning in 1998, the DCH will begin a more ambitious managed care plan wherein local Community Mental Health Service Programs (CMHSPs) will assume responsibility for the behavioral health needs of the majority of Medicaid recipients, as well as the uninsured and severely ill persons who make up the bulk of their mentally ill clients.

Under the plan, the state will enter into exclusive contracts with CMHSPs to provide services within their respective catchment areas on a risk-based, capitated payment basis. To facilitate the change, the state has developed a new funding formula for CMHSPs based on sophisticated statistical estimates of the number of potential clients—i.e., Medicaid recipients, persons without insurance, and severely mentally ill persons—in each local service area.

In the future, the state plans to move into a fully competitive phase in which CMHSPs lose their exclusive contractual arrangement and are forced to compete with other health care providers for state management contracts. As the Citizens Research Council of Michigan recently noted, full-blown competition would raise a "substantial prospect" for the privatization of mental health services in some parts of the state.

If this were indeed to occur, the process of "devolution" would be complete. A system of care, once largely a state responsibility, would devolve to the local level and potentially out of the hands of government altogether.

Finally, in 1996 the U.S. Congress passed the Mental Health Parity Act (MHPA) which makes it illegal for employer health plans to place annual or lifetime dollar limits on mental health payments that are not also applied to payments for other illnesses. Although the final legislation was considerably less expansive and costly than earlier versions, it will affect some Michigan employers and has rekindled the parity debate anew.

Employers and insurers traditionally oppose health insurance mandates of any sort on the grounds that they inevitably restrict choice and increase costs. Some find mental health coverage mandates particularly troublesome because changes in treatment and an explosion in the number of officially recognized diagnoses make them fearful of their ability to control utilization and costs.

Practitioners and mental health advocates see these changes as signs of a maturing discipline. They argue that mental health diagnosis and treatment is at least as precise and effective as that

of traditional medicine. Practitioners and advocates believe that traditional insurance arrangements unfairly discriminate against the mentally ill and are costly to society to the degree that patients with treatable conditions are prevented from seeking help.

This updated report to the Flinn Foundation addresses these and other mental health issues in greater detail.

In general, routinely compiled, readily available information on Michigan's mental health care system was included in this updated report. Sections of the report were not revised in instances where newer information was either not available or where the failure to include it would not materially alter the report's major conclusions. Examples of the types of information that were *not* updated include: 1997 data on the number and types of mental health care providers; proprietary expenditure data provided to Public Sector Consultants by Blue Cross/ Blue Shield of Michigan during 1996; and information based upon certain ad hoc reports issued by the Michigan Senate Fiscal Agency during 1996.

INTRODUCTION

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 5.4 percent (10 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 [DMH]). In a 1996 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, though reputable studies vary substantially in their dollar estimates. According to one study cited by the U.S. Department of Health and Human Services (DHHS), the total direct cost nationwide was $67 billion in 1990, or 11.4 percent of all personal health care expenditures. Furthermore, the same study estimates that the indirect costs—loss of productivity and function—were $147.8 billion in 1990, more than two times higher. Another study, also cited by DHHS, estimated the total direct cost of mental illness to be considerably lower in 1990—$42.4 billion.

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. Many observers, including a number of advocate groups, believe that the code revisions and the departmental consolidation within state government have worked fairly well, though all concede that the effects of 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. In addition, recent scientific advances have made it clear that many mental problems have a biological and chemical basis, a development that 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. It is important to note that legislation passed in 1995 changed the name of these local institutions to Community Mental Health Service Programs (CMHSPs), which is how they are known today.

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 1997, the State of Michigan operated psychiatric hospitals with a capacity of just under 1,000 beds. In 1997, the private system had a capacity of more than 5,100 beds in 127 institutions, located in 38 Michigan counties. Fifty CMHSPs 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.

CHAPTER 1

MENTAL HEALTH PROFESSIONALS

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 counselor 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, counselors, 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 CMHSP 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 counselor 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 counselors 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 certainly one of the few, if not 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, counselors, 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 counselors. 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. Unfortu-

EXHIBIT 1.1

Mental Health Professionals in Michigan, 1996

Profession	Number	% of Total
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	100.0[a]

SOURCES: Michigan Department of Consumer and Industry Services; Michigan Psychiatric Association, Michigan Chapter; and National Association of Social Workers.
[a]Does not equal 100 percent due to rounding.

nately, data on how many of these are actually employed in such a setting are not readily available.

In 1996, there were 52 Michigan CMHSP districts, and mental health professionals operated in each of them. As Exhibit 1.2 demonstrates, however, there was considerable variation in the population-to-provider ratio (PPR) in the districts. The statewide average in 1996 was 652 people for each mental health professional, but this figure masked a considerable range. In Allegan County, the PPR was 2,529, compared to 220 in Washtenaw County, or more than a tenfold differential.

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 have been within the CMHSP district where they did the majority of their work. For example, the Allegan County CMHSP with its unfavorable ratio in 1996 is next door to Kalamazoo County, where the PPR was 310; there is evidence that a number of professionals who lived or had their office in the latter served the Allegan population.

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

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. It should be noted, however, that Michigan CMHSPs generally have been able to find a 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 observers 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; over the past decade, however, there has been increasing reliance 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 working 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, indigence, 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.

EXHIBIT 1.2

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 9

CMHB	1994 Pop.	Psychologists	Counselors	Therapists	Social Workers	Psychiatrists	CMHB Total	Population per Provider
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.

CHAPTER 2

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. Again, it should be noted that the $42.4 billion in estimated mental health expenditures is conservative. Other reputable estimates set the figure as much as 50 percent higher.

EXHIBIT 2.1

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

Source	Payments	% of Total
Private	$18.8	44.3
State and	11.7	27.5
Medicaid	8.1	19.1
Veterans Administration	1.5	3.5
Medicare	1.5	3.5
Other federal	0.8	1.8
TOTAL	$42.4	100.0[a]

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

[a]Does not equal 100 percent due to rounding.

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.

More recent data available from the Employee Benefits Research Institute (EBRI) suggests that, if anything, the extent of health insurance coverage in the United States is on a downward trend—although, as will subsequently be discussed, this does not appear to be true in Michigan. According to EBRI, in 1996, 17.7 percent of the nonelderly population, or 41.4 million

individuals, were not covered by health insurance. In that same year, 150 million individuals, or 64.1 percent, were covered by employer-sponsored plans.

In addition to the large numbers of people who lack any health insurance are those whose private plans do not cover mental health. According to the DHHS study, approximately 2 percent of the U.S. population falls into that category. Therefore, when the percentage of individuals with plans that do not cover mental health services is added to the percentage with no insurance at all, it becomes apparent that some 20 percent of Americans lack mental health coverage.

EXHIBIT 2.2

Insurance Coverage for the Nonelderly in the United States, 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.

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 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.

EXHIBIT 2.3

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

	Hospital Care			Outpatient Care		
Benefits	**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 Statistics Employee Benefits Survey, 1986, 1989, and 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 taken place 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.

In 1996, the National Association of State Mental Health Program Directors (NASMHPD) estimated that state mental health agencies oversaw expenditures in excess of $12.3 billion in 1990. As a percentage of state spending on health and welfare, this represented a drop of about 1 percent from 1983 levels, but as a percentage of overall state budgets, the figure remained fairly constant.

State per-capita spending on mental health varied 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.

In 1997, NASMHPD partially updated these estimates using 1992 data. According to the later estimates, total state mental health agency expenditures reached $13.8 billion in 1992—a 12 percent increase over 1990. Per-capita expenditures in 1992 again showed considerable variability, ranging from a high of $316 in the District of Columbia to a low of $13 in Iowa with its largely county-based system. The median per-capita expenditure in the United States in 1992 was $44, while per-capita expenditures in Michigan were $74.

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 DMH, while Medicaid spending was handled by the former Department of Social Services (DSS), now the Family Independence Agency (FIA).

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 was intended to improve service coordination and provide more efficient management and administration of similar service providers. A number of observers hoped that, in the long term, centralization would lead to better cost data as well. As of 1997, there is some evidence that this is happening.

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

EXHIBIT 2.4

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

	Dollars	Percentage of Total
Public expenditures		
Department of Mental Health[a]	$ 891,504,523	37.6%
Medicaid[b]	410,921,909	17.4
Subtotal	1,302,426,432	55.0
Private expenditures		
BCBSM Ins.[c]	57,785,682	2.4
BCBSM TPA[d]	86,678,523	3.7
Other private insurers[e]	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 (BCBSM), 1996; and Public Sector Consultants, 1996.

[a]Fiscal 1995, excluding developmental disability.

[b]State spending minus funds paid to CMHBs.

[c]Reimbursement for psychiatric services, calendar 1995. Insurance products are estimated to be 40 percent of BCBSM's business.

[d]Estimated psychiatric reimbursements in third-party administrator plans.

[e]Estimated at 50 percent of private insurance market.

billion. Of the private-sector amounts, only the $57.8 million in BCBSM reimbursements for psychiatric care in fully insured plans is based on hard data, the remainder on commonly accepted estimates.

State Appropriations

Between fiscal year (FY) 1987-88 and FY 1997-98, gross state appropriations for mental health services rose in current dollars in every year except FY 1996-97, when they dropped by approximately $6 million. Exhibit 2.5, developed by the Michigan Senate Fiscal Agency, shows that the current dollar increase in gross state appropriations for mental health over that decade was $850,033,800, or approximately 78 percent. Michigan's General Fund/General Purpose current dollar contribution to mental health rose by $286,800,400, or approximately 38 percent, over the same period.

Yet, as the Fiscal Agency analysis makes clear, a simple recitation of these facts does not provide a complete picture of state mental health financing. In FY 1997-98, for example, changes in the accounting procedures used to develop the mental health portion of the budget produced a gross appropriation figure that was artificially high in relation to that of previous years. Analysts stress that while the accounting changes were perfectly appropriate, the gross appropriations figure for FY 1997-98 cannot be compared to those of previous years without adjustments.

The final column provides just such an adjusted picture. With the effects of the accounting change factored in, the increase in state funding for mental health services over the decade appears less dramatic. As Exhibit 2.5 shows, the adjusted increase in current dollar state appropriations for mental health between FY 1987-88 and FY 1997-98 was just over $590 million, or 54 percent. The General Fund/General Purpose figures remain unchanged.

Exhibit 2.5 also makes clear that controlling for the effects of inflation further refines the picture of state mental health funding. When adjusted for both accounting changes and the Detroit Consumer Price Index (CPI), gross appropriations for mental health rose by $162,238,728, or 15 percent between FY 1987-88 and FY 1997-98. Fully adjusted General Fund/General Purpose appropriations, which contain the bulk of Michigan's contribution, rose from $759,930,900 in FY 1987-88 to $779,417,762 in FY 1997-98. This represents an increase of only about $19.5 million or 2.5 percent in real dollar terms.

The figures for institutional appropriations and the number of people being treated in state facilities are also significant. Between FY 1987-88 and FY 1997-98, General Fund/General Purpose appropriations for state mental health facilities (including forensic facilities for the treatment of mentally ill convicts) dropped by 47.7 percent in current dollars and 60 percent in real dollars. This closely tracks a simultaneous decline in the population of state facilities at the end of each fiscal year. The population of mentally ill adults and mentally ill children dropped by 68 percent and 67 percent, respectively, over the decade.

The population found in "other facilities," which includes patients in forensic centers, was the sole exception to this trend. Between FY 1987-88 and FY 1996-97, the population in these facilities increased by 202, or 64 percent.

EXHIBIT 2.5

Mental Health Appropriations History, FY 1987–88 through FY 1997–98

	FY 1987–88[a]	FY 1988–89	FY 1989–90	FY 1990–91	FY 1991–92	FY 1992–93	FY 1993–94	FY 1994–95	FY 1995–96	FY 1996–97	FY 1997–98	Adjusted FY 1997–98[b]
FTE	11,030.0	10,786.5	10,436.5	9,529.5	8,071.5	6,247.5	6,719.0	6,489.0	5,803.0	5,957.0	6,225.0	6,225.0
GROSS APPROPRIATION	1,086,313,300	1,160,168,600	1,244,456,700	1,281,024,500	1,316,398,600	1,330,512,300	1,450,327,200	1,524,797,500	1,606,778,400	1,600,881,800	1,936,347,100	1,676,347,100
Interdepartmental Grants	799,300	915,000	765,000	829,500	1,820,000	3,525,400	56,771,000	54,408,100	71,878,000	65,957,100	74,501,300	74,501,300
ADJUSTED GROSS APPROPRIATION	1,085,514,000	1,159,253,600	1,243,691,700	1,280,195,000	1,314,578,600	1,326,986,900	1,393,556,200	1,470,389,400	1,534,900,400	1,534,924,700	1,861,845,800	1,601,845,800
Federal	233,686,600	240,956,100	276,374,500	298,885,600	311,480,300	337,986,800	333,261,900	395,794,900	450,198,900	455,158,100	503,167,700	503,167,700
Local	43,467,600	40,822,100	41,264,600	41,815,600	38,960,600	34,967,000	30,614,500	29,401,300	26,769,200	24,349,300	287,259,400	27,259,400
Private								2,200,000	2,310,000	2,200,000	2,200,000	2,200,000
State Restricted	48,428,900	45,755,600	47,913,500	51,540,000	53,523,000	42,967,000	39,671,400	31,739,000	36,767,200	28,149,400	22,487,400	22,487,400
General Fund/General Purpose	759,930,900	831,719,800	878,139,100	887,953,800	910,614,700	911,066,100	990,008,400	1,011,254,200	1,018,855,100	1,025,067,900	1,046,731,300	1,046,731,300
Hospital population at end of Fiscal Year	5,024	4,742	4,046	3,350	2,952	2,734	2,563	2,254	2,158	1,902	NA	NA
Mentally Ill Adult	2,979	2,838	2,478	2,050	1,933	1,790	1,571	1,286	1,173	952	NA	NA
Mentally Ill Child	345	391	302	268	252	256	181	117	117	115	NA	NA
Developmentally Disabled	1,385	1,176	978	768	522	476	412	402	352	318	NA	NA
Other Facilities (Forensic, etc)	315	337	288	264	245	212	399	449	516	517	NA	NA
GF/GP appropriation for Institutions[c]	380,755,700	403,728,000	438,406,200	441,976,700	433,599,500	371,613,600	333,936,000	340,260,000	290,831,900	281,075,500	202,198,000	202,198,000
Percent of total GF/GP budget	50.1%	48.5%	49.9%	49.8%	47.6%	40.8%	33.7%	33.6%	28.5%	27.4%	19.3%	19.3%
Detroit CPI in calendar year	114.7	120.8	126.5	131.1	133.4	135.2	138.7	143.6	147.3	150.7	154.0	154.0
GF/GP Institutional spending in 1988 dollars	380,755,700	383,341,073	397,511,392	386,687,471	372,817,561	315,266,863	276,153,275	271,781,490	226,414,198	213,899,109	150,560,810	150,560,810
Gross appropriations in 1988 dollars	1,086,313,300	1,101,583,927	1,128,372,992	1,120,774,296	1,131,865,963	1,128,770,420	1,199,369,357	1,217,926,694	1,250,885,626	1,218,274,772	1,441,844,075	1,248,552,028
GF/GP appropriations in 1988 dollars	759,930,900	789,720,704	796,225,729	776,874,911	782,964,813	772,923,681	818,701,972	807,735,771	793,184,175	780,079,055	779,417,762	779,610,910

SOURCE: Michigan Senate Fiscal Agency, 1997.

[a] Amount in "Local" for years prior to FY 1994–95 combines both Local and Private.

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

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

NA = Not available.

EXHIBIT 2.6

Michigan Department of Mental Health CMH vs. Institutional Appropriations, FY 1980 and FY 1995 (dollars in millions)

	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

SOURCE: Michigan Department of Mental Health, 1995.

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 CMHSPs. By 1995, the last year for which fully comparable data are available, the situation was completely reversed: state facilities and community mental health took up 23 percent and 69 percent of the mental health budget, respectively.

As will be discussed at greater length in the next chapter, recent revisions to the Michigan Mental Health Code will save money and push the state even further in the direction of community-based services, although officials insist that cost cutting was not the prime objective.

The Uninsured and Managed Care for Medicaid

Despite the enormous outlays over the years, it is apparent that many people 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 Michiganians did not have public or private health care coverage and thus no mental health care benefits. Among the uninsured were:

- more than 158,000 children under age 15,
- more than 155,000 young men between the ages of 12 and 18,
- more than 125,000 women between the ages of 45 and 65,
- 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 lacked mental health insurance of any sort in 1990. Those with severe conditions likely became a state responsibility and received some care, particularly if they presented a danger to themselves or others, but many people who may have benefited from psychiatric help probably had no access to it.

There is, however, increasing evidence that the problem of the uninsured in Michigan may have diminished somewhat since the time of the last Census. For example, an EBRI analysis of more recent Census Bureau data revealed that, between 1994 and 1995, the percentage of

persons without health insurance coverage dropped by more than 1 percent. As of 1995, an estimated 938,000 citizens of the state were without health care coverage—a high number, but down substantially from the estimated 1.07 million without coverage in 1990.

Recent state and federal developments seem destined to bring additional improvements. In September 1997, the Engler administration unveiled a joint federal/state plan—called in Michigan the Michigan's Children's Health Plan, or MIChild—which would afford additional protection to many children living in families with income below 200 percent of the poverty level. The recently enacted Federal Budget Reconciliation contained $4.2 billion in funds to provide coverage for poor children not otherwise eligible for Medicaid. Michigan will receive almost $92 million in the next fiscal year to provide health insurance to 156,000 children. With the matching dollars the state is expected to provide, total funding for the program could exceed $130 million in 1998 alone.

Medicaid Managed Care

In an era of tight state budgets and high demand for services, state policy makers have become increasingly reliant upon managed care, that is, risk-based, often capitated systems for the delivery of mental health services to state Medicaid recipients. This has been done to control costs, certainly, but also to improve access to services and assure quality care.

Although initiated in the early years of the decade, the managed care program gained momentum in 1995 when the Michigan departments of Social Services, Mental Health, and Public Health began a jointly administered and coordinated system of mental health services for state Medicaid recipients. Michigan is not unique among states in this respect. In a recent survey of its membership, the National Association of State Mental Health Program Directors (NASMHPD) found that 32 of the 47 responding states had adopted some form of managed care for mental services provided under the state Medicaid program.

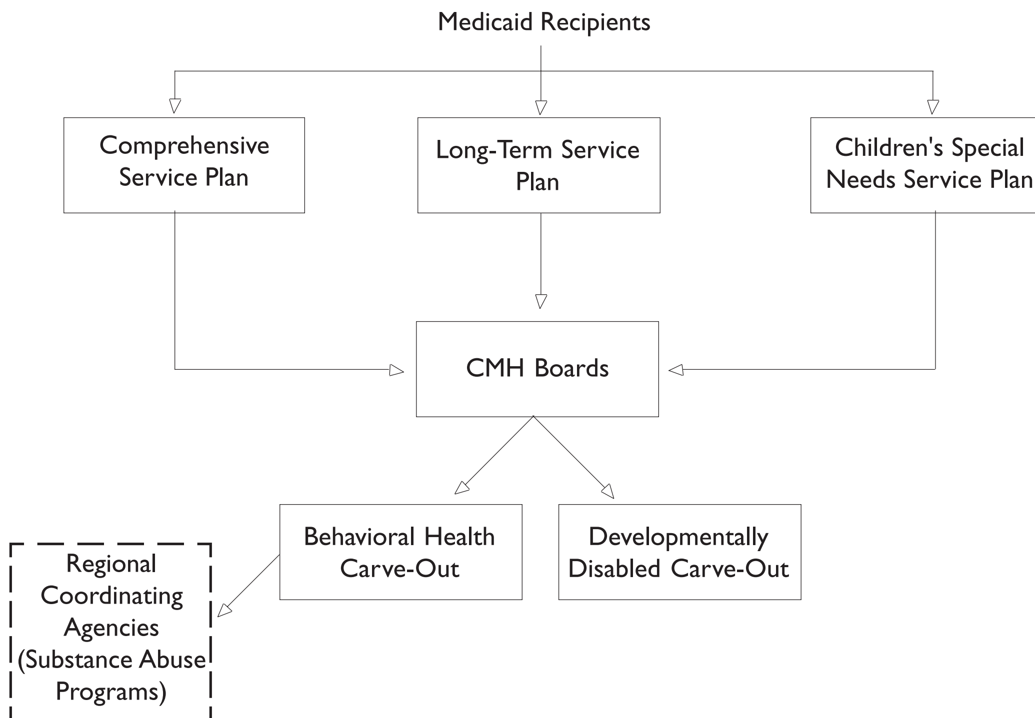
Of course, these developments within state Medicaid programs simply mirrored what had been taking place within the world of employer-based health coverage for some time. Roughly three out of every four Americans with employer-based health coverage are in managed care plans, according to the National Health Policy Forum. Many of these plans offer specialty care carve-outs for mental health.

In recent years, Michigan has been aggressive in its movement toward capitated managed care arrangements for the Medicaid program generally. As result of a plan announced during 1997, the state managed care system for delivering behavioral health services covered under Medicaid will be especially forceful.

Under the new plan, the bulk of the state's Medicaid recipients will receive medical services under three managed care arrangements: (1) a "Comprehensive Plan" serving Medicaid's traditional low-income client base; (2) a "Children's Special Services Plan" for children with serious diseases and conditions; and (3) a "Long-Term Service Plan" serving the elderly. These three

EXHIBIT 2.7

Medicaid Managed Care Program



SOURCE: Citizens Research Council of Michigan.

plans will, in turn, funnel those among its clients requiring behavioral health or developmentally disabled services into two specialty managed care service "carve-outs." Exhibit 2.7 demonstrates how the new system is expected to function.

As the DCH noted in a recent description of the program:

> *. . . nearly all Medicaid developmental disability, mental health and substance abuse services will be 'carved out' of Medicare primary health care plans and arrangements. The department will contract (on a sole source basis) with county-sponsored Community Mental Health Service Programs (CMHSPs) to manage these Medicaid services and dollars on a shared risk, prepaid, basis. Under the department's plan CMHSPs will be designated as the managing entity or contractor which receives a prepayment (capitation) to provide or arrange all necessary covered developmental disabilities and mental health and/or substance abuse services for Medicaid recipients.*

The department report makes two other significant points. First, CMHSPs will continue to provide services to the non-Medicaid developmentally disabled and mentally ill clients who make up their client base. Second, with few exceptions, all Medicaid recipients will be re-

quired to access these specialty carve-out services through the CMHSP that serves the recipient's geographic region.

The carve-out programs were originally scheduled to begin on January 1, 1998. The DCH, however, is in the process of negotiating the necessary federal waivers with the Health Care Financing Administration (HCFA). This process could delay the planned startup beyond the first quarter of 1998.

Finally, the DCH also has made it clear that the implementation of this program is unlikely to be the last iteration of the managed care approach to the delivery of mental health services in Michigan. The current phase calls for local CMHSPs to assume full responsibility for the delivery of services on a capitated basis. State officials have made it clear, however, that they envision a subsequent phase involving an open-bidding process in which both public CMHSPs and private health care providers compete for state contracts. All bidders will be required to meet the same standards for organizational capacity, quality care, consumer involvement, and cost effectiveness.

It is not overstating the case to say that this subsequent phase could usher in a period of extraordinary change in mental health care delivery in Michigan. The future, and perhaps even the survival of, local CMHSPs would depend on their success in the bidding process. Competition for state contracts likely would be intense in some areas and less so in others. Yet, as the authors of the Citizens Research Council of Michigan report note in their discussion of this issue: "It is clear that a substantial prospect exists for privatizing the delivery of CMH services in many parts of the state."

While few doubt that the plan has potential merits, it has raised 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?

In an effort to address and anticipate some of these questions, the DCH contracted with the Michigan Public Health Institute (MPHI) to analyze cost, utilization, and quality of care data provided to the state by local CMHSPs between 1995 and 1997. In general, the MPHI reports, entitled *Quality Improvement and Performance Monitoring*, paint a favorable picture of the Medicaid managed care experiment over these years. The Medicaid managed care program is meeting or exceeding state quality standards in most categories, according to MPHI. Also, actual expenditures have been well below expenditure targets. For example, the managed care program saved the state almost $20 million in the first half of 1997 alone.

Although conceding that the Medicaid managed care program has saved money, some observers have expressed concern that the MPHI reports are based on an "in-house" evaluation pro-

cess and run the risk of painting an overly optimistic picture of the program. Concerns have been raised regarding the quality of care indicators (which changed substantially in the last year), the confidentiality of responses to surveys, certain key definitions (e.g., that of "recidivism"), and a focus on processes rather than clinical outcomes.

A New CMHSP Distribution Formula

An important concomitant to Michigan's move toward managed care in recent years was a revision of the CMHSP funding formula for FY 1996-97. The change appears to have been long overdue. The new funding formula, which is based upon estimates of the extent and severity of need in each CMHSP catchment area, is both more rational and more equitable than the old system, which perpetuated serious inequities.

The promise of managed care provided part of the impetus for the development of a new formula. It is, after all, nearly impossible to conceive of a risk-based, capitated system that is not based on careful assessments of local CMHSP need. In other respects, the new funding formula corrects what might be called "accidents of history." As will be seen in the next chapter, the per-capita appropriations to local CMHSPs vary in ways that have little to do with need.

While all of the 50 current CMHSPs now operate under what are called "full management contracts"—contracts under which all responsibility for public mental health services is assumed by the local board—this change happened gradually. For the last 15 years, a number of local boards continued to operate under "shared management" contracts which made public mental health services a joint state/local responsibility.

For complex historical reasons, the timing of when the local boards entered into full management contracts greatly affected their funding. Those boards that adopted full management contracts earliest have seen their financial position erode, while those who adopted them later have done comparatively well. The situation was further complicated in FY 1997 when a gap between the legislative appropriation and the state's contractual obligation to the local CMHSPs led to a large budget shortfall and the potential of a $15 million across-the-board cut in local programs.

As the Citizens Research Council of Michigan noted in its report, the funding formula devised in FY 1996-97 reflects a concern for achieving equity in CMH funding, an interest in supporting managed care, and the necessity of dealing with a short-term budget shortfall of approximately $15 million. In general terms, the new CMHSP funding formula targets client populations as follows:

- Medicaid recipients (approximately 25 percent of allocation),
- the uninsured (approximately 25 percent of allocation), and
- people with serious mental disorders (approximately 50 percent of allocation).

To refine their estimates as to how many potential clients reside in each CMHSP catchment area, state budget officials were required to undertake a series of sophisticated analyses. The number of Medicaid clients was estimated from Medicaid data. The number of the uninsured

was estimated on the basis of an updated survey first done in conjunction with the 1988 Governor's Task Force on Access to Health Care.

The estimates as to the number of persons with serious mental disorders were based upon a well-publicized formula for distributing CMH funds in Ohio. The Ohio formula, now adapted to Michigan, uses demographic variables such as age, race, sex, education, and marital status to estimate the extent and severity of the need for mental health services within each CMHSP catchment area.

Exhibit 2.8, adapted from the Citizens Research Council of Michigan report, suggests that the practical effect of the funding formula change on some local CMHSPs was significant. The two columns to the left depict the dollar and percent funding change that would have ensued from full application of the new formula. Absent adjustments, the Superior Behavioral CMHSP would have lost $366,547 or nearly 54 percent of its state allocation. The Montcalm Center, on the other hand, would have gained nearly $1.7 million in state funds.

In order to avoid disruption and to cover the $15 million shortfall, the allocation was adjusted so that only "overfunded" CMHSPs and those that were significantly "underfunded" were affected. As the two columns to the right show, after the adjustment Superior Behavioral experienced a reduction of $110,598 or 16.2 percent. The funding for the Montcalm Center was increased by $432,481 (38.5 percent). Funding for 14 of the 50 CMHSPs was reduced, while funding was increased for 4 CMHSPs. The application of the new formula and adjustments had no net effect on the remaining 34 CMHSPs in FY 1996-97.

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 backseat 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

EXHIBIT 2.8

Effect of Funding Formula Change on Distribution of CMH Funds

CMH Board	Dollar Change from FY 1995–96 State Funding	Percentage Change	Adjusted Dollar Change	Adjusted Percentage Change
Superior Behavioral	$-366,547	-53.71%	$-110,598	-16.21%
Grand Traverse/Leelanau	-2,311,170	-41.31	-697,352	-12.46
Kalamazoo County	-5,964,097	-40.14	-1,799,553	-12.11
Schoolcraft County	-174,051	-28.55	-52,516	-8.61
Gogebic County	-275,288	-26.57	-83,063	-8.02
Copper Country	-892,250	-26.18	-269,219	-7.90
Detroit-Wayne	-31,498,880	-19.78	-9,504,190	-5.97
Oakland County	-7,598,748	-15.88	-2,292,778	-4.79
Macomb County	-3,658,197	-12.14	-1,103,792	-3.66
Livingston County	-481,920	-11.27	-145,410	-3.40
Delta County	-150,877	-8.07	-45,524	-2.44
Northpointe Behavioral	-97,189	-3.73	-29,325	-1.12
St. Joseph County	-14,070	-0.61	-4,245	-0.18
Antrim-Kalkaska	-443	-0.03	-134	-0.01
Mason-Lake-Oceana	16,350	0.55		
Alger-Marquette	41,250	1.35		
St. Clair County	222,703	3.27		
Muskegon County	349,091	4.74		
Washtenaw County	938,399	9.84		
Calhoun County	620,580	10.55		
Kent County	2,159,932	12.32		
Berrien County	880,552	12.90		
Bay-Arenac	765,149	13.54		
Monroe County	670,271	13.99		
Branch County	219,959	15.06		
Northern Michigan	526,568	15.32		
Woodland Behavioral	290,125	15.70		
Jackson-Hillsdale	1,259,636	17.23		
Manistee-Benzie	296,457	21.52		
Eastern UP	402,482	23.33		
North Central	873,734	30.59		
Genesee County	6,060,045	31.86		
VanBuren County	850,226	33.55		
Northeast Michigan	782,104	34.02		
Barry County	487,569	37.71		
Tuscola County	924,350	52.83		
Ottawa County	2,110,244	55.51		
Lenawee County	1,389,341	58.37		
Clinton-Eaton-Ingham	7,635,426	62.23		
Allegan County	1,317,564	62.76		
AuSable Valley	1,057,267	65.13		
Saginaw County	4,904,567	68.23		
Huron Behavioral	727,625	70.10		
Newaygo County	790,058	71.11		
Central Michigan	2,839,556	72.64		
Lapeer County	1,668,649	101.38		
Shiawasee County	1,634,528	103.20		
Sanilac County	1,027,255	105.70		
Ionia County	1,439,179	114.02	50,771	4.02
Midland-Gladwin	2,524,454	130.31	393,469	20.31
Gratiot County	1,113,261	143.68	260,980	33.68
Montcalm Center	1,667,221	148.53	432,481	38.53

SOURCE: Citizens Research Council of Michigan, "Funding Community Mental Health in Michigan," Report #318, January 1997.

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, past 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."

The Question of "Parity"

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. Practitioners and advocates alike have long sought equal status with the mainstream of U.S. medicine and the provision of more comprehensive mental health services.

In April 1996, the U.S. Senate passed the Domenici-Wellstone bill, legislation that prohibited group, individual, or other health insurance plans from imposing any treatment limits or cost-sharing restrictions upon mental health services that were not imposed upon other medical conditions. The senators were persuaded by testimony that costs could be controlled and that in states such as Maryland and Minnesota, which have similar legislation, costs and use of mental services have not risen.

A cosponsor of the bill, 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."

In the U.S. House of Representatives, the Domenici-Wellstone measure proved controversial to the point that it threatened to derail the broader Kassebaum-Kennedy health insurance portability bill to which it was attached. In the end, the provisions of the Domenici-Wellstone bill were restricted significantly, and it was eventually passed as the Mental Health Parity Act (MHPA) of 1996.

Although full parity was not achieved through the passage of the MHPA (the new law only required parity in the annual or lifetime dollar limits applied to benefits), the issue remains a serious one. Many employers have been placing restrictions on mental health benefits in an attempt to make risks and costs more manageable. Yet this attempt at cost management engendered its own set of problems and difficulties. While relatively few people were affected by the restrictions, the problems they generated for afflicted individuals and their families could be serious indeed.

For example, a recent report by the National Advisory Mental Health Council (NAMHC) found that, assuming typical insurance arrangements, a person with a severe episode of mental illness could expect out-of-pocket expenses of nearly $26,700. With full parity of the sort not achieved in the MHPA, the same episode would cost the victim only $1,800—a fifteen-fold differential. Lesser illnesses would produce a significant, though less dramatic differential according to the NAMHC report.

Not surprisingly, mental health care advocates have sought to correct what they perceive to be a serious inequality. At the state level, they have enjoyed a good deal of success. At least 15 states—including Arkansas, Arizona, Colorado, Connecticut, Indiana, Maine, Maryland, Min-

nesota, Missouri, New Hampshire, North Carolina, Rhode Island, South Carolina, Texas, and Vermont—had some form of parity legislation as of late 1997. In addition, at least 31 states mandate mental health coverage.

The MHPA is certainly a precedent for this sort of legislation on the federal level. At the core of the new legislation is a simple prohibition: employers are not allowed to place yearly or lifetime dollar limits on mental health coverage which are more restrictive than those placed on other health benefits. In the end, however, the final version of the MHPA contained significant limitations designed to reduce its cost and scope.

- While annual or lifetime dollar limits for mental health are impermissible unless applied to all health benefits, other differences between mental and other health benefits, such as cost control measures, including limits on inpatient stays, outpatient visits, and various cost-sharing mechanisms, are acceptable.
- Employers can circumvent the MHPA simply by dropping all employee health care coverage.
- Employers with 50 or fewer employees are exempt, as are employers that can demonstrate that the MHPA would lead to an increase of more than 1 percent in their health benefit costs.

The effect of the legislation on employers will probably be less than one might suppose because persons with severe mental illness tend to have a tenuous relation to the workforce.

Studies published since the passage of the MHPA demonstrate that the costs of the legislation for employers are unlikely to be exorbitant. For example, the Congressional Budget Office (CBO) estimated that the premium increases necessary to satisfy the requirements of the original Domenici-Wellstone legislation would be 4 percent. But the CBO estimates that the less-ambitious MHPA will lead only to a .16 percent premium increase for affected employers.

Similarly, a recent study by an economist at the Rand Corporation suggests that the net cost to employers of the MHPA would be minimal. The study, which was published in the *Journal of the American Medical Association*, found that the most expensive changes brought about by the MHPA would result in a premium increase of only $7 per enrollee. A vice president of the U.S. Chamber of Commerce in *Business and Health* remarked that parity "adds little to health care costs, and might even save money over the long term if properly managed."

Despite these observations and findings, the MHPA, as well as the parity issue in general, remains contentious. Senator Domenici was accused of having engineered the passage of a "stealth bill" by one prominent business publication. As the date approached for the MHPA to take effect, both supporters and detractors of the bill were trying to influence the drafting of federal regulations required to implement it. Employers would like to be able to claim an exemption from the law if statistical projections indicate that their premium costs are likely to rise by more than 1 percent in 1998. Mental health advocates, on the other hand, insist that the exemption should be granted only to employers who can demonstrate a premium increase of 1 percent after full compliance with the MHPA for one year. According to press reports, the Clinton administration seems likely to side with employer groups.

The reaction of many employers to the MHPA is part principle, part experience, and part, perhaps, lack of familiarity with the field of mental health treatment. In general, employers oppose mandated health benefits of any sort, believing them to be unwarranted government interference that is likely to restrict choice and increase cost. In their view, insurance mandates run the risk of increasing the number of uninsured while decreasing the dollars available for wages, salaries, and other health care benefits. Employers who opposed the MHPA point to the experience of the Xerox Corporation, which saw mental health costs rise to 40 percent of its total health insurance payout after the company adopted parity of coverage in 1988.

It is also likely that employers are inherently skeptical of their ability to manage costs and utilization in a portion of the health system that has undergone such extensive change in recent decades. As an "Issue Brief" published by the National Health Policy Forum noted:

> *Employer confidence has not been improved by the radical changes that have occurred over the past 40 or 50 years. During that period, the nation has seen a shrinkage of mental hospitals to a mere fraction of their former size, movement of community mental health centers into and out of vogue, massive deinstitutionalization efforts with rather mixed success, development of effective new antidepressants as well as other pharmacotherapies, and greatly reduced reliance on such former staples of the psychiatric regimen as electroshock therapy.*

The authors of the brief also take note of reports that over the past 20 years the number of mental illnesses recognized and classified in the Diagnosis and Statistical Manual of Mental Disorders (DSM) has risen from 108 to more than 300. The DSM is the classification system upon which the diagnostic codes used in insurance billing are based. In theory, at least, more diagnostic codes lead to more billings to insurers and employers.

Mental health advocates, of course, view all of this as evidence that mental health care is getting better and that the diagnoses of mental health practitioners are getting more scientific and more precise. The net effect of change, advocates argue, is less suffering and more people leading productive lives. In the view of mental health advocates, parity legislation merely acknowledges in the field of insurance the progress that has been made in science and medicine.

CHAPTER 3

MENTAL HEALTH CARE INSTITUTIONS AND ORGANIZATIONS IN MICHIGAN

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. In other words, 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 15 May 1997, there were 127 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 5,133 licensed beds in private psychiatric facilities, 914 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 51 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. One hundred nineteen of the 127 facilities offering inpatient care, or 94 percent, are south of a line extending from the north border of Bay County to the north border of Muskegon County. Two of the eight north of this line are located in the Upper Peninsula.

It is significant that all the beds are in 38 counties, that is, the other 45 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

As the recent Citizen's Research Council report notes, the state's interest in the care and treatment of the mentally ill is encompassed in the "police power" of the state—that is, the broad authority each state has to insure the well being of its citizens and the good order of society.

Further, Section 8 of Article 8 of the 1963 Michigan Constitution clearly and explicitly makes the well being of the mentally ill a state responsibility:

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

Public mental health institutions fall into two categories: (1) state-run psychiatric hospitals; and (2) 50 CMHSPs subject to state regulations but most directly accountable to local communities, county commissions, or governance boards. 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) was allocated to community mental health, while $280 million (18 percent) was spent on hospitals, treatment centers, and institutional services.

State Hospitals

The State of Michigan operates six psychiatric hospitals. The Hawthorn Center serves children exclusively. Caro Regional, the Center for Forensic Psychiatry, Kalamazoo Regional, Northville Regional, and Walter Reuther serve adults.

Three of the hospitals are located in the tricounty 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 November 1997 had 1,198 beds, with 118 of these reserved for children.

EXHIBIT 3.1

Inpatient Psychiatric Capacity of State Mental Hospitals in Michigan, 1997

Institution	Adult Beds	Child/Adolescent Beds	Total Beds
Caro Regional	180	0	180
Center for Forensic Psychiatry	210	0	210
Hawthorn Center	0	118	118
Kalamazoo Regional	130	0	130
Northville Regional	350	0	350
Walter Reuther	210	0	210
TOTAL	1,080	118	1,198

SOURCE: Michigan Department of Mental Health, 1997.

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

EXHIBIT 3.2

Admissions to State Mental Hospitals in Michigan, 1990 and 1995

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

SOURCE: Michigan Department of Community Health, 1996.

From 1980 to 1997, the decrease in DMH employees closely tracked the declining number of state hospital patients. In 1980 the department had 15,800 workers, down to 6,200 by 1997.

Exhibit 3.3 shows the number of state mental health facilities and programs that were closed from 1972 to 1992. Eighteen of the 34 closures took place between 1990 and 1997. The three hospital closures that took place during 1997 proved to be especially controversial. Although some observers were prepared to concede that previous closures may have been justified, they expressed concern that the latest wave created the possibility that the state would not be able to meet the needs of some of its most vulnerable citizens.

Both the Michigan Psychiatric Society and the Mental Health Association of Michigan opposed the closing of the Detroit Psychiatric Institute, the Clinton Valley Center, and Pheasant Ridge. Both organizations also called for the creation of a broad-based panel to study the need for long-term psychiatric care in Michigan as well as the future role of state hospitals in the mental health service delivery system. In 1997, the Alliance for the Mentally Ill in Michigan (AMIM) went a step further by filing suit in Wayne County Circuit Court in an effort to prevent closure of the three hospitals.

The administration and the DCH argued strongly that the closures were necessary for several reasons: (1) the number of residents in state institutions had dropped precipitously due to improvements in community-based care; (2) keeping these hospitals open would waste millions in taxpayer dollars; and (3) private hospital beds are available to meet the needs of patients.

Opponents of closure argued that cost, not quality of care, appeared to drive state policy, and that the administration had engineered the decline in state hospital admissions in order to save money. They argued further that the "continuum of care" for the mentally ill in Michigan would be broken because the private sector did not, in fact, have long-term beds available for the sorts of patients who were typically treated in state hospitals.

There were several notable developments in 1997:

- In April, the Mental Health Standing Committee of the Michigan House of Representatives issued its *Report and Recommendations on the Governor's Proposed Closure of: Detroit Psychiatric Institute, Pheasant Ridge Center, Clinton Valley Center*. The report con-

EXHIBIT 3.3

Public Mental Health Facilities Closed in Michigan, 1972–1992

Facility	Location	Year Closed
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
Fairlawn Center	Pontiac	1996
Pheasant Ridge	Kalamazoo	1997
Clinton Valley Center	Pontiac	1997
Detroit Psychiatric Institute	Detroit	1997
TOTAL CLOSURES	34	

SOURCE: Michigan Department of Mental Health, 1995.

cluded, among other things, that the Detroit Psychiatric Institute and the Pheasant Ridge Center should remain open. With respect to the Clinton Valley Center, the House report agreed that its "deteriorated condition" justified closure, but recommended that the Fairlawn Center, which was closed in 1996, should be reopened immediately to accept Clinton Valley's patients.

- In September, Judge J. William Callahan of the Wayne County Circuit Court ruled in favor of AMIM and permanently enjoined the state from closing the three hospitals. Judge Callahan ruled that allowing the closures to proceed would amount to allowing the state to renege on its constitutional obligation to "foster and support" mental health

> institutions. As part of his ruling the judge also noted evidence that the DCH actively discouraged admissions to state hospitals, and noted as well the testimony of a DCH official to the effect that state hospitals are the only institutions in Michigan that provide long-term care to mentally ill adults and children.

In press releases and in public statements, representatives of the department denounced the conclusions of both the House Committee and the circuit court, arguing that their findings were both biased and unduly influenced by special interests such as the public service unions whose members stood to lose employment as a result of the closures. The DCH filed an emergency appeal with the Michigan Court of Appeals which quickly granted it at least partial relief. The Court of Appeals stayed the circuit court injunction, preventing the closing of the three hospitals while denying the state's petition for peremptory reversal.

The constitutional issues raised by the circuit court will be argued before the Court of Appeals in January 1998, with a decision likely issued the same month.

Community Mental Health Boards

Although the concept of community-based services was around much earlier, the legal mandate creating CMHBs (now called CMHSPs) 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 DMH 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 CMHSPs serving all 83 Michigan counties. In 1997, the former Schoolcraft County CMHSP merged with the Eastern Upper Peninsula board to form the Hiawatha CMHSP. Similarly, the Marquette-Alger CMHSP joined with Luce County to form a newly reconstituted Superior Behavioral Health CMHSP. Exhibit 3.4 gives the name and location of these boards as of December 1997. A fuller description is included in the original report.

As the Senate Fiscal Agency 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. Once those data were collected and transmitted by 50 or more separate organizations, problems with uniformity and completeness emerged. 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.

CMHSP Demographics

The DCH report published in 1996 is the basis for the statistical snapshot contained in Exhibit 3.5. In 1996, CMHSPs served at least 150,000 clients statewide. This represents an official decrease from 1995 when CMHSPs served more than 170,000 clients. Since several CMHSPs did not report, however, the numbers are not comparable. The 1996 figure still showed a marked increase over 1990 when 120,490 people were served.

EXHIBIT 3.4

Michigan Community Mental Health Service Programs, 1997

CMHSP	County or Counties Served
Allegan County	Allegan
Antrim/Kalkaska	Antrim, Kalkaska
Ausable Valley	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
Hiawatha	Chippawa, Mackinac, Schoolcraft
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
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
Shiawassee County	Shiawassee
Superior Behavioral	Alger, Luce, Marquette
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.

EXHIBIT 3.5

Demographic Summary Data, 1996, Mentally Ill Adults and Children

	Number	% of Total
Gender		
Males	72,555	47.8
Females	77,796	51.3
Unreported	1,410	0.9
Total	**151,761**	**100.0**
Age		
0 to 3	1,006	0.7
4 to 12	18,136	11.9
13 to 18	16,791	11.0
19 to 26	16,783	11.0
27 to 64	81,398	53.4
65 and over	14,837	9.7
Unreported	3,417	2.2
Total	**152,368**	**100.0**
Race/Ethnicity		
Native American	1,524	1.0
Asian or Pacific Islander	361	0.3
African American/Black	38,736	25.6
White/Caucasian	97,486	64.4
Hispanic	2,481	1.6
Multiracial	1,456	1.0
Unreported	9,277	6.1
Total	**151,321**	**100.0**
Corrections Status		
Prison	210	0.2
Jail	1,458	1.1
Paroled from prison	99	0.1
Paroled from jail	110	0.1
Juvenile detention center	56	0.0
Court supervision	568	0.4
Not in a corrections status	134,535	98.2
Total	**137,036**	**100.0**
Residence		
Homeless/homeless shelter	2,222	1.5
Private - with relatives	78,764	52.0
Private - no relatives	22,456	14.8
Foster family	889	0.6
Specialized residential	3,157	2.1
General residential	5,430	3.6
Prison/Jail/juvenile detention	966	0.6
AIS/MR facility	191	0.1
Nursing care facility	5,532	3.7
Other institutional setting	3,902	2.6
Unreported	27,843	18.4
Total	**151,352**	**100.0**

	Number	% of Total
Annual Household Income		
Below $10,000	83,243	56.6
$10,000 to $20,000	19,341	13.2
$20,001 to $30,000	7,101	4.8
$30,001 to $40,000	2,507	1.7
$40,001 to $60,000	2,090	1.4
Over $60,000	914	0.6
Unreported	31,842	21.7
Total	**147,038**	**100.0**
Payment Source (can be more than one)		
Assessed as having ability to pay	22,946	14.9
Commercial health insurance	21,541	14.0
Service contract	2,903	1.9
Medicare	21,634	14.1
Medicaid	65,864	42.8
Habilitation support waiver	7	0.0
Workers' compensation	61	0.0
Adoptive subsidy	54	0.0
Other public sources	2,067	1.3
Board resources not included	16,640	10.8
Total	**153,717**	**100.0**
Employment		
Employed part-time	10,610	7.1
Employed full-time	14,705	9.9
Unemployed	41,348	27.8
Not in the labor force	56,838	38.2
Unreported	25,150	16.9
Total	**146,651**	**100.0**
Education		
Less than high school	32,139	21.7
Completed high school	57,167	38.5
In School - K-12 or special	28,726	19.4
In-training program	308	0.2
Unreported	30,084	20.3
Total	**148,424**	**100.0**

SOURCE: Michigan Department of Community Health, 1997.

More than half the clients of CMHSPs (53.4 percent) are adults between the ages of 27 and 64; approximately 24 percent are 18 years old and younger; seniors aged 65 and older account for about 10 percent. Nearly two-thirds are white, and about one-quarter are African Americans (25.6 percent). Among the 6 percent of clients for whom race/ethnicity was not reported, it is likely that the vast majority fall into one of these categories. Roughly 2 percent of all clients are known to be incarcerated or otherwise involved with the criminal justice system.

Compared to the population at large, the data suggest that CMHSP clients are notably poorer—about 57 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. A similar percentage have no more than a high school education. Nearly two-thirds report being unemployed or not in the labor force at the time of treatment.

Residents of every CMHSP 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 CMHSP. Part of the reason for this tenfold differential has to be 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 CMHSPs in the exhibit are rural and can fit this explanation.

Exhibit 3.7 suggests that poverty and indigency are predictors of who will use CMHSP services. It is probably not accidental that counties such as Luce and Delta rank high in usage and high

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.

EXHIBIT 3.7

Medicaid Spending per Capita by CMHBs, Fiscal 1995

CMHB	Medicaid per Capita
Superior Behavioral Health	$149.24
Kalamazoo County	79.10
Northeast	78.93
Copper Country	74.55
Gogebic County	73.18
Delta County	69.73
MuskegonCounty	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.

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 CMHSP 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 CMHSP 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 CMHSPs to be more aggressive in seeking Medicaid reimbursement.

CMHSP Funding and Priorities

Exhibit 3.8 gives information on state authorization for CMHSP funding between fiscal 1987 and fiscal 1995. Over this period, the amount jumped from $335 million to $891 million, or by 166 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 CMHSPs. 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 CMHSPs for fiscal 1996. Whereas Exhibit 3.8 gave the original authorization, spending may be more or less than authorized depending on actual need. This ex-

EXHIBIT 3.8

State Authorization for CMHBs, Fiscal 1987 and 1995

CMHB	FY 1986–87 ($000s)	FY 1994–95 ($000s)	Percentage Change
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	235.0
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.

EXHIBIT 3.9

Per-Capita Spending on the Mentally Ill[a], 1996

CMHSP	1995 Population	Gross Spending	Per-Capita Spending
Schoolcraft County	8,700	$991,192	$113.93
Copper Country	55,239	5,272,446	95.44
Gr. Traverse/Leelanau	89,371	8,412,082	94.12
Kalamazoo County	227,973	20,493,955	89.89
Gogebic County	17,894	1,573,601	87.94
Alger-Marquette	75,288	5,769,099	76.62
Delta County	38,655	2,773,991	71.76
Manistee-Benzie	36,573	2,514,811	68.76
St. Clair County	154,231	10,000,457	64.84
Detroit-Wayne	2,055,500	132,247,000	64.33
Van Buren County	74,591	4,793,752	64.26
Summit Pointe	140,689	9,031,638	64.20
Washtenaw County	292,609	17,736,307	60.61
Bay-Arenac	127,680	7,716,759	60.44
Huron County	35,224	2,087,640	59.26
St. Joseph County	60,684	3,590,786	59.17
Muskegon County	164,459	9,678,848	58.85
Jackson-Hillsdale	199,234	11,667,807	58.56
Western Michigan	61,026	3,505,246	57.43
Eastern UP	47,837	2,708,692	56.62
Genesee County	436,381	24,438,291	56.00
Berrien County	162,623	9,102,319	55.97
Oakland County	1,153,461	64,245,240	55.70
Kent County	525,355	28,515,272	54.28
North Central Michigan	78,324	4,218,047	53.85
Northeast Michigan	65,353	3,418,085	52.30
Antrim-Kalkaska	34,953	1,803,548	51.60
Northpointe Behavioral	64,922	3,343,062	51.49
Lenawee County	96,706	4,670,245	48.29
Saginaw County	212,295	10,153,561	47.83
Northern Michigan	94,020	4,463,945	47.48
Au Sable Valley	53,723	2,498,846	46.51
Monroe County	139,550	6,441,452	46.16
Branch County	42,738	1,924,758	45.04
Woodland Behavioral	49,603	2,192,855	44.21
Tuscola County	57,491	2,411,243	41.94
Midland-Gladwin	104,052	4,235,925	40.71
Clinton-Eaton-Ingham	437,633	17,428,438	39.82
Central Michigan	143,772	5,587,653	38.86
Allegan County	97,692	3,535,791	36.19
Lapeer County	83,854	3,017,462	35.98
Livingston County	133,601	4,633,226	34.68
Shiawasee County	72,079	2,240,358	31.08
Sanilac County	42,203	1,275,823	30.23
Ottawa County	210,389	5,940,504	28.24
Barry County	52,643	1,371,775	26.05
Montcalm Center	57,866	1,435,354	24.80
Ionia County	59,846	1,436,291	24.00
Gratiot County	NA	39,973	NA
Macomb County	NA	733,607	NA
Newaygo County	NA	43,587	NA
Superior Behavioral	NA	5,599	NA
MICHIGAN	9,549,353	587,984,868	$61.57

SOURCE: Michigan Department of Community Health, 1997.

[a]Spending includes totals for mentally ill adults and children, but not the developmentally disabled.

NA = Not available.

hibit 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 CMHSPs' philosophies and approaches 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 1995 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 CMHSPs, gross and per-capita spending tend to be higher in northern Michigan and lower to the south, but there is no clear pattern.

The CMHSP in Schoolcraft County spends a good deal per capita on both mentally ill adults and children, while the Eastern UP CMHSP, which adjoins that area to the east, spends only moderately on both groups. These two boards merged in 1997 and it will be interesting to see how this will affect future expenditures.

The Berrien County board spends fairly liberally on adults per capita but not on children; the Manistee-Benzie CMHSP spends considerably above average on children but only moderately on adults; and the Sanilac County CMHSP spends comparatively 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 that outlays for mentally ill adults and children in the Sanilac CMHSP are small because most of the money goes to the developmentally disabled (nearly 77 percent in 1995). The Northeast Michigan and Tuscola County CMHSPs 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.

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;

EXHIBIT 3.10

Fiscal 1996 CMHSP Expenditures per Capita, Mentally Ill Adults

CMHSP	Cost	Adult Population 1995	Cost per Capita
Detroit-Wayne County	$91,237,915	1,499,706	$127.52
Schoolcraft County	812,946	6,461	125.82
Copper Country	4,826,060	42,443	113.71
Grand Traverse/Leelanau	7,049,263	65,232	108.06
Kalamazoo County	17,541,238	172,339	101.78
Gogebic County	1,323,698	13,865	95.47
Delta County	2,311,741	28,112	82.23
Alger-Marquette	4,488,856	55,904	80.30
Muskegon County	8,136,755	118,193	68.84
Van Buren County	3,627,097	52,817	68.67
Bay-Arenac	6,450,567	94,015	68.61
Berrien County	8,149,880	118,909	68.54
Manistee-Benzie	1,897,851	27,760	68.37
St. Clair County	7,575,154	111,236	68.10
Washtenaw County	15,461,535	229,648	67.33
Huron County	1,726,795	25,752	76.05
Kent County	24,776,029	376,520	65.80
Genesee County	20,461,054	313,679	65.23
Eastern UP	2,337,115	36,317	64.35
Oakland County	55,753,823	867,690	64.26
Calhoun County	6,523,241	103,104	63.27
Jackson-Hillsdale	9,197,977	146,621	62.73
Northpointe Behavioral	2,884,676	48,382	59.62
West Michigan	2,587,886	44,298	58.42
St. Joseph County	2,452,438	43,271	56.68
North Central	3,239,533	57,729	56.12
Antrim-Kalkaska	1,395,838	25,418	54.92
Saginaw County	8,360,468	152,553	54.80
Northern Michigan	3,656,007	68,598	53.30
Northeast Michigan	2,609,076	49,122	53.11
Au Sable Valley	2,032,088	39,746	51.13
Lenawee County	3,531,897	69,281	50.98
Monroe County	4,974,484	99,545	49.97
Cass County	1,795,906	36,344	49.41
Tuscola County	1,976,727	41,094	48.10
Branch County	1,412,661	30,915	45.70
Clinton-Eaton-Ingham	14,221,033	325,095	43.74
Allegan County	2,950,918	68,647	42.99
Midland-Gladwin	3,194,274	75,826	42.13
Lapeer County	2,475,922	59,019	41.95
Sanilac County	1,177,186	30,229	38.94
Central Michigan	4,030,384	108,904	37.01
Livingston County	3,486,375	95,418	36.54
Ottawa County	5,104,359	148,705	34.33
Shiawasee County	1,545,030	51,593	29.95
Barry County	928,497	37,852	24.53
Montcalm Center	973,424	41,232	23.61
Ionia County	974,982	42,818	22.77
Gratiot County	NA	29,169	NA
Macomb County	NA	557,643	NA
Newaygo County	NA	30,661	NA
Superior Behavioral	NA	4,069	NA
MICHIGAN	$485,638,659	7,019,499	$69.18

SOURCE: Michigan Department of Community Health, 1997.

NA = Not available.

EXHIBIT 3.11

Fiscal 1996 CMHSP Expenditures per Capita, Mentally Ill Children

CMHSP	Cost	Child Population 1995	Cost per Capita
Schoolcraft County	$178,246	2,239	$79.61
Detroit-Wayne County	41,009,085	555,794	73.78
Manistee-Benzie	616,960	8,815	69.99
Calhoun	2,508,397	37,585	66.74
Alger-Marquette	1,280,243	19,384	66.05
Gogebic County	249,903	4,029	62.03
Grand Traverse/Leelanau	1,362,819	24,139	56.46
St. Clair County	2,425,303	42,995	56.41
West Michigan	917,360	16,728	54.84
Van Buren County	1,166,655	21,774	53.58
Kalamazoo County	2,952,717	55,634	53.07
Northeast Michigan	809,009	16,231	49.84
North Central	978,514	20,595	47.51
Jackson-Hillsdale	2,469,830	52,613	46.94
Central Michigan	1,557,269	34,868	44.66
Delta County	462,250	10,543	43.84
Branch County	512,097	11,823	43.31
Antrim-Kalkaska	407,710	9,535	42.76
Lenawee County	1,138,348	27,425	41.51
St. Joseph County	677,738	17,413	38.92
Huron County	360,845	9,472	38.10
Midland-Gladwin	1,041,651	28,226	36.90
Monroe County	1,466,968	40,005	36.67
Washtenaw County	2,274,772	62,961	36.13
Copper Country	446,386	12,796	34.88
Bay-Arenac	1,166,192	33,665	34.64
Shiawasee County	695,328	20,486	33.94
Au Sable Valley	466,758	13,977	33.39
Muskegon County	1,542,093	46,266	33.33
Genesee County	3,977,237	122,702	32.41
Eastern UP	371,577	11,520	32.25
Northern Michigan	807,938	25,422	31.78
Livingston County	1,146,651	38,183	30.04
Saginaw County	1,793,093	59,742	30.01
Barry County	443,278	14,791	29.97
Cass County	396,949	13,259	29.94
Oakland County	8,491,417	285,771	29.71
Clinton-Eaton-Ingham	3,207,405	112,538	28.50
Montcalm Center	461,930	16,634	27.77
Northpointe Behavioral	458,386	16,540	27.71
Ionia County	461,309	17,028	27.09
Tuscola County	434,516	16,397	26.50
Kent County	3,739,243	148,835	25.12
Lapeer County	541,540	24,835	21.81
Berrien County	952,439	43,714	21.79
Allegan County	584,873	29,045	20.14
Ottawa County	836,145	61,684	13.56
Sanilac County	98,637	11,974	8.24
Gratiot County	NA	10,804	NA
Macomb County	NA	175,964	NA
Newaygo County	NA	12,926	NA
Superior Behavioral	NA	1,530	NA
MICHIGAN	$102,346,209	2,529,854	$40.46

SOURCE: Michigan Department of Community Health, 1997.

NA = Not available.

EXHIBIT 3.12

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

CMHB	Mentally Ill Adults	Mentally Ill Children	Developmentally Disabled
Alger/Marquette	37.3	10.6	52.1
Allegan County	27.9	5.5	66.6
Antrim/Kalkaska	22.9	6.7	70.4
Au Sable Valley	30.4	6.9	62.7
Barry County	36.5	17.4	46.1
Bay/Arenac	34.7	6.3	59.0
Berrien County	37.4	4.4	58.2
Branch County	22.7	8.2	69.1
Calhoun County	38.5	14.8	46.7
Woodland Behavioral Healthcare	30.6	6.8	62.6
Central Michigan	22.0	8.5	69.5
Clinton/Eaton/Ingham	34.8	7.8	57.4
Copper Country	47.8	4.4	47.8
Delta County	32.7	6.5	60.8
Detroit/Wayne County	39.5	17.5	42.7
Eastern UP	38.2	6.0	55.8
Genesee County	32.8	6.4	60.8
Gogebic County	33.8	6.4	59.8
Grand Traverse/Leelanau	51.7	10.0	38.3
Gratiot County	NA	NA	NA
Huron Behavioral Health Serv.	35.3	7.4	57.3
Ionia County	25.4	12.0	62.6
Jackson/Hillsdale	41.3	11.1	47.6
Kalamazoo County	43.9	7.4	48.7
Kent County	40.1	6.1	53.8
Lapeer County	93.0	9.4	47.6
Lenawee County	31.3	10.1	58.6
Livingston County	36.0	11.8	52.2
Superior Behavioral Health	NA	NA	NA
Macomb County	NA	NA	NA
Manistee/Benzie	27.8	9.0	63.2
Midland/Gladwin	28.7	9.4	61.9
Monroe County	30.4	9.0	60.6
Montcalm Cent. for Behav. Health	32.9	15.6	51.5
Muskegon County	33.4	6.3	60.3
Newaygo County	NA	NA	NA
North Central	33.4	10.1	56.5
Northeast	21.5	6.7	71.8
Northern Michigan	36.2	8.0	55.8
Northpointe Behav. Healthcare	32.7	5.2	62.1
Oakland County	50.7	7.7	41.6
Ottawa County	31.8	5.2	63.0
Saginaw County	32.1	6.9	61.0
St. Clair County	30.1	9.9	60.0
St. Joseph County	35.3	9.8	54.9
Sanilac County	20.1	1.7	77.2
Schoolcraft County CMH Serv.	34.9	7.7	57.4
Shiawassee County	25.6	11.5	62.9
Tuscola County	21.6	4.7	73.7
Van Buren County	44.6	14.3	41.1
Washtenaw County	47.6	7.0	45.4
Western Michigan CMH System	32.1	11.4	56.5
MICHIGAN	39.9	8.4	51.7

SOURCES: Michigan Senate Fiscal Agency, 1996; Michigan Department of Mental Health; and Public Sector Consultants.
NA = Not available.

- group homes, in which six or fewer people live and which are managed by not-for-profit agencies or CMHSPs 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 CMHSPs have established a number of innovative services to help clients with independent living. These include

- psychosocial rehabilitation, a program for people 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.

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 21 February 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.*

EXHIBIT 3.13

CMHSP Costs for Mentally Ill Adults, 1996

	Cases		Cost	
	Number	% of Total	Amount	% of Total
Board Managed Local Inpatient	18,721	5.0	$31,630,310	6.5
Board Managed State Inpatient	1,928	0.5	96,194,441	19.8
Board Managed Residential - Local	8,455	2.2	86,892,771	17.9
Board Managed Residential - State or Other	403	0.1	13,986,367	2.9
Board Managed Residential - Supported Independence	1.026	0.3	6,487,036	1.3
Board Managed - Crisis Residential	1.782	0.5	4,512,790	0.9
Partial Hospitalization	429	0.1	567,928	0.1
Psychosocial Rehabilitation	2,571	0.7	10,273,443	2.1
Other Day Programs	6,360	1.7	22,775,016	4.7
Outpatient Clinic Services	96,362	25.5	87,039,671	17.9
Emergency Services	185,599	49.1	19,885,839	4.1
Assertive Community Treatment	6,520	1.7	38,246,625	7.9
Crisis Stabilization Team	0	0	0	0.0
Community Treatment Team	371	0.01	1,312,432	0.3
Client Services Management	42,167	11.1	58,357,141	12.0
Family Support Services/Home Based Services	276	0.01	235,767	0.0
Integrated Employment Services	2,005	0.5	4,823,202	1.0
Community Integration Services	2,351	0.6	2,001,835	0.4
Respite Residential Services	324	0.01	416,045	0.1
Direct PreventionServices	0	0	0	0.0
TOTAL	377,650	100.0%[a]	$485,638,659	100.0%[a]

SOURCE: Michigan Department of Community Health, 1997.
[a]May not add to 100 percent due to rounding.

Exhibits 3.13 and 3.14 present expenditure data by program category for mentally ill adults and children, 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-managed state inpatient care is employed in only .5 percent of the cases involving adults, yet it accounts for nearly 20 percent of the CMHSP dollars spent on mentally ill adults. 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.

Although not reflected in these exhibits, the CMHSPs spent approximately $67.5 million on administration in 1996, or about 5.5 percent of total expenditures. Furthermore, the DCH spends approximately $11 million each year on prevention services, with $1.5 million going to program development and $9.5 million going to established programs, including those targeting infants, school-age children, and the children of mentally ill parents.

New Directions

The recent revisions to the Michigan Mental Health Code (P.A. 290 of 1995) 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.

EXHIBIT 3.14

CMHSP Costs for Mentally Ill Children, 1996

	Cases		Cost	
	Number	% of Total	Amount	% of Total
Board Managed Local Inpatient	861	1.4	$1,695,965	1.7
Board Managed State Inpatient	143	0.2	9,046,007	8.8
Board Managed Residential - Local	545	0.9	12,458,523	12.2
Board Managed Residential - State or Other	48	0.07	836,288	0.8
Board Managed Residential - Supported Independence	1	0.0	6,337	0.0
Board Managed - Crisis Residential	33	0.05	255,774	0.2
Partial Hospitalization	2	0.0	682	0.0
Psychosocial Rehabilitation	0	0.0	0	0.0
Other Day Programs	633	1.0	1,316,084	1.3
Outpatient Clinic Services	33,602	52.7	39,394,825	38.5
Emergency Services	11,631	18.2	2,491,713	2.4
Assertive Community Treatment	192	0.3	644,855	0.6
Crisis Stabilization Team	0	0	118,618	0.1
Community Treatment Team	199	0.3	1,126,874	1.1
Client Services Management	6,815	10.7	10,073,357	9.8
Family Support Services/Home Based Services	6,899	10.8	19,257,383	18.8
Integrated Employment Services	2	0.0	10,390	0.0
Community Integration Services	49	0.07	443,228	0.4
Respite Residential Services	2,151	3.42	3,169,307	3.1
Direct Prevention Services	0	0.0	0	0.0
TOTAL	63,806	100.0%[a]	$102,346,210	100.0%[a]

SOURCE: Michigan Department of Community Health.
[a]May not add to 100 percent due to rounding.

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, then director of the Department of Mental Health, 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 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 Community Mental Health Authority (CMHA), a new entity created by the bill.
- The CMHA provisions in effect give localities a third option for structuring. Under previous law, CMHSPs 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. As of September 1997, 17 local CMHSPs had applied for and received "authority" status. An additional 11 CMHSPs either were awaiting approval of their application or in the process of developing it.
- 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 CMHSPs, recipients' rights committees, and the state advisory council be comprised of consumers and family members.
- CMHSPs 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 CMHSP 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. AMIM and the Michigan Association for Children with Emotional Disabilities (MACED) opposed the bill, as did a number of labor unions, which 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 CMHSPs, 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.

CHAPTER 4

FUTURE POLICY DIRECTIONS

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 grounds 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 between mental and physical illnesses in health insurance plans. The passage of the Mental Health Parity Act in 1996 is a step in this direction.

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 improvement and decline 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. While most now concede that the changes are working well, many believe that certain issues must continue to be monitored.

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, observers saw the possibility of better coordinated and truly integrated care, but there were also fears that mental health might become the neglected stepchild of a super-department. After a year's experience, it seems clear that this particular fear was unfounded and that mental health issues have not been neglected.

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 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 consortia, 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

Few other mental health topics in recent years have inspired so much distrust and controversy as the closure of state mental health hospitals. Tensions were heightened when the Engler administration announced in spring 1996 that it would not seek funding for the Fairlawn Hospital in Pontiac, a facility for mentally ill children, even though $6 million recently had been spent on upgrading the facility. Tensions were heightened even more during 1997 when the administration succeeded in closing three more state mental health facilities—Pheasant Ridge for children and the Clinton Valley Center and the Detroit Psychiatric Institute for adults.

State officials claimed that the number of patients in these facilities had declined, that the expenditure per patient was ruinous, and that private psychiatric hospitals and the state's remaining facilities were available for patients who needed hospitalization. Opponents believe these arguments conceal a narrow cost-cutting agenda and maintain that usage of state 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 and adults with the most serious, chronic emotional disturbances. In their view, individuals who require long-term hospitalization and their families are simply going to suffer. In 1997, the Michigan Psychiatric Society issued a report suggesting that the needs of mentally ill children were unlikely to be met by the continued closure of state hospital beds. Opponents of closure also point to the fact that DCH officials have testified, as part of proceedings in the Wayne County Circuit Court, that only the state offers long-term psychiatric care beds.

The issue cannot be resolved here. Yet, however the court challenges ultimately 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. People of good will 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.

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. Southeastern 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 four of the six state hospitals are in that area, as are 66 percent of licensed psychiatrists.

At the other extreme, 45 counties have no private facility whatsoever (the two outlying state hospitals are in Kalamazoo and Tuscola Counties), and as of 1996 there were 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 CMHSPs 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 1996, the 52 CMHSPs again reported no expenditures in this category. The DCH claims that it spends approximately $11 million on prevention services each year, or significantly less than 1 percent of total expenditures.

Giving prevention short shrift is probably shortsighted, 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 confirms that CMHSPs in 1996 provided mental health services for 1,458 persons in jail and another 99 in prison.
- The Michigan Department of Social Services (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, according to some advocate groups, the number and percentage of persons with mental illness in the state's jails are at a 100-year high. Jail diversion programs, however, have not been politically popular of late. Language dealing with the issue was not included in the 1995 mental health code revisions and related bills did not receive favorable consideration during the most recent legislative session. Still, the issue remains worthy of further investigation.

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 more problematic as they age.

During 1997, the issue of hospital closures made the link between the mental health and correctional systems even more important from a public policy perspective—and even more contentious. Opponents of closure, including the House Mental Health Standing Committee, have repeatedly expressed that the decline in population of state mental hospitals may have led directly to an increase in the number of persons with mental illness being incarcerated in state correctional facilities.

Officials at the DCH have maintained steadfastly that there was little or no evidence that this was actually occurring. However, a front-page story appearing in the *Detroit News* raises the distinct possibility that the concerns are well founded. According to the story, which was based upon DCH sources, the number of state prisoners who were formerly inmates in state mental hospitals increased by 23 percent between 1993 and 1997. Over that same period, the increase in the number of state prisoners was 11 percent—less than half as much.

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 anytime 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, public 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 DMH. 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 that 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 as the Senate Fiscal Agency made clear in a 1996 report, data on Michigan's $1 billion community mental health system

were not at that time of sufficient quality to allow the legislature to perform its oversight function properly or to keep the public fully informed.

Ideally, all CMHSPs would keep data that at a minimum include 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.

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 CMHSPs 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 CMHSP system. Equally important, it would allow the CMHSPs 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 CMHSP system seriously disputes this. The revised code and the last two appropriations bills require the DCH and CMHSPs to provide more comprehensive reports and better data. In fairness, most observers now believe that the quality of data has improved in the last 18 months. Still, the DCH has had trouble getting satisfactory reports from all CMHSPs, and whether the data/management information issue evolves in a way that is fully satisfactory remains to be seen.