Mental Health in Michigan

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List of Exhibits

Introduction

This report describes and analyzes the existing structure of mental health care in Michigan to identify its most important characteristics, including who primarily provides services, types of treatment, the structure and financing of the mental health system, and issues that will shape future policy decisions affecting mental health services in Michigan.

BACKGROUND

Mental health is commonly accepted to mean a state of successful performance of mental function resulting in productivity, fulfilling relationships with others, and the ability to adapt and cope with change or adversity.[1] Conversely, mental illness is defined as all diagnosable mental disorders that are characterized by changes in thinking, mood, and behavior that cause distress and/or impaired functioning.[2] Since its first publication in 1952, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) has been used to identify and diagnose mental illness. The fourth edition, which is the most recent, was published in 1994 and revised in 2000 and is commonly referred to as the DSM-IV. Each new edition reflects changes in knowledge and understanding of mental illness. Mental illnesses range from mild to serious and encompass mood and anxiety disorders, schizophrenia, and personality disorders. These illnesses can range in duration from acute, moderate episodes to long-term, chronic illness.

Approximately 26 percent of American adults (57.7 million) experience mental illness in a given year; 1 in 17 lives with serious mental illness.[3] Serious mental illness is defined as a diagnosable mental, behavioral, or emotional disorder of sufficient duration that meets diagnostic criteria specified in the DSM-IV, excepting substance abuse disorders and developmental disabilities, and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities.[4] Serious mental illness generally encompasses schizophrenia, major depression, and bipolar disorder. Almost half of those identified with a mental illness meet criteria for two or more disorders. In Michigan, almost two million adults experience a mental disorder each year, and almost 450,000 adults live with a serious mental illness.[5] Children are also significantly affected by mental illness, with 1 in 10 children nationwide affected by a

[1] U.S. Department of Health and Human Services (DHHS), *Mental Health: A Report of the Surgeon General* (Rockville, Md.: DHHS, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1999).
[2] Ibid.
[3] R. C. Kessler, W. T. Chiu, O. Demler, and E. E. Walters, "Prevalence, Severity, and Comorbidity of Twelve-month DSM-IV Disorders in the National Comorbidity Survey Replication (NCS-R)," *Archives of General Psychiatry* 62, no. 6 (June 2005): 617–627.
[4] Federal Register 58, no. 96 (May 20, 1993): 29422–29425.
[5] U.S. Census Bureau, *2006–2008 American Community Survey*; available online at: *http://factfinder.census.gov/servlet/ADPTable?_bm=y&-geo_id=04000US26&-qr_name=ACS_2008_3YR_G00_DP3YR5&-ds_name=ACS_2008_3YR_G00_&-_lang=en&-_sse=on* (accessed 6/14/10).

serious mental or emotional disorder.[6] In Michigan, approximately 244,000 children live with a serious mental or emotional disorder.[7]

Even with such large numbers of persons experiencing some form of mental illness, only one-third of adults and one-half of children needing treatment receive it in a given year.[8] The stigma associated with mental illness and the costs for treatment remain the primary barriers to accessing care. While the stigma historically associated with mental illness has greatly decreased over the last century, people continue to perceive physical and mental illness differently, even though mental illness often manifests itself through physical symptoms. The historic association of institutionalization and the mentally ill, along with a perception of violent behavior among mentally ill persons and a lack of understanding about the science of mental illness contribute to its continued stigma.[9]

Cost is a primary barrier in accessing treatment for mental illness. The number of people paying annually for services has, however, almost doubled between 1986 and 2006, rising from 19.3 million to 36.2 million. During roughly the same period, however, direct medical expenditures for mental illness have tripled, rising from $33 billion in 1986 to $100 billion in 2003.[10] Mental disorders are among the five costliest health conditions, and out--of-pocket costs for mental illness rank highest, at 25 percent of total mental illness costs.[11] Although the cost of medical treatment overall has risen dramatically, the *rate* of increase for mental health services spending compared to traditional health spending has been significantly lower. Health care spending on non-mental illness rose consistently between 1970 and 2003 at two to three percentage points above the rate of growth in the gross domestic product (GDP), while mental health spending grew at about the same rate as GDP.[12] This is likely due to increased use of pharmacologic agents to control mental illness and increased utilization of community services.

In addition to the financial costs of mental illness, the societal costs cannot be ignored. Mental illness is associated with the following social problems:

- Loss of or exclusion from employment
- Lowered educational achievement
- Economic hardship
- Involvement with the criminal justice system

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[6] DHHS, *Report of the Surgeon General*.
[7] U.S. Census Bureau, *2006–2008 American Community Survey*.
[8] DHHS, *Report of the Surgeon General*.
[9] J. Phelan, B. Link, A. Stueve, and B. Pescosolido, "Public Conceptions of Mental Illness in 1950 in 1996: Has Sophistication Increased? Has Stigma Declined?" Paper presented at meeting of the American Sociological Association, Toronto, Ont., August 1997.
[10] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Projections of National Expenditures for Mental Health Services and Substance Abuse Treatment 2004-2014* (Rockville, Md.: DHHS, 2008).
[11] Anita Soni, *The Five Most Costly Conditions, 1996 and 2006: Estimates for U.S. Civilian Noninstitutionalized Population*, Statistical Brief #248, Medical Expenditure Panel Survey (Agency for Healthcare Research and Quality, July 2009); available online at: *http://www.meps.ahrq.gov/mepsweb/data_files/publications/st248/stat248.pdf* (accessed 6/14/10).
[12] R. Frank, H. Goldman, and T. McGuire, "Trends in Mental Health Cost Growth: An Expanded Role for Management?" *Health Affairs* 28, no. 3 (May/June 2009): 649–659.

- Victimization by others
- Homelessness
- Social isolation

The indirect cost of mental illness due to lost productivity in the United States was estimated in 2002 at $193.2 billion.[13] The World Health Organization, the World Bank, and Harvard University, in their Global Burden of Disease Study, rank mental illness as the second most burdensome disease in established market economies, causing an estimated average 15 years of life lost due to premature death and disability.[14]

As comprehension of, perceptions about, and spending on mental illness have evolved, so too has the structure through which people access services. In the mid-nineteenth century, institutional care was considered enlightened public policy and a humane response to treating mental disorders. In 1859, the Kalamazoo Asylum for the Insane was established and by the end of the century, other mental health facilities had been established in Newberry, Pontiac, and Traverse City. During this time, institutionalization was not generally long term and most people in treatment were discharged back into the community. In the early twentieth century, the growing perception of mental illness as a lifelong, disabling illness with no hope for recovery resulted in rapidly increasing hospital populations. By the mid-1950s, Michigan's publicly operated psychiatric hospitals housed more than 20,000 people.

At this time, the medical and psychiatric professions called for a comprehensive study of the treatment of persons with mental illness. In 1955, Congress accepted the recommendation and passed the Mental Health Study Act. The resulting report, *Action for Mental Health*, was completed in 1961,[15] and suggested drastic changes to treatment methods for the mentally ill, primarily by shifting persons out of long-term institutions and back into the community.

MENTAL HEALTH SERVICES IN MICHIGAN

The Michigan constitution stipulates that "institutions, programs, and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise seriously disabled shall always be fostered and supported."[16] More specifically, the Michigan Mental Health Code (PA 258 of 1974) mandates that the Michigan Department of Community Health (MDCH) fulfill the following responsibilities:

- "Continually and diligently endeavor to assure that adequate and appropriate mental health services are available throughout the state"[17]

[13] Kessler, Chiu, Demler, and Walters, Prevalence, Severity, and Comorbidity of Twelve-month DSM-IV Disorders.
[14] Murray and Lopez, *The Global Burden of Disease.*
[15] Joint Commission on Mental Illness and Health, *Action for Mental Health: Final Report, 1961* (New York: Basic Books, 1961).
[16] Constitution of the State of Michigan of 1963, Article 8, Section 8.
[17] MCL 330.1116 (1).

- "Promote and maintain an adequate and appropriate system of community mental health services programs throughout the state"[18]
- "Shift primary responsibility for direct delivery of services from the state to community mental health services programs…whenever there is a demonstrated willingness and capacity to provide an adequate and appropriate system of mental health services to citizens of that area"[19]

The rights of mental health services recipients are statutorily defined to guarantee service delivery in the least restrictive setting that is appropriate and available.[20] Statute also requires that services be determined using a person-centered planning process in partnership with the recipient.[21]

Changes to public policy during the 1960s were significant in altering the delivery systems for mental health treatment in the state. The Michigan Legislature passed Public Act 54 in April 1963, authorizing the creation of Community Mental Health Boards to stimulate the formation of community care programs. That same year the federal government passed the Community Mental Health Centers Act, which provided funding aimed at developing community-based care centers in order to reduce hospital populations by 50 percent within ten years. These policies were effective, and by 1975, patient census at state hospitals was around 5,000, down from 17,000 in 1965.

Community-based treatment presented its own set of challenges, however, and many people became critical of the system, citing insufficient care supports, a lack of capacity, and inadequate coordination. In response, the legislature passed the Mental Health Code in 1974 as a framework for organizing and operating the public mental health system. The legislation focused on service recipients' rights and service requirements, and put in place monitoring and protection systems for programs.

Since the 1970s, Michigan's mental health system has continued to move from an institution-based system to a community-focused one. Scientific developments in pharmaceuticals have facilitated the movement of people out of institutions and into the community by providing methods to control chronic, serious mental illnesses. The introduction of psychotropic drugs as an element of treatment has proved successful for many persons with mental illness. Between 1974 and 2009, 40 state institutions were closed. Some closures, mostly those occurring in the late 1990s, have been extremely controversial.

The system today is a decentralized one, with more authority and responsibility being exercised by local agencies, now called community mental health service programs (CMHSPs). The MDCH requires CMHSPs to administer only 2 types of evidence-based interventions, assertive community treatment and integrated treatment for co-occurring disorders. Beyond those, CMHSPs determine services based on local needs. Service delivery has become increasingly focused on the needs and preferences of individuals, encouraging patients to play an active role in care planning instead of following a

[18] MCL 330.1116 (2.b).
[19] MCL 330.1116 (2.b).
[20] MCL 330.1708 (1–4).
[21] MCL 330.1712 (1).

standardized plan, with those principles incorporated into the Mental Health Code in 1995. One reason for the increased autonomy was the adoption of a managed care model, whereby local authorities receive a capitated payment (that is, providers receive one payment for each patient, instead of reimbursement for individual services) to provide specialty mental health services for Medicaid recipients. In 1998, the state submitted a waiver request to the federal government to implement this model; the federal government approved the request and the model was implemented that year.

In 2004, Gov. Jennifer Granholm set up the Mental Health Commission, comprised of 29 appointed members. The commission's task was to evaluate the current public mental health system and provide recommendations for improvement. The recommendations were released in October 2004. Progress made toward achieving these recommendations will be discussed later in this report.

Today, more than 11,000 licensed and registered professionals in Michigan provide services to the mentally ill. Since all nurses and social workers are also potentially available to the mental health system, the actual number of professionals in the mental health sector is most likely higher. Many of these people are in private practice, while others are in institutional settings. As of 2010, the State of Michigan operated five hospitals (serving adults, children, persons in the corrections system, and persons with developmental disabilities) with a capacity of 818 beds. In 2010, the private system had a capacity of more than 2,000 beds in 59 institutions, located in 32 counties. Forty-six CMHSPs serve all 83 counties in Michigan and coordinate community-based programs and services.

Since its inception, the mental health system has changed significantly. The following sections of this report will summarize the current mental health system in Michigan, including who provides mental health services and the types of treatment they provide, the organizational structure of the system, and how it is funded. The report will also discuss policy issues and other changes that may impact this system in the future.

Mental Health Professionals in Michigan

The Michigan Mental Health Code[22] defines "mental health professional" as an individual who is trained and experienced in the area of mental illness or developmental disabilities and who is also one of the following:

- A physician who is licensed to practice medicine or osteopathic medicine and surgery in Michigan;
- A psychologist licensed to practice in Michigan;
- A registered professional nurse licensed to practice in Michigan;
- A licensed master's social worker licensed to practice in Michigan;
- A professional counselor licensed to practice in Michigan; or
- A marriage and family therapist licensed to practice in Michigan.

The code also prohibits these professionals from performing an act, task, or function within the field of mental health that they have 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 above 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 treatment of mental illness are, of course, psychiatrists. The Mental Health 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 12-month psychiatric rotation and are *enrolled* in a residency program; psychiatrists employed by or under contract to the MDCH or a CMHSP as of March 28, 1996 (when the statute was last revised); and any physician who devotes a substantial amount of time to the practice of psychiatry and who receives the approval of the director of the MDCH.[23]

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 fully licensed psychologist must have a doctoral degree and two years postdoctoral experience in the practice of psychology. Limited-practice licenses are available for those who have a master's degree in the field and a prescribed amount of practical experience. 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.

[22] MCL 330.1100b.
[23] MCL 330.1100c.

NUMBER AND AVAILABILITY OF MENTAL HEALTH PROFESSIONALS

In 2010, slightly more than 11,000 mental health professionals could be identified in Michigan. The numbers of fully licensed professional counselors (5,444), marriage and family therapists (634), and psychologists (2,466) with Michigan addresses could be identified through state licensure files.[24] Psychiatrists, as licensed physicians, are not required to report their specialty on their licensure application. Registered nurses and social workers also are not asked to indicate their main areas of practice.

Recent surveys of licensed physicians and registered nurses allow us, however, to estimate how many of these professionals are working in psychiatry or mental health. Approximately 4 percent of licensed physicians who practice in Michigan indicate that adult psychiatry is their primary specialty.[25] Another 1 percent indicate child and adolescent psychiatry as their primary specialty. This amounts to about 1,031 adult psychiatrists and 258 child and adolescent psychiatrists.[26] Of registered nurses who provide direct patient care in Michigan, about 3.4 percent (or about 2,796) indicate that their main practice area is in psychiatric or mental health care.[27] Similar surveys of social workers have not been conducted. The Michigan Chapter of the National Association of Social Workers reports that 1,291 of their members work in mental health care.[28] While this is likely a conservative estimate, it would appear that only a small proportion of the 18,169 master's-prepared social workers licensed in Michigan[29] are working in mental health care.

While recognizing the obvious limits of the available data, it is clear that more than half of mental health professionals in Michigan are either counselors or psychologists. Therapists, social workers, and psychiatrists make up a much smaller proportion of the total.

The distribution of mental health workers is uneven across the state. Exhibit 1 shows that 47 counties are designated as mental health care health professional shortage areas (HPSAs). This designation generally occurs when one of three criteria are met:

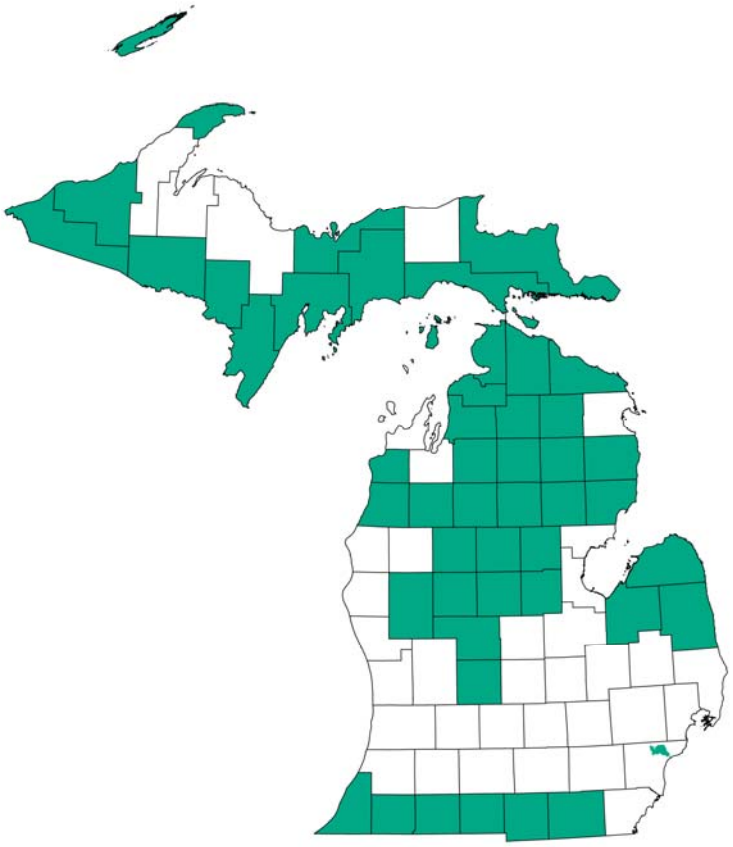
- The ratio of psychiatrists to population is less than 1:30,000; or

[24] Michigan Department of Community Health (MDCH) Bureau of Health Professions, Health Profession Licensure Database, as of April 1, 2010.
[25] The figures for adult psychiatrists have been calculated by Public Sector Consultants using data from the *Michigan Department of Community Health Survey of Physicians*: 2007, 2008, and 2009 (Lansing, Mich.: Public Sector Consultants, 2007, 2008, 2009). For a detailed explanation of the methodology, please see Appendix 3.
[26] The figures for child and adolescent psychiatrists have been estimated by Public Sector Consultants using data from the *Michigan Department of Community Health Survey of Physicians:* 2007, 2008, and 2009. For a detailed explanation of the methodology, please see Appendix 3.
[27] Public Sector Consultants, *Michigan Center for Nursing Survey of Nurses 2009* (Lansing, Mich.: PSC, 2009). For a detailed description of this survey, please see Appendix 3.
[28] Personal communication on May 11, 2010, with Vince Coraci, Membership Development Director, National Association of Social Workers—Michigan Chapter.
[29] MDCH, Health Profession Licensure Database, as of April 1, 2010.

- The ratio of core mental health providers (including psychiatrists) to the population is less than 1:9,000; or
- The ratio of psychiatrists to population is less than 1:20,000 and the ratio of core mental health providers (including psychiatrists) to the population is 1:6,000.

Separate mental health care HPSA criteria exist for geographic areas where unusually high needs exist and for population groups (i.e., the low-income population of an area).

EXHIBIT 1
Mental Health Care Health Professional Shortage Areas (HPSAs), 2009



SOURCE: MDCH Health Planning and Access to Care Section.

According to state licensure files, a plurality of counselors, psychologists, and therapists (nearly 25 percent of each) are located in the Oakland County CMH Authority region,[30] and more than 10 percent of each of these mental health professionals are located in the Detroit-Wayne County CMH Agency region. It is important to note that these calculations are based on the *mailing address* of the licensed professionals, which may not be in the CMHSP region where they conduct the majority of their work.

[30] The Michigan Department of Community Health provided Public Sector Consultants with a count of each of these licensed professionals by county. PSC then converted the counts to CMHSP regions and calculated the percentages of the total number of licensed professionals in the state by CMHSP.

For the survey of licensed Michigan physicians, respondents are asked to provide the ZIP Code for their main practice site. According to the survey, nearly 25 percent of psychiatrists indicate that their main practice area is in the Oakland County CMH Authority region.[31] Another 20 percent of psychiatrists practice in the Detroit-Wayne County CMH Agency region.

As is demonstrated by the map of mental health care HPSAs, residents of the Upper Peninsula and the northern half of the Lower Peninsula are likely to have more difficulty obtaining mental health treatment than residents in other areas of the state.

TYPES OF MENTAL HEALTH INTERVENTIONS

Mental health professionals typically diagnose mental illnesses and disorders using DSM-IV. Once a diagnosis is made, the mental health professional must identify a protocol for treating the illness based upon his or her training in the treatment of mental illness and any available evidence-based guidelines for the particular disorder.

Mental health treatment includes both psychotherapy and pharmacological therapies, often in conjunction. The intensity and duration of therapy vary depending on the severity of the mental illness and also, unfortunately, on the patient's resources. The following interventions are examples of services offered in the public sector. Private treatment may include any of the following interventions, but access to intervention may be limited by private insurance.

Prevention and Early Intervention

While virtually everyone close to the mental health system agrees on the importance of prevention and early intervention to mitigate long-term, negative effects of mental illness, financial resources are scarce and are dedicated primarily to treating people already coping with mental illness. A number of interventions have been piloted across the nation, mostly aimed at identifying risk factors in children. In fact, cost benefit analyses of some of these programs prove how effective they are in the long term. Programs such as life-skills training and Strengthening Families, targeted to elementary and middle school students, have demonstrated saving anywhere from $700 to $8,000 per person in the program.[32] Programs such as the nurse-family partnership, which operates in four geographic areas in Michigan, target low-income pregnant women. This program has demonstrated savings of up to $17,000 per person.[33] Although the cost-savings from programs such as these could help ease the burden on the mental health system, they are not administered widely enough to be as effective as they could be.

[31] Using ZIP Code data from the 2007, 2008, and 2009 *MDCH Survey of Physicians*, PSC calculated the number and percentage of psychiatrists in each CMHSP region.
[32] U.S. Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *Promotion and Prevention in Mental Health: Strengthening Parenting and Enhancing Child Resilience*, DHHS Publication No.CMHS-SVP-0175 (Rockville, Md.: DHHS, 2007).
[33] Ibid.

Psychotherapy

There are three general types of mental health psychotherapy upon which all other therapeutic techniques are based.

- **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 communication skills.
- **Cognitive-behavioral** therapy helps patients recognize and change distorted thought patterns and behavior.

For people with mild or moderate mental illness or disorders, regular visits with a mental health professional are often sufficient to manage their illness. For people with serious mental illness, however, more intensive treatments and therapies are often needed. Several evidence-based practice (EBP) models have been developed based on the recognition of the interdependent relationship between a person's mental health and his or her environment, family, and other life factors such as employment. The following EBPs—and many more—have been or are in the process of being incorporated into Michigan's public mental health system.

Assertive Community Treatment (ACT)

Assertive Community Treatment, or ACT, is an evidence-based team treatment approach that is designed to "provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness."[34] One of the primary goals of ACT is to prevent people with serious mental illness from having to seek treatment in an inpatient setting by helping them develop skills for living in the community while managing their mental illness.[35] ACT services are customized for each individual and are delivered by a team of practitioners with background and training in social work, rehabilitation, counseling, nursing, and psychiatry, who are available 24 hours a day.[36] The staff-to-consumer ratio is at least 1:10. ACT team members are responsible for the development of the consumer's person-centered plan and for supporting consumers in all aspects of community living, including:[37]

- Symptom management
- Housing
- Finances

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[34] Assertive Community Treatment Association website: *www.actassociation.org/actModel* (accessed 6/14/10).

[35] Michigan Department of Community Health (MDCH), Practice Improvement Steering Committee, November 9, 2009, *Compendium of Michigan's Evidence-Based Best and Promising Practices*; available online at *http://www.michigan.gov/documents/mdch/Practice_Improvement_Steering_Committee_Meeting_11_9_09_302903_7.pdf* (accessed 6/14/10).

[36] Assertive Community Treatment Association website.

[37] U.S. Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration, National Mental Health Information Center, Center for Mental Health Services, *About Evidence-Based Practices KITs: Shaping Mental Health Services Toward Recovery*; available online at: *http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/default.asp* (accessed 6/14/10).

- Employment
- Medical care
- Handling substance abuse issues
- Family life
- Activities of daily life

In fiscal year 2009, more than 6,100 individuals received ACT services through Michigan's mental health system.[38]

Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy (DBT) is an evidence-based practice used primarily to treat people who are chronically suicidal, who often have multiple diagnoses, and who have difficulty staying engaged in mental health treatment.[39] DBT consists of three main modes of treatment (all of which must be present): individual psychotherapy, skills training (provided in a group setting), and around-the-clock phone assistance.[40] DBT was initially introduced in Michigan's community-based programs in fiscal year 2007. DBT is provided by a team, one member of which is expected to be a certified peer support specialist (see page 14). Since 2007, approximately 350 community mental health program staff have received training in DBT and 35 DBT teams have been established.[41] As the service is expanded, MDCH staff are hopeful that consumers will have the opportunity to choose DBT through the person-centered planning process.[42]

Parent Management Training—Oregon Model

Parents play a vital role in improving and maintaining their children's mental health. Parent Management Training—Oregon Model (PMTO) is an evidence-based approach that is tailored to help the parents of children—from preschool through adolescence—who have serious behavior problems. Through PMTO, parents receive training in the provision of appropriate care, instruction, and supervision of their children. The five core components of PMTO are encouragement, limit setting, problem solving, monitoring, and positive involvement.[43] The MDCH has incorporated extensive tools to ensure that implementation of PMTO in the state adheres to the model. As of November 2009, five staff across the state had been certified to rate fidelity to the PMTO.[44] Another 100 community mental health staff had been trained and 34 therapists had been certified to provide PMTO services. These providers cover approximately three-fourths of the state.

[38] MDCH, Practice Improvement Steering Committee, *Compendium of Michigan's Evidence-Based Best and Promising Practices.*
[39] Ibid.
[40] Behavioral Tech, LLC, *Dialectical Behavior Therapy Frequently Asked Questions*; available online at: *http://www.behavioraltech.com/downloads/dbtFaq_Cons.pdf* (accessed 6/14/10).
[41] MDCH, Practice Improvement Steering Committee, *Compendium of Michigan's Evidence-Based Best and Promising Practices.*
[42] Ibid.
[43] Ibid.
[44] Ibid.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based therapeutic technique designed to address the needs of children with post-traumatic stress disorder (PTSD) or other problems related to traumatic life experiences and their families.[45] TF-CBT combines trauma-sensitive interventions with cognitive behavioral therapy to provide children and their families with knowledge and skills to process trauma; manage distressing thoughts, feelings, and behaviors; and enhance parenting skills and family communication. Staff from CMHSPs are currently undergoing training to provide the intervention to children who meet the criteria for TF-CBT.[46]

Integrated Treatment for Co-Occurring Disorders

Quite often, mental illness is accompanied by a co-occurring substance use disorder or addiction. Estimates of people with co-occurring disorders in the public mental health and substance use systems range from 50 to 70 percent.[47] Historically, it has been challenging for individuals with co-occurring disorders to receive treatment for both disorders at the same time or in a single setting. This has led to separate and, usually, uncoordinated care. CMHSPs in Michigan have been working to implement Co-Occurring Disorders: Integrated Dual Disorder Treatment (COD: IDDT), an evidence-based practice that helps people who have both a serious mental illness and a substance use disorder.[48] The practice includes:[49]

- Individualized treatment based on the person's current stage of recovery
- Education about the illness
- Case management
- Housing assistance
- Financial management assistance
- Counseling designed especially for people with co-occurring disorders

As of November 2009, 78 teams were providing COD: IDDT throughout Michigan.[50]

Family Psychoeducation

Family psychoeducation (FPE) is an evidence-based practice that engages consumers and their families and supporters in a partnership with treatment providers to maximize the use and effectiveness of available mental health services.[51] FPE provides consumers and their families with information about what mental illness is and how it is treated. It also helps families understand outpatient treatment programs, prescribed medications, how to

[45] National Child Traumatic Stress Network, *Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)*; available online at: *http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/TF-CBT_fact_sheet_3-20-07.pdf* (accessed 6/14/10).
[46] MDCH, Practice Improvement Steering Committee, *Compendium of Michigan's Evidence-Based Best and Promising Practices*.
[47] Ibid.
[48] Ibid.
[49] DHHS, *About Evidence-Based Practices KITs*.
[50] MDCH, Practice Improvement Steering Committee, *Compendium of Michigan's Evidence-Based Best and Promising Practices*.
[51] Ibid.

cope with alcohol or other drug abuse problems, and how to manage the symptoms of the mental illness.

The MDCH has implemented FPE services in Michigan through its federal community mental health block grant. As of FY 2009–10, all prepaid inpatient health plans (PIHPs) are required to include FPE in their service array. As of July 2009, Michigan had nearly 700 trained FPE facilitators, 90 FPE advanced facilitators, and about 80 FPE trainers/supervisors.[52]

Pharmacological Therapy

The past two decades have seen enormous growth in the use of drugs to treat mental illness as new medications have become more targeted in their application and more effective. While this has been a positive development for those suffering from mental illness and the therapists who treat them, these rapid advances have created challenges for therapists, who must be able to identify the best medication for the needs of their clients. Guidelines and algorithms have been developed to support therapists in this endeavor; in practice, however, these tools are underused.

The Michigan Mental Health Evidence-Based Practice Initiative, funded by the Michigan-based Ethel and James Flinn Foundation, is a quality improvement project aimed at improving the prescription of drugs to treat schizophrenia, major depression, and bipolar disorder.[53] The project identified an optimal set of algorithms (the Texas Implementation of Medication Algorithms) and modified them to meet the needs of providers in Michigan, thus developing the Michigan Implementation of Medication Algorithms (MIMA). Use of the algorithms has been piloted in six test sites, and expansion of the algorithms throughout the state will be implemented through the use of Web-based software, which is currently under development.

A RECOVERY-BASED PUBLIC MENTAL HEALTH SYSTEM

The U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration defines recovery as "a journey of healing and transformation, enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential."[54] The MDCH has made a commitment to supporting a recovery-based public mental health system in Michigan. Several initiatives that have been implemented in Michigan's public mental health system are aimed at creating an environment that supports recovery for people with mental illness.

[52] MDCH, Practice Improvement Steering Committee, *Compendium of Michigan's Evidence-Based Best and Promising Practices*.
[53] Ibid.
[54] U.S. Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *National Consensus Statement on Mental Health Recovery*, December 2004; available online at: *http://download.ncadi.samhsa.gov/ken/pdf/SMA05-4129/trifold.pdf* (accessed 6/23/10).

Recovery Council

In December 2005, the Recovery Council was established by the MDCH with a Mental Health Systems Transformation Grant from the federal Centers for Medicare and Medicaid Services. The mission of the Recovery Council is to transform the public mental health system so that each person can achieve recovery. To do this, the council:

- promotes consumer control, empowerment, self-determination, and peer supports;
- promotes partnerships and the creation of a network of consumers and others who will promote messages of recovery;
- provides leadership, education, training, and technical assistance on recovery; and
- recommends systems, policies, and practices that support recovery.[55]

The Recovery Council, which consists primarily of mental health system consumers, is responsible for the establishment of the Michigan Recovery Center of Excellence (MRCE), a Web-based initiative that promotes recovery and provides information on resources that support recovery. The council has also selected the Recovery Enhancing Environment (REE) measure, developed by a Yale-based researcher, to monitor system-wide progress on the implementation of a recovery-based system.[56] The REE is implemented through surveys of public mental health system users to identify what is working and what needs to be improved.

Person-Centered Planning

Michigan's Mental Health Code establishes the right for all individuals to have their Individual Plan of Services developed through a person-centered planning process.[57] Person-centered planning (PCP), which is designed to allow mental health system consumers to express their personal needs and goals related to treatment, is a critical element in enhancing and promoting recovery in Michigan. While professionally trained staff has a role in the planning and delivery of treatment, the expressed needs and desires of the individual seeking treatment are the primary basis for the development of an Individual Plan of Services.[58]

For children in Michigan, the MDCH has supported a family approach to service planning that recognizes both the importance of the family in a child's recovery and the fact that treatment services impact the entire family.

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[55] MDCH, Practice Improvement Steering Committee, *Compendium of Michigan's Evidence-Based Best and Promising Practices.*

[56] Michigan Recovery Center of Excellence, *REE: Michigan Statewide Implementation*; available online at: *http://www.mirecovery.org/PartnersinRecovery/REEMichiganStatewideImplementation/tabid/102/Default.aspx* (accessed 6/14/10).

[57] MCL 330.1712.

[58] MDCH, Practice Improvement Steering Committee, *Compendium of Michigan's Evidence-Based Best and Promising Practices.*

Practice guidelines for PCP include essential elements of PCP and provide recommended strategies for carrying out the planning process based on the needs expressed by the individual.[59]

Certified Peer Support Specialists

Peer support specialists are individuals who have received treatment through the public mental health system and have received comprehensive training and certification that allows them to work with persons who are currently receiving treatment. Employing peer support specialists has been an essential component of supporting the recovery of individuals served by the mental health system in Michigan since 1998, when community mental health block grant funds were first used to pay for these positions.[60] In March of 2006, peer support specialists became a Medicaid-covered service under a 1915 b(3) waiver.[61]

The value that peer support specialists provide is in their ability to gain the trust of those receiving treatment based on shared experience. In addition, their knowledge of the treatment system from the perspective of the consumer allows peer support specialists to offer advice and insights that may not come from other treatment professionals. Peer support specialists are often included in mental health treatment teams and can facilitate the person-centered planning process. The assistance provided by these specialists is not limited to navigating the mental health system, but includes helping clients obtain other supports that will contribute to their recovery, such as housing and vocational assistance.

As of 2009, nearly 650 individuals had been trained and certified as peer support specialists, and many have received additional training in evidence-based practices to allow them to provide even more support to consumers.[62]

[59] MDCH, *Person-Centered Planning Revised Practice Guideline, October 2002*, available online at: *http://www.michigan.gov/documents/PCPgud02_83966_7.pdf* (accessed 6/14/10).
[60] March 1, 2007, memo from Patrick Barrie, then Deputy Director, MDCH Mental Health and Substance Abuse Administration regarding Michigan Department of Community Health Recovery Policy and the Role of Peer Support Specialists; available online at: *http://michigan.gov/documents/mdch/March12007 MemofromPatrick_188884_7.pdf* (accessed 6/16/10).
[61] MDCH, Practice Improvement Steering Committee, *Compendium of Michigan's Evidence-Based Best and Promising Practices*.
[62] Ibid.

Current Programs and Services in Michigan

A good deal of mental health care in Michigan is provided in private offices. 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 in recent decades, as well as cost concerns, have shifted the locus of care from institutional settings into the community. In other words, best practice for some time has been 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 delivery of mental health care services today is based primarily in the community.

THE PRIVATE SECTOR

Private Institutions

As of April 1, 2010, there were 59 private psychiatric hospitals in Michigan providing inpatient care. Some offer only partial hospitalization, which are programs where patients participate in day-long sessions in a hospital setting but return home at night. Overall, Michigan has 2,181 licensed beds in private psychiatric facilities, 253 of which are reserved for children. In addition, 939 "positions" are available for partial hospitalization care; of these, 259 are reserved for children.[63] The distribution of facilities and beds reflects state population patterns. Wayne, Oakland, and Macomb Counties have 27 of the hospitals, more than 40 percent of the total. Other private hospitals are located in and around such major population centers as Grand Rapids, Muskegon, Flint, Saginaw, Bay City, Midland, Kalamazoo, and Battle Creek. Fifty-four of the 59 facilities offering inpatient care, or 92 percent, are in the southern part of the Lower Peninsula; only two are in the Upper Peninsula.

All licensed beds are in 32 counties; the state's other 51 counties do not have a private psychiatric facility. Patients who live in the more populated areas have more private hospitalization choices than do those who live in more rural areas. While the statewide average may suggest sufficient beds, people in many areas of Michigan have no facility close by.

The move toward the deinstitutionalization of care, which is evident in the public sector, is a very strong trend in the private sector as well. The number of licensed private

[63] Michigan Department of Community Health, Bureau of Health Systems, Division of Licensing and Certification, Licensed Active Psychiatric Programs, Inpatient & Partial Hospitalization Programs, April 1, 2010 By-County Listing.

institutions has dropped by more than 50 percent since 1997. A full listing of Michigan's private licensed psychiatric institutions is available in Appendix 1.

Private Outpatient Services

Outpatient mental health services may be accessed through private insurance, but attempting to identify which interventions are most commonly sought or delivered and the number of people being treated is impossible without access to insurer claims data. Private insurance coverage for mental health services varies from insurer to insurer and from policy to policy. Some group insurance policies are subject to federal regulation, which dictates the amount of coverage required for mental health services. State-governed policies are not required to provide any benefit for mental health services. Additionally, because private insurance contracts are regulated through contract and trust law, health plan administrators are vested with considerable power to decide whether a beneficiary is entitled to the benefits they seek.[64]

Private health insurers are obligated to ensure that the treatment beneficiaries receive is medically necessary and appropriate. Insurance companies make these decisions through internal utilization review techniques. The definition of medical necessity is not standard in the insurance industry; rather, it is broadly framed, multidimensional, and controlled by the insurer, not the treating professional.[65] The definition of medical necessity does encompass the following dimensions: the contractual scope of the insurance policy, or what the policy explicitly does or does not cover (this element preempts any other coverage decisions); standards of practice, or whether the treatment is generally accepted in the profession; patient safety and setting; and whether the treatment is cost-effective.[66]

This means that if an individual has benefits for mental health services through private insurance, the type of interventions for which the insurer will pay must meet the test of medical necessity, as determined by the insurer. Generally, inpatient and outpatient treatments are most often covered by health insurers, as well as services that bridge the inpatient and outpatient divide. These include nonhospital residential services and partial hospitalization, and case management. On average, insurers cover 30 days of inpatient and care and 30 outpatient visits annually.[67] Typically, individuals with private insurance also have access to pharmacological interventions through private prescription coverage.

THE PUBLIC SECTOR

Public mental health institutions and programs fall into three categories: (1) state-run psychiatric hospitals; (2) 46 CMHSPs subject to state regulations but most directly accountable to local communities, county commissions, or governance boards; and (3) 18 PIHPs, covering all 83 Michigan counties, which manage Medicaid mental health care

[64] S. Rosenbaum, B. Lamoie, D. R. Mauery, and B. Walitt, *Medical Necessity in Private Health Plans: Implications for Behavioral Health Care*, DHHS Pub. No. (SMA) 03-3790 (Rockville, Md.: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003).
[65] Ibid.
[66] Ibid.
[67] M. Sing, S. Hill, and L. Puffer, *Improving mental health insurance benefits without increasing costs*, DHHS Publication. No. SMA 01-3542 (Rockville, Md.: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2001).

services. The PIHPs receive Medicaid funds and contract with affiliated CMHSPs to provide mental health services.

A recent MDCH presentation to the Michigan Legislature clearly delineates the move from institution-based to community-based care that has taken place over the past 45 years (see Exhibit 2).

EXHIBIT 2
Transition to Community Services

1965	1991	2010
12 county community health boards covering 16 counties; 7 in the planning process	55 community mental health boards covering all 83 counties	46 community mental health service programs covering all 83 counties
41 state-operated psychiatric hospitals and centers for persons with developmental disabilities—about 29,000 residents	20 state psychiatric hospitals and centers for persons with developmental disabilities—total census: 3,054	5 state-operated hospitals and centers on February 24, 2010, with a resident census of 818

SOURCE: MDCH Senate Budget Presentation, March 2010.

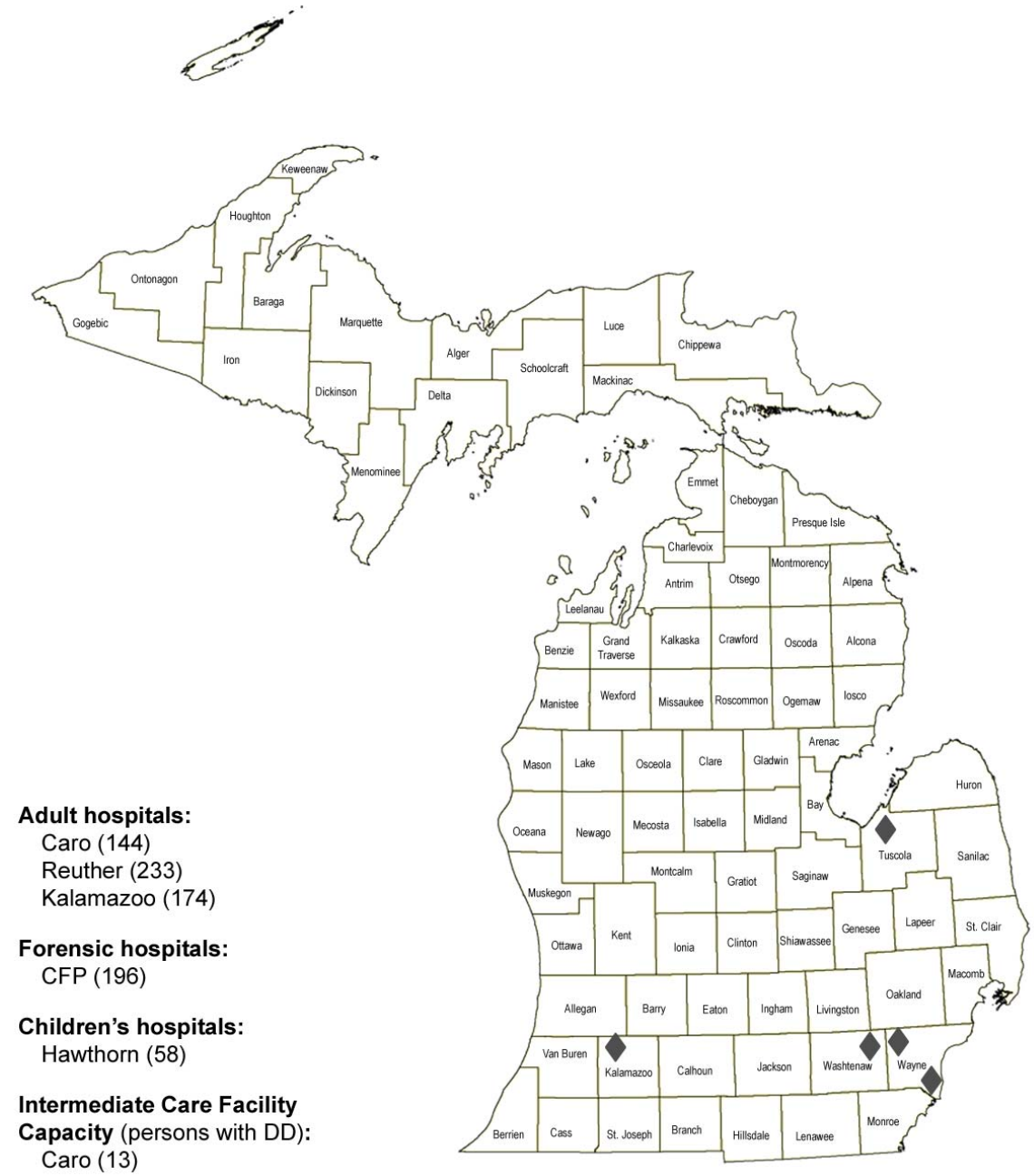
As the exhibit shows, the number of community mental health boards increased rapidly between 1965 and 1991. In 1965 there were only 12 county community mental health boards covering 16 counties. By 1991 that number had risen to 55 boards covering all 83 Michigan counties. Over the past 20 years there has been some consolidation and 46 CMHSPs now serve the entire state. These CMHSPs coordinate care locally. While MDCH requires extensive reporting on services delivered, populations served, and funds expended, the types of interventions available vary among CMHSPs. For example, the interventions for a person with schizophrenia may be different in Oakland County than Alpena. Proponents of this system argue that local control of service design and delivery is important for serving the unique needs of each region. Opponents contend that this system is disjointed and acts as a barrier to coordinating care throughout the state.

Exhibit 2 also demonstrates a clear and dramatic trend with regard to state hospitals. In 1965 there were 41 state-operated psychiatric hospitals and centers serving some 29,000 mentally ill patients and persons with developmental disabilities. By 1991 there were 20 state facilities serving 3,054 persons. In 2010 there were just six facilities serving 818 persons, with five serving the mentally ill and one for the developmentally disabled.

State Hospitals

The State of Michigan currently operates three psychiatric hospitals for adults: the Caro Center, located in Caro, the Kalamazoo Psychiatric Hospital, and the Walter Reuther Psychiatric Hospital in Westland. The Hawthorn Center in Northville serves children exclusively, while the Center for Forensic Psychiatry in Ann Arbor serves persons who have been charged with a crime and are in need of treatment or assessment. The MDCH also operates a facility for the developmentally disabled in Caro. Exhibit 3 shows the location of state hospitals as well as the February 2010 census of residents.

EXHIBIT 3
Hospitals and Centers



Adult hospitals:
Caro (144)
Reuther (233)
Kalamazoo (174)

Forensic hospitals:
CFP (196)

Children's hospitals:
Hawthorn (58)

Intermediate Care Facility Capacity (persons with DD)**:**
Caro (13)

SOURCE: Adapted from MDCH Senate Budget Presentation, March 2010.

The latest census showed that there were 818 residents in state hospitals in early 2010. Two of the hospitals are located in the tri-county region around Detroit, and the Center for Forensic Psychiatry is in nearby Washtenaw County. 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.

Community Mental Health Service Programs (CMHSPs)

The 1974 Michigan Mental Health Code (P.A. 258) provided for the formation of "community mental health boards" at the option of the county board of commissioners and directed the then Department of Mental Health to "shift from the state to a county the primary responsibility for the direct delivery of public mental health services whenever the county shall have demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of the county." The boards described in the Mental Health Code are now known as Community Mental Health Service Programs (CMHSPs). CMHSPs are now the primary provider of public mental health services. The organizations work to coordinate treatment and services in their respective areas, either by providing treatment directly or contracting with other mental health agencies and professionals for service. They are also the primary provider of mental health treatment in county jails. Each CMHSP develops and administers services at the local level, and while extensive data collection is required by the state, the types of services offered are not uniform statewide.

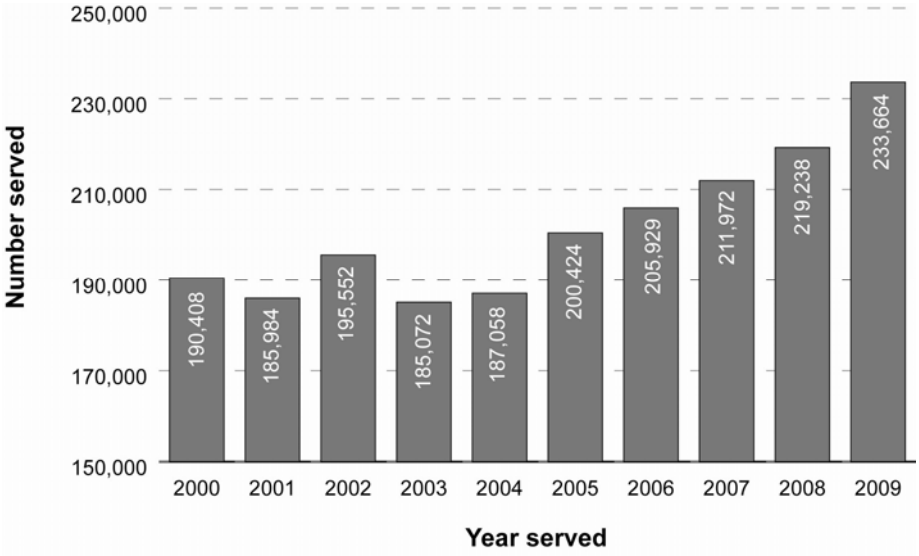
As of May 2010, there were 46 CMHSPs serving all 83 Michigan counties. Appendix 2 provides the most current listing of CMHSPs, along with contact information and the counties they serve. Under 1996 revisions to the Mental Health Code, CMHSPs can be structured in one of three ways:

- A county community mental health *agency* is an agency of the county it represents and most closely reflects the structure of the single-county community mental health boards in place in 1996. Under this governance structure, all funding for the CMHSP is appropriated within the county budget.
- A community mental health *organization* is a separate public government entity created by two or more counties under the Urban Cooperation Act.
- A community mental health *authority* is created through an enabling resolution adopted by the board of commissioners of each creating county. This is a separate public government entity that is independent of county government. Under this governance structure, funding is appropriated by the authority and is never passed through county government.

Of the 46 existing CMHSPs, 37 are organized as independent authorities. An additional seven CMHSPs are agencies of county government: Allegan, Genesee, Lapeer, Macomb, Muskegon, Ottawa, and Detroit-Wayne. Only two CMHSPs, Manistee-Benzie and Washtenaw, are "organizations." Although the great majority of CMHSPs are independent authorities, some of the very largest—such as Detroit-Wayne and Macomb—are county agencies.

Exhibit 4 demonstrates trends in the number of individuals served by Michigan CMHSPs between 2000 and 2009, the last year for which there is available data.

EXHIBIT 4
CMHSPs, Persons Served (Includes both mentally ill and developmentally disabled)



SOURCE: MDCH Senate Budget Presentation, March 2010.

While remaining fairly constant for the first four years of this ten-year period, the number of persons being served rose in every year between 2003 and 2009. The overall rate of increase from 2003 to 2009 was 26 percent. Since these increasing service demands have come during a time of serious budget constraints, it is easy to appreciate why state officials are concerned about an erosion of service capacity.

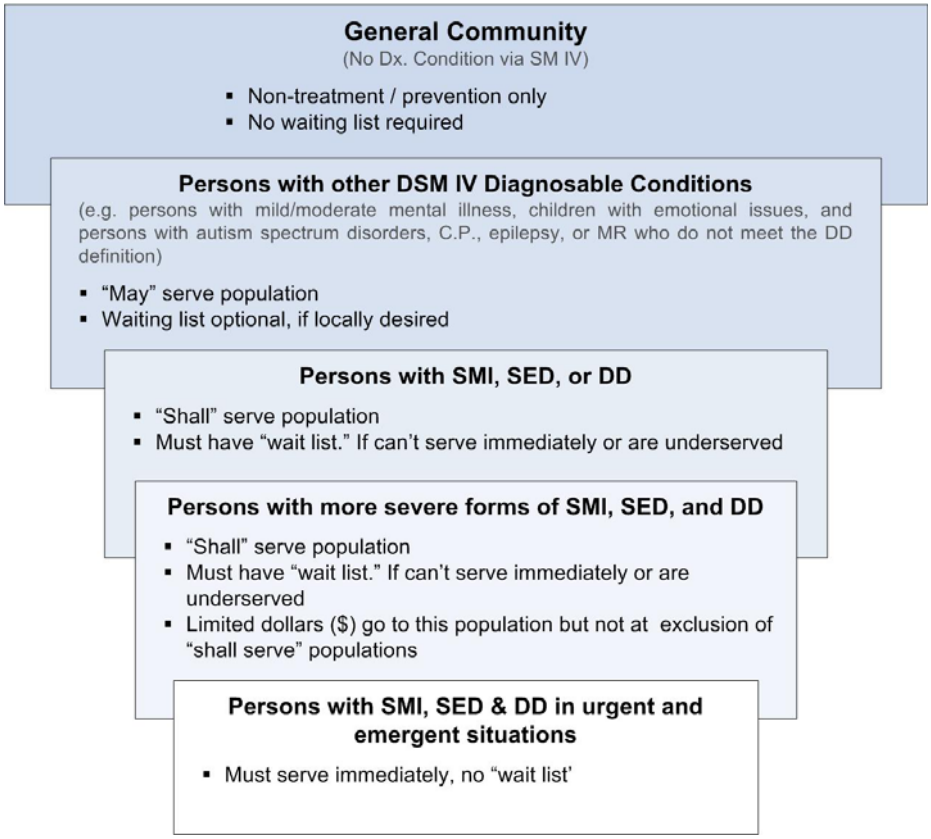
Exhibit 5 gives a sense of CMHSP service priorities, an important consideration when budgets are tight. As the figure shows, the core mission for CMHSPs is to treat persons with serious mental illness or serious emotional disturbances who are in urgent or emergency situations.[68] One of the following criteria must be met to qualify as an emergency situation:

- An individual can reasonably be expected within the near future to physically injure himself, herself, or another individual, either intentionally or unintentionally.
- An individual is unable to provide himself or herself food, clothing, or shelter or to attend to basic physical activities, and this inability may lead in the near future to harm to the individual or to another individual.
- An individual's judgment is so impaired that he or she is unable to understand the need for treatment and, in the opinion of the mental health professional, his or her continued behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.[69]

[68] MCL 330.1208(3).
[69] MCL 330.1100(a)(25).

Serving persons who have severe forms of mental illness or emotional disturbance is the next priority. While still important, persons who have less severe mental illness or disturbances, or who merely exhibit a "diagnosable condition," are less of a priority. In a time of budget crisis, it is reasonable to suppose that the system will continue to treat crises and severe cases, but possibly at the expense of those with less severe conditions. The risk, of course, is that, absent treatment, less serious cases of mental illness and emotional disturbance will worsen.

EXHIBIT 5
Service Priority Matrix



SOURCE: Adapted from MDCH Senate Budget Presentation, March 2010

CMHSP Demographics

In 2009, CMHSPs served more than 180,000 mentally ill clients statewide. Some 38,517 of these clients (21.3 percent) were minors under the age of 18. Almost 10 percent of those served were under some form of supervision from the courts and criminal justice system.

The data also suggest that African Americans and persons with lower income are disproportionally more likely to be served by the public CMHSPs. Almost one-quarter of the mentally ill persons served by the CMHSPs in FY 2008–09 were African American. According to the U.S. Census Bureau, African Americans made up just over 14 percent

of the Michigan population in 2009. In contrast, whites make up about 81 percent of the Michigan population but only 62 percent of the mentally ill population served by state CMHSPs. In general, Hispanics and persons of Asian descent are somewhat underrepresented in the CMHSP population. Persons of American Indian or Alaskan Native descent are slightly overrepresented.

Nearly three-fourths of the mentally ill persons treated by CMHSPs in FY 2008–09 lived in households with income under $20,000. Fully 62 percent lived in households with income under $10,000. In Michigan in 2009, the median household income was approximately $48,600, according to the Census Bureau.

The demographics of persons served by CMHSPs are summarized in Exhibit 6.

EXHIBIT 6
Demographics of Persons Served by CMHSPs, 2009

Demographic Characteristics	MI Consumers	
	Number	Percentage
Gender		
Males	89,755	49.60%
Females	90,761	50.16
Unknown gender	424	0.23
Age		
Age 0 through 3	1,340	0.74%
Age 4 through 12	17,286	9.55
Age 13 through 17	19,891	10.99
Age 18 through 26	26,009	14.37
Age 27 through 64	106,696	58.97
Age 65 and over	9,630	5.32
Unknown Age	88	0.05
Race/Ethnicity		
White/Caucasian	112,096	61.95%
African American/Black	44,762	24.74
American Indian or Alaskan Native	1,491	0.82
Asian	413	0.23
Native Hawaiian or other Pacific Islander	56	0.03
Other race	7,802	4.31
Multiracial	7,660	4.23
Unknown/Refused/Missing	6,660	3.68
Hispanic		
Hispanic or Latino	5,925	3.27%
Not Hispanic or Latino	148,848	82.26
Unknown/Missing	26,167	14.46

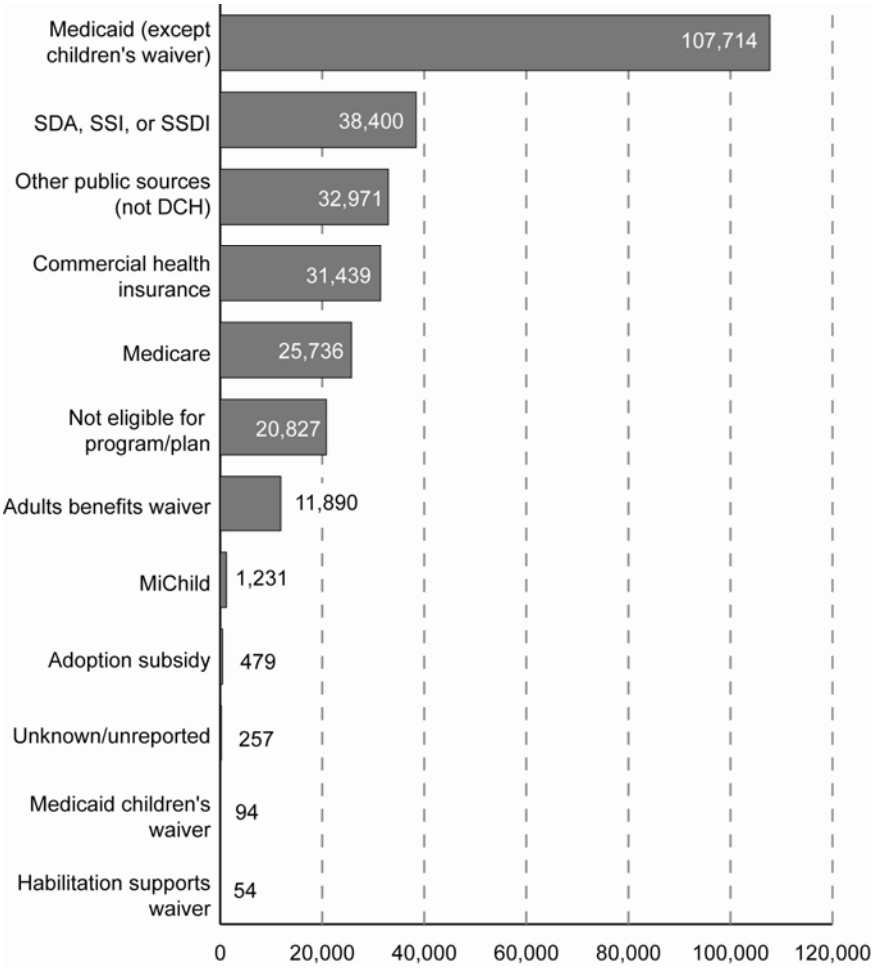
Demographic Characteristics	MI Consumers	
	Number	Percentage
Corrections Status		
In prison	119	0.07%
In jail	3,707	2.05
Paroled from prison	2,108	1.17
Probation from jail	5,748	3.18
Juvenile detention center	370	0.20
Court supervision	3,118	1.72
Not in a corrections status	99,325	54.89
Awaiting trial	934	0.52
Awaiting sentencing	800	0.44%
Minor referred by the Court	578	0.32
Arrested and booked	214	0.12
Diverted from arrest or booking	135	0.07
Corrections status refused/unreported	63,784	35.25
Residence		
Homeless/homeless shelter	5,816	3.21%
Private—with relatives	73,649	40.70
Private—non-relatives	54,404	30.07
Foster family	2,796	1.55
Specialized residential	5,225	2.89
General residential	3,548	1.96
Prison/jail/juvenile detention	4,532	2.50
Nursing care facility	3,443	1.90
Other institutional setting	894	0.49
Supported Independence Program	1,226	0.68
Residential arrangement unknown/unreported	25,407	14.04
Total Annual Household Income		
Income Below $10,000	112,762	62.32%
Income $10,001 to $20,000	19,033	10.52
Income $20,001 to $30,000	5,658	3.13
Income $30,001 to $40,000	2,153	1.19
Income $40,001 to $60,000	1,429	0.79
Income over $60,000	1,288	0.71
Income unreported	38,617	21.34
Program Eligibility (Persons May be Eligible for More than One Group)		
Adoption subsidy	479	0.26%
Habilitation Supports Waiver	54	0.03
Medicare	25,736	14.22
Medicaid (except Children's Waiver)	107,714	59.53
MIChild	1,231	0.68

Demographic Characteristics	MI Consumers	
	Number	Percentage
Program Eligibility, cont. (Persons May be Eligible for More than One Group)		
Medicaid Children's Waiver	94	0.05
SDA, SSI, SSDI	38,400	21.22
Commercial health insurance	31,439	17.38
Other public sources—not DCH	32,971	18.22
Not eligible for program/plan	20,827	11.51
Adult Benefit Waiver	11,890	6.57
Program eligibility unknown/unreported	257	0.14
Employment		
Employed full time	6,419	3.55%
Employed part time (less than 30 hours/week)	11,144	6.16
Unemployed—looking for work	38,085	21.05
Not in competitive labor force	57,813	31.95
Retired from work	4,168	2.30
Sheltered workshop/work services, non-integrated	1,347	0.74
Not applicable (i.e., child)	32,104	17.74
Supported employment only	321	0.18
Supported and competitive employment	189	0.10
In unpaid work	156	0.09
Employment status unknown/unreported	29,194	16.13
Education		
Completed less than high school	32,425	17.92%
Completed high school or more	45,245	25.01
In school—K to 12	30,433	16.82
In training program	436	0.24
In special education	2,559	1.41
Attended or attending undergraduate college	16,920	9.35
College graduate	5,833	3.22
Education unreported	47,089	26.02
Total Served Persons served by CMHSPs	**180,940**	**100.00%**

SOURCE: Michigan Department of Community Health, Adapted from the Section 404 Report to the Legislature and House and Senate Fiscal Agencies, May 31, 2010.

Exhibit 7, a summary of public program eligibility of CMHSP clients, underscores the extent to which CMHSP dollars come from federal and state sources.

EXHIBIT 7
Eligibility Summary, Persons Receiving CMHSP Services, FY 2008–09



SOURCE: Michigan Department of Community Health, Division of Mental Health Quality Management and Planning, March 2009.

The total is higher than actual persons served because individuals may qualify under more than one eligibility category.

In FY 2008–09, 107,714 mentally ill persons served were Medicaid eligible. Approximately 75 percent of those served were eligible for Medicaid, Medicare, State Disability Insurance, Supplemental Security Income, Social Security Disability Insurance, or some other public funding program. Only 31,439 persons (17 percent) had commercial health insurance coverage. It is important to note, however, that services provided do not differ based on eligibility category. CMHSPs administer interventions to all persons. Persons who are eligible for services through Medicaid are more likely to receive them than others with no mechanism for payment, because the public system receives most of its funding through Medicaid.

Exhibit 8 provides a snapshot indication of how CMHSP funds were spent during FY 2008–09.

EXHIBIT 8

Per Capita and Per Person Served CMHSP Expenditures by CMHSP
Adults with Mental Illness, FY 2008-09

CMHSP	Cost	2006 adult population	Cost per capita	Total MI-adults served	Cost per person served
Allegan	$4,545,804	84,412	$53.85	820	$5,543.66
AuSable Valley	3,678,799	46,081	79.83	1,458	2,523.18
Barry	3,243,303	45,553	71.20	1,249	2,596.72
Bay-Arenac	13,912,997	97,410	142.83	3,843	3,620.35
Berrien	17,772,710	121,952	145.74	3,120	5,696.38
Clinton Eaton Ingham	27,509,140	349,845	78.63	4,158	6,615.95
CMH for Central Michigan	19,670,209	214,318	91.78	5,161	3,811.32
Copper Country	5,476,469	42,963	127.47	670	8,173.83
Detroit-Wayne	250,072,240	1,431,181	174.73	43,681	5,724.97
Genesee	49,598,197	327,136	151.61	8,303	5,973.53
Gogebic	1,959,943	13,638	143.71	302	6,489.88
Gratiot	1,917,725	32,965	58.17	723	2,652.46
Hiawatha	4,995,169	47,067	106.13	1,031	4,844.97
Huron	3,815,016	26,970	141.45	782	4,878.54
Ionia	4,501,724	49,081	91.72	1,638	2,748.31
Kalamazoo	23,998,809	184,779	129.88	3,656	6,564.23
Lapeer	5,058,907	71,198	71.05	930	5,439.69
Lenawee	5,378,797	78,261	68.73	1,277	4,212.06
Lifeways	14,301,695	160,523	89.09	5,467	2,616.00
Livingston	5,937,985	139,477	42.57	1,088	5,457.71
Macomb	52,700,736	639,058	82.47	7,820	6,739.22
Manistee-Benzie	4,036,406	33,944	118.91	901	4,479.92
Monroe	7,766,739	117,862	65.90	1,161	6,689.70
Montcalm	2,738,183	48,243	56.76	714	3,834.99
Muskegon	15,312,254	130,840	117.03	2,944	5,201.17
Network180	42,668,862	436,261	97.81	7,857	5,430.68
Newaygo	4,153,593	36,977	112.33	1,025	4,052.29
North Country	10,225,947	119,543	85.54	2,713	3,769.24
Northeast Michigan	5,033,003	53,920	93.34	1,844	2,729.39
Northern Lakes	14,396,765	153,137	94.01	3,730	3,859.72
Northpointe	5,029,822	51,074	98.48	979	5,137.71
Oakland	91,696,177	918,866	99.79	12,409	7,389.49
Ottawa	8,855,827	190,405	46.51	2,154	4,111.34
Pathways	9,691,152	95,995	100.95	1,545	6,272.59
Pines	3,914,898	35,161	111.34	1,488	2,630.98
Saginaw	20,212,790	154,951	130.45	3,541	5,708.22
Sanilac	5,153,292	33,836	152.30	703	7,330.43
Shiawassee	4,817,008	55,250	87.19	971	4,960.87
St. Clair	13,862,590	130,480	106.24	2,529	5,481.45

CMHSP	Cost	2006 adult population	Cost per capita	Total MI-adults served	Cost per person served
St. Joseph	4,054,460	46,353	87.47	1,132	3,581.68
Summit Pointe	15,088,371	103,957	145.14	3,662	4,120.25
Tuscola	3,124,486	44,181	70.72	860	3,633.12
Van Buren	8,265,308	58,862	140.42	1,811	4,563.95
Washtenaw	24,731,722	269,950	91.62	2,609	9,479.39
West Michigan	5,869,211	53,649	109.40	1,728	3,396.53
Woodlands	3,515,524	39,722	88.50	785	4,478.37
State Totals	**$854,260,762**	**7,617,287**	**$112.15**	**158,972**	**$5,373.66**

SOURCE: Service costs and consumer counts were obtained from the annual sub-element cost report submitted by the 46 CMHSPs for FY 2008-09. Population for 2006 released by the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.

Exhibit 8 gives per capita and per person served cost data for each of the 46 CMHSPs. Both measures are affected by the severity of illnesses being treated, but in general, "per capita" costs are driven by utilization and "per person served" costs are driven by the cost of care. There is considerable variation in the expenditure data, but not all of it is readily explainable. The range in expenditures per capita is immense—from $42 to $174. With annual per capita expenditures of nearly $175, the Detroit-Wayne CMHSP easily has the highest costs in the state, some 55.8 percent above the state average. In fact, such large expenditures in Michigan's largest CMHSP definitely skew those average costs upward. Yet, it is also true that in the group of next highest per capita costs are small, mainly rural CMHSPs, including Huron, Sanilac, and Gogebic. For whatever reason—be it poverty, higher incidence of mental illness, or more aggressive diagnosing—these CMHSPs have higher costs per capita costs than other CMHSPs.

As the exhibit also shows, there is considerable variation in the cost per person served. Copper Country CMHSP and AuSable Valley CMHSP have roughly the same population. Yet they also define the range of costs per person served. With a cost of $8,173, Copper Country CMHSP is the second most expensive in the state by this measure. With a cost of $2,523, AuSable Valley CMHSP is the lowest. Again, the reasons for the variation are not immediately obvious. Four CMHSPs had per person costs higher than $7,000 in FY 2008–09: Oakland and Washtenaw Counties in populous southeast Michigan, and the Copper Country and Sanilac CMHSPs, which serve rural areas.

Prepaid Inpatient Health Plans (PIHPs)

Prepaid inpatient health plans (PIHPs) manage mental health services for persons enrolled in Medicaid. PIHPs act as managed care organizations and receive capitated payments for each person in the plan. All CMHSPs belong to a PIHP, and contract with their respective PIHP to provide Medicaid-funded services for its members. A full listing of current PIHPs by county is included in Appendix 2. According to the Michigan Association of Community Mental Health Boards website, administering PIHPs has been a CMHSP responsibility for more than a decade:

> Since 1998, CMHSPs have been responsible for managing the Medicaid specialty services benefit for 1.3 million beneficiaries under federal 1915(b) and (c) waivers. This authority was renewed by the federal Center for Medicare and Medicaid Services (CMS) in February of 2001 and again in December of 2003. This program has been recognized as the only managed Medicaid specialty services program in the country serving all three populations—persons with mental illness, developmental disabilities and substance abuse disorders.[70]

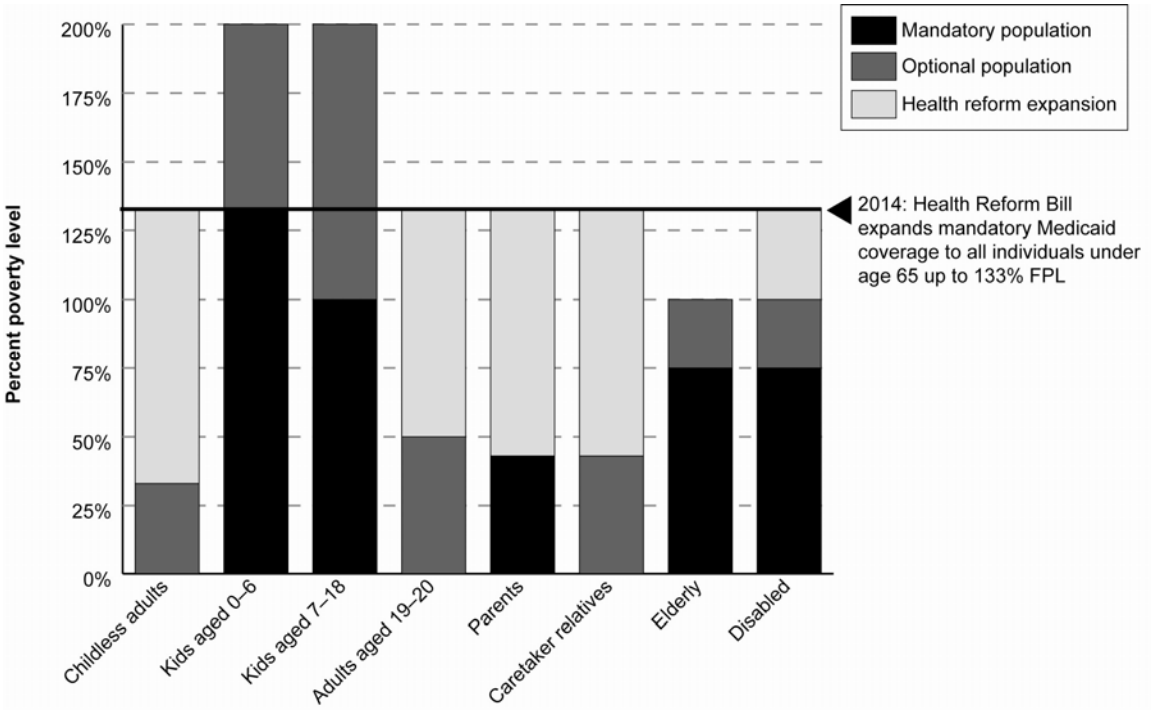
The PIHPs contract with providers, provide gatekeeper services, and monitor the quality of services. They are not, however, fully at risk, nor are they required to provide a full scope of services. The Medicaid covered services they may provide include:

- Inpatient psychiatric hospitalization (not mandated by federal Medicaid rules)
- Intermediate Care Facility for Individuals with Mental Retardation (ICF/MR) (not mandated by federal Medicaid rules)
- Mental health services, including psychiatric evaluation and psychological testing, crisis interventions, crisis residential services, family and individual/group therapy, and others (not mandated by federal Medicaid rules)
- Children with Serious Emotional Disturbance Home and Community Based Waiver (not required by federal Medicaid rules)

Exhibit 9 provides a description of current Medicaid eligibility thresholds and the changes that will be made to eligibility pursuant to the Patient Protection and Affordable Care Act of 2010.

[70] About MACMHB: Mission Statement, Michigan Association of Community Mental Health Boards website; available online at: *http://www.macmhb.org/MACMHB%20Background.html* (accessed 6/14/10).

EXHIBIT 9
Current MICHIGAN Medicaid Eligibility and Health Care Reform Expansion



SOURCE: Janet Olszewski, Director of Michigan Department of Community Health, Health Care Reform and Michigan, presentation for State Roles in Health Care Reform Roundtable, May 12, 2010.

CHILDREN

As discussed earlier, almost 40,000 minors received CMHSP services in 2009. Of those, 10 percent entered the public mental health system through the justice system. However, children represent just over 20 percent of the number of persons served by the public system. Because of limited funding and the variability of service provision between regions, programs focusing on prevention and intervention for children are scarce. Many children qualify for public mental health services through Medicaid and, similar to adults, do not enter the system until their mental illness has become severe.

Michigan, however, has made an effort to avoid placing children in institutions. A home- and community-based waiver for children with serious emotional disturbance is administered by the MDCH. Commonly referred to as the SEDW (serious emotional disturbance waiver), it is designed to provide in-home services and supports for Medicaid-eligible children under the age of 18 who meet criteria for admission to a state inpatient hospital and who are at risk for hospitalization if in-home services are not provided. A serious emotional disturbance is defined as "a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits the minor's role or

functioning in family, school, or community activities."[71] The SEDW is very limited, however; currently, only 43 "slots" are approved statewide for this program. The SEDW is available in the following areas: CMH Authority of Clinton-Eaton-Ingham Counties, CMH for Central Michigan, Livingston County CMH Authority, Macomb County CMH Services, and Van Buren Community Mental Health Authority.

QUALITY

Under the federal laws that govern Medicaid plans, both managed care organizations and PIHPs are required to file reports that analyze the adequacy of these organizations and plans regarding the quality and timeliness of services as well as access to care. More specifically, they are to do so in a way that examines their adherence to compliance standards, the reliability of their performance measures, and the extent to which they have shown progress on various performance improvement projects (PIPs).

As the authors of the review make clear, Michigan PIHPs performed fairly well. The data from 2006 showed a clear improvement over 2005. As the exhibit shows, the state average was 90 percent or higher in six out of eight categories. Further, five PIHPs—the CMH Affiliation of Mid-Michigan, the CMH Partnership of Southeastern Michigan, the Lakeshore Behavioral Health Alliance, NorthCare, and the Oakland County CMH Authority—received above-average scores across the eight categories. Nevertheless, the data also suggest areas for improvement:

- The CMH for Central Michigan and the Detroit-Wayne County CMH Agency both scored lower than the state average by all measures captured in the exhibit.
- Michigan PIHPs generally scored lower on their PIPs than they did on compliance and performance measures. The state averages in this area were dragged down by quite low scores in the Access Alliance, the CMH for Central Michigan, Detroit-Wayne, Lifeways, the Northwest CMH affiliation, and the Thumb Alliance.

Exhibit 10 shows how the 18 Michigan PIHPs met quality, timeliness, and access standards during the most recent external quality review.

EXHIBIT 10

Quality, Timeliness, and Access Scores for Compliance Standards (CS), Performances Measures (PM), and Performance Improvement Projects (PIPs), 2006

	Quality			Timeliness		Access		
PIHP	CS	PM	PIP	CS	PM	CS	PM	PIP
Access Alliance of Michigan	99%	91%	78%	100%	92%	100%	92%	78%
CMH Affiliation of Mid-Michigan	99	94	90	100	97	100	97	90
CMH for Central Michigan	93	82	61	79	86	84	86	61
CMH Partnership of Southeastern Michigan	96	90	100	100	96	100	96	100
Detroit-Wayne County CMH Agency	82	86	77	82	81	77	81	77

[71] MCL 330.1100(d)(2).

	Quality			Timeliness		Access		
PIHP	**CS**	**PM**	**PIP**	**CS**	**PM**	**CS**	**PM**	**PIP**
Genesee County CMH	100	88	90	100	91	100	91	90
Lakeshore Behavioral Health Alliance	99	90	94	100	93	100	93	94
Lifeways	100	92	79	100	94	100	94	79
Macomb County CMH Services	99	81	100	100	87	100	87	100
Network 180	89	88	90	94	89	98	89	90
NorthCare	98	93	100	98	96	100	96	100
Northern Affiliation	95	94	86	94	95	94	95	86
Northwest CMH Affiliation	99	91	71	100	91	100	91	71
Oakland County CMH Authority	99	94	92	100	97	100	97	92
Saginaw County CMH Authority	94	90	90	90	92	100	92	90
Southwest Affiliation	98	84	95	100	95	100	95	95
Thumb Alliance PIHP	100	95	78	100	97	100	97	78
Venture Behavioral Health	100	89	89	100	91	100	91	89
State Average	**96%**	**90%**	**87%**	**96%**	**92%**	**98%**	**92%**	**87%**

SOURCE: 2005–2006 External Quality Review Technical Report for Prepaid Inpatient Health Plans, prepared by the Health Services Advisory Group for the Mental Health and Substance Abuse Administration, Michigan Department of Community Health, October 2006.

MENTAL HEALTH AND THE CRIMINAL JUSTICE SYSTEM

The relationship between crime and mental health, between the criminal justice and mental health systems, has always been close and problematic. Both systems deal with individual behavior that falls outside accepted or desirable social norms and the systems often intersect. In fact, the MDCH, under a 1992 interdepartmental agreement, provides mental health services to some 6,000 prisoners annually. In total, the MDCH provides services to approximately 20,000 persons who have some involvement with the criminal justice system.[72] Integrating mental health treatment in the criminal justice system has long been a major goal of mental health policy advocates. The 2004 Mental Health Commission Final Report identified as one of three principal "challenges" the fact that an increasing number of individuals with mental health problems are showing up among the clientele served by other public systems.[73]

More particularly, the report cites evidence that the dramatic drop in the number of institutionalized mental health patients in Michigan coincided with a corresponding dramatic increase in mental illness among the state's jail population. One highly reliable observer noted that "the Wayne County Jail is the largest inpatient mental 'hospital' in Michigan."[74] The Commission report identified a broad continuum of recommended

[72] Michael Head, Director, Mental Health and Substance Abuse Administration, Michigan Department of Community Health, March 4, 2010. The information is contained in a PowerPoint presentation used at a legislative briefing.

[73] Michigan Mental Health Commission, *Michigan Mental Health Commission, Part I: Final Report* (Lansing, Mich.: Public Sector Consultants Inc., October 15, 2004), 9.

[74] Hon. Milton L. Mack, Jr., "What We Can Do About Mental Health Costs." Guest Column in *Fresh Thoughts for Michigan's Transformation*, Center for Michigan, May 6, 2010; available online at: *http://www.thecenterformichigan.net/blog/guest-column-what-we-can-do-about-mental-health-costs/* (accessed 6/16/10).

action including early treatment, jail diversion programs, better care for persons who are incarcerated, and continued access to care for prisoners returning to society.

In the immediate aftermath of the Commission's report, the MDCH issued a plan for implementing its recommendations.[75] Progress in implementing them proved to be slow, however. In a "Three Year Report Card," which was developed to chart progress toward meeting the Commission's goals and recommendations, the Mental Health Association in Michigan offered the following searing indictment:

> Michigan and the nation have not deinstitutionalized mental illness. Rather, the focus of institutionalization has switched from psychiatric hospitals to jails, prisons, and juvenile justice facilities. Meanwhile, the horrible circumstances and health consequences for Michigan prison inmates with mental illness (including multiple fatalities) have been widely publicized over the past two years by state and national media (e.g., "60 Minutes" coverage of the brutal death of a young adult with mental illness in the state prison at Jackson).[76]

Since the "report card" was published, there has been progress, at least on the planning front. Between August 2007 and June 2008, key mental health stakeholders met under the auspices of the Michigan Department of Corrections (MDOC) and the MDCH to review the delivery of mental health care in the correctional system. The group's final report, published in February 2009, offers 18 recommendations.[77]

[75] Michigan Department of Community Health, *Transforming Mental Health Care in Michigan: A Plan for Implementing Recommendations of the Michigan Mental Health Commission* (Lansing, Mich.: MDCH, April 2005); available online at: *http://www.michigan.gov/documents/DCH_Implementation_Plan_April_2005_122025_7.pdf* (accessed 6/16/10).

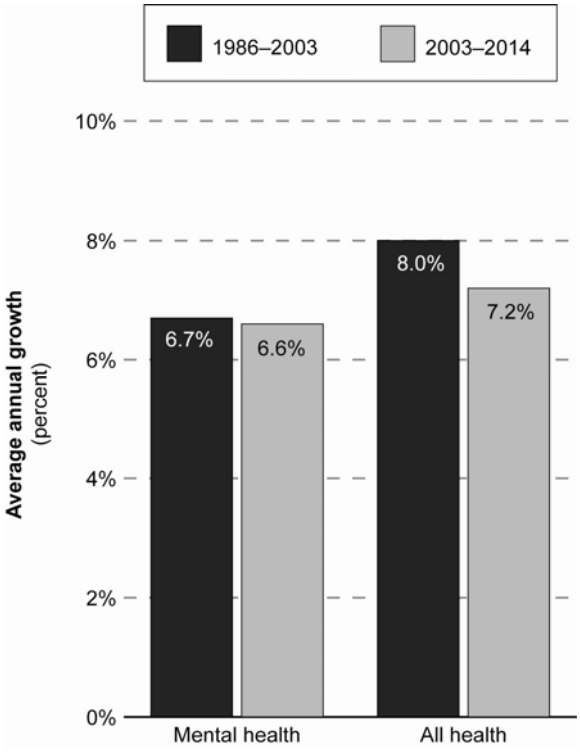
[76] The Mental Health Association in Michigan, *A Three-Year Report Card: Progress by the State of Michigan in Implementing Recommendations of the Governor's Mental Health Commission: October 2004 – December 2007* (Southfield, Mich.: Mental Health Association in Michigan, January 2008), 9.

[77] Michigan Department of Corrections and Michigan Department of Community Health, *The Michigan Prisoner Mental Health Care Improvement Project: A Blueprint for Transforming Prisoner Mental Health Care, Report and Recommendations of the Interagency Mental Health Care Workgroup* (Lansing, Mich.: MDOC and MDCH, February 2009).

NATIONAL MENTAL HEALTH EXPENDITURES

The devolution of the mental health system from an institutional to a community-based system, along with new medications for mental illness that can be obtained through primary care providers, has created access for many people who previously were unable to obtain treatment. Mental health spending accounted for 6.2 percent of all health spending in 2003, totaling $100 billion. This is up from $33 billion in 1986, and is projected to increase to $203 billion in 2014. However, mental health spending as a proportion of all health expenditures has been decreasing; in 1986, it accounted for 7.5 percent of total health spending and is projected to decline to 5.9 percent of spending in 2014.[78]

EXHIBIT 11
Growth in Mental Health Expenditures and All Health Expenditures: 1986–2003 and 2003–2014



SOURCE: DHHS, Substance Abuse and Mental Health Services Administration, *Projections of National Expenditures for Mental Health Services and Substance Abuse Treatment 2004–2014*, 2008.

Spending on mental health is expected to increase at a lower rate than all health spending, with a 6.6 percent average increase projected annually until 2014 compared to a 7.2 increase for all health spending (see Exhibit 11). This sustained growth is attributed to increased utilization of pharmaceuticals, which represent a higher proportion of mental health spending (30 percent by 2014), compared to all health spending (a projected 15 percent).[79]

Payment for mental health services comes from both public and private funds. Public funding includes Medicaid, supported by both state and federal dollars, Medicare and other federal funds, and other state and local dollars that pay for services or populations not covered by Medicaid or Medicare. Private funding is comprised mostly of private insurance and out-of-pocket payments, with some funding from philanthropic sources.

[78] DHHS, *Projections of National Expenditures.*
[79] Ibid.

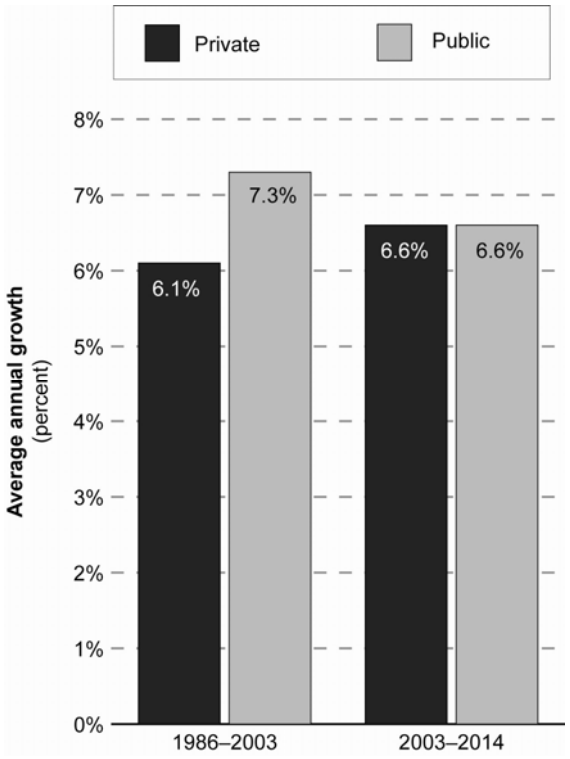
Public Expenditures

Public funding for mental health services accounts for the majority of mental health spending. In 1986, public funds supported 54 percent of mental health spending, increasing to 58 percent in 2003. This level has remained constant since 2003 and is not expected to change in the foreseeable future.[80]

Medicaid

In the late 1990s, adoption of managed care models by state Medicaid programs for mental health systems began to temper the growth in public spending. The federal government began granting state Medicaid plan waivers to states, which allowed them to provide capitated payments to mental health providers, thereby reducing outpatient treatment costs and slowing spending growth. In 2006, states reported spending more than $13.6 billion for Medicaid mental health services.[81] Because the public system could not incorporate the cost saving measures of managed care until the end of the 1990s, public spending grew more quickly between 1986 and 2003 than private spending, by 7.3 percent annually, compared to 6.1 percent for private spending (see Exhibit 12). Trends indicate that future spending will accelerate for areas that rely more on private sources, like physicians and prescription drugs, and the annual rate of increase for public and private spending will even out, at 6.6 percent through 2014.[82]

EXHIBIT 12
Growth in Public and Private Mental Health Expenditures



SOURCE: DHHS, Substance Abuse and Mental Health Services Administration, *Projections of National Expenditures for Mental Health Services and Substance Abuse Treatment 2004–2014*, 2008.

Nationally, Medicaid spending is high compared to other public funding sources for mental health expenditures. The movement to shift treatment from institutions into the community by providing more access to outpatient services, generally funded through Medicaid, spurred many states to transition mental health services recipients from state-paid hospitals into the Medicaid program, resulting in

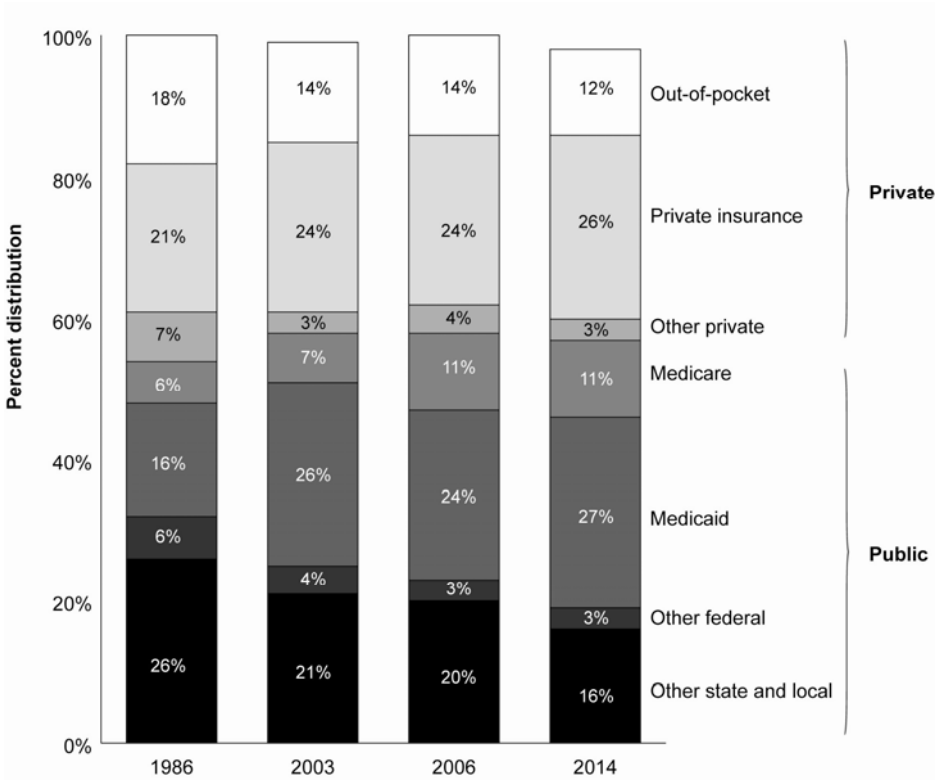
[80] DHHS, *Projections of National Expenditures.*
[81] National Association of State Mental Health Program Directors Research Institute, Inc., *State Mental Health Agency Revenues and Expenditures Report 2006* (Alexandria, Va.: NASMHP, 2006).
[82] Ibid.

more Medicaid spending on mental health. Additionally, the current economic climate nationally has forced states to cut programs that are considered non-essential or are not required by the federal government; therefore, many optional services have experienced severe spending reductions over the last few years. Thus, state discretionary funds pay for fewer mental health services in proportion to Medicaid, since the optional, expanded services have been reduced.

Medicare

Medicare's portion of mental health spending has increased over the past decade as well. In 2003, Medicare paid for just 7 percent of mental health expenditures, but that is expected to increase to 11 percent in 2014 (see Exhibit 13).[83] In 2006, states reported $616 million in Medicaid mental health services.[84] This increase is due in large part to two reasons. First, the population is aging rapidly and more people are becoming eligible for Medicare coverage. Second, the passage of Medicare Part D in 2003, which provides a prescription drug benefit to Medicare beneficiaries, began paying for medications that had previously been paid for by private insurers, out-of-pocket payments, or Medicaid.

EXHIBIT 13
Distribution of Expenditures, by Payer



SOURCE: DHHS, Substance Abuse and Mental Health Services Administration, *Projections of National Expenditures for Mental Health Services and Substance Abuse Treatment 2004–2014*, 2008.

[83] National Association of State Mental Health Program Directors Research Institute, *State Mental Health Agency Revenues and Expenditures Report 2006.*
[84] Ibid.

Private Expenditures

Growth in public spending was faster than private spending mainly because of the private sector's ability to implement cost-control measures through managed care models. By incorporating the care-management principles of managed care, private spending grew more slowly than public spending throughout the 1980s and early 1990s. Spending growth began to increase again, however, after the one-time savings from reduced hospitalizations were exhausted and pharmaceutical use increased. In 2003, private expenditures were estimated at about $42 billion.

Private insurance spending for mental health is expected to increase to 26 percent in 2014, up from 24 percent in 2003. Out-of-pocket payments as a proportion of all mental health spending are expected to decline, however, from 14 percent in 2003 to 12 percent in 2014.[85] Out-of-pocket expenses for mental health remain high compared to other health conditions. According to data gathered by the Agency for Healthcare Research and Quality, mental disorders rank among the five most expensive conditions in the United States. For public citizens (non-military and non-incarcerated), out-of-pocket costs for treatment are highest among those five, at 25 percent of total costs.[86]

Where the Money Goes

Spending for mental health is divided among hospitals (both general and specialty), prescription drugs, physicians, and community mental health organizations. Nursing homes, other health professionals, insurance administration, and home health also account for some expenditures, though at much lower levels. Traditionally, hospitalization represented the largest proportion of expenditures. In 1986, hospitalization accounted for 41 percent of spending; in 2003, that had decreased to 28 percent and is expected to further decrease to 22 percent in 2014.[87]

Prescription drug costs have seen substantial growth, representing only 7 percent of mental health spending in 1986 and expecting to reach 30 percent by 2014. Prescription drug cost increases have slowed annually, however, with the increased availability of generic drugs. Mental health prescription drugs also represent more than 10 percent of all health drug costs nationally. While mental health spending is expected to be $203 billion in 2014, prescription drugs will account for 30 percent of that, hospitals for 22 percent, and physicians for 16 percent.[88]

STATE EXPENDITURES

State governments have historically recognized the responsibility for providing mental health services to their residents. In Michigan, this responsibility is dictated through the state constitution. State governments also have been vital in developing the system by which society provides services to the mentally ill. Most states provide treatment and support services for the mentally ill, substance abusers, and the developmentally disabled.

[85] National Association of State Mental Health Program Directors Research Institute, *State Mental Health Agency Revenues and Expenditures Report 2006.*
[86] Soni, *The Five Most Costly Conditions.*
[87] DHHS, *Projections of National Expenditures.*
[88] Ibid.

Because all states offer different types of programs, estimating the total expenditure can be difficult.

State funding, both Medicaid and other state sources, accounts for the majority of mental health spending. In 2006, the Association of State Mental Health Program Directors estimated that state expenditures for mental health totaled almost $31 billion. This represents more than 2 percent of all state government expenditures.[89] Spending in 2006 represented an increase of almost 35 percent from 2001. The bulk of that increase is attributed to a sharp uptick in Medicaid mental health spending, which increased by 60 percent from 2001.[90]

State Medicaid spending in 2006 represented 44 percent of all state mental health spending. Medicaid paid more than $13 billion nationwide for mental health services. States also strive to provide a safety net for persons who do not qualify for Medicaid. In 2006, general fund spending from all states for mental health services outpaced Medicaid spending by just over $500 million.[91] This was not true in Michigan.

The average total amount spent in 2006 by each state for mental health services, excluding federal Medicaid match dollars, was around $600 million. The average spent per capita in 2006 was $106. Michigan spent $1 billion dollars to provide mental health services, which accounted for 2.4 percent of total government spending (see Exhibit 14). This is $100 per capita. Compared to surrounding states, Michigan was second in the amount of state funding for mental health services in 2006. Illinois spent almost $1.1 billion in 2006 (2.4 percent of total government spending), but spent only $83 per capita. Ohio spent $781 million, or 1.5 percent of total government spending, with a per capita spending rate of $68. Wisconsin allocated $600 million for mental health services, which represented 1.8 percent of total spending, but averaged a per capita rate of $108. Indiana spent $556 million for mental health services, which accounted for 2.5 percent of its total budget, and represented $88 per capita.

Since 2006, however, all of these states have seen a severe decline in economic growth and have been facing extremely difficult state budget situations. All programs funded by state dollars continue to be at risk while states struggle through economic recovery.

[89] National Association of State Mental Health Program Directors Research Institute, *State Mental Health Agency Revenues and Expenditures Report 2006.*
[90] Ibid.
[91] Ibid.

EXHIBIT 14

State Per Capita Spending, State Mental Health Agency (SMHA) Mental Health Expenditures and Total State Government Expenditures, FY 2006 (in millions)

State	Total SMHA expenditure	SMHA as % of state total	SMHA expenditure per capita	Rank	Total state government expenditure	State gov't per capita	Rank	Notes
Illinois	$1,052.4	2.4%	$82.59	29	$43,422	$3,407.76	46	
Indiana	$556.0	2.5%	$88.27	27	$21,831	$3,465.69	41	
Michigan	**$1,010.0**	**2.4%**	**$100.03**	**23**	**$41,728**	**$4,132.71**	**35**	*
Ohio	$781.3	1.5%	$68.22	36	$53,448	$4,666.62	27	
Wisconsin	$600.4	1.8%	$107.81	19	$33,481	$6,011.35	12	

SOURCE: : National Association of State Mental Health Program Directors Research Institute, *State Mental Health Agency Revenues and Expenditures Report 2006.*
* = SMHA-Controlled Expenditures include funds for mental health services in jails or prisons, substance abuse, and services for the developmentally disabled.

MICHIGAN

Mental health services in Michigan are financed through MDCH appropriations, which undergo annual legislative approval. Mental health funding comes primarily from the following two lines in that budget: Medicaid mental health services and community mental health (CMH) non-Medicaid (general fund/general purpose dollars). Other items that fund mental health services include CMH purchase of state services, CMH multicultural services, the federal mental health block grant, and CMH respite services.

In FY 2008–09, about $2.2 billion was appropriated for mental health services (see Exhibit 15). This represented an increase of almost 23 percent from FY 2001–02.[92] While this appears to be a significant funding increase, the bulk of the funds are due to increased Medicaid funding and the addition of quality assurance assessment program (QAAP) revenues, which are redirected back for service provision. The increase in Medicaid revenues does not represent a renewed commitment from the state to mental health service provision either. Throughout the decade, Michigan's economy continued to decline, which resulted in an increase to the federal match dollars provided for the Medicaid program. Therefore, the state portion of the Medicaid increases was relatively small compared to the federal portion. Non-Medicaid CMH funding has remained relatively stable, going from $311 million in FY 2001–02 to $322 million authorized by the legislature in FY 2008–09.[93] With unemployment skyrocketing in the state, thousands of people were losing private health insurance, which may have covered mental health services. So, while this line received modest increases, the number of people those dollars were meant to serve no doubt outpaced the capacity of growth in funding. Additionally, an executive order issued in May 2009 reduced non-Medicaid CMH funding by $10 million. This reduction was carried over in FY 2009–10, resulting in a total of $40 million cut from FY 2008–09 non-Medicaid CMH appropriated levels. This line had not been funded at an amount this low since the late 1980s.

[92] Michigan Senate Fiscal Agency, *State Notes: An Overview of Community Mental Health Service.* (Lansing, Mich.: January/February 2009).
[93] Ibid.

EXHIBIT 15
Overview of State Funding, FY 2001–02 to FY 2009–10

	FY 2001–02	FY 2002–03	FY 2003–04	FY 2004–05	FY 2005–6	FY 2006–07	FY 2007–08	FY 2008–09	FY 2009–10*
Community Mental Health (CMH) Expenditures	$1,595,488,900	$1,728,484,600	$1,657,927,000	$1,720,514,500	$1,787,147,500	$1,857,626,500	$1,911,509,700	$2,004,098,300	$2,139,997,300
CMH Medicaid Line	$1,283,810,300	$1,417,965,500	$1,356,892,700	$1,423,785,200	$1,571,653,500	$1,637,945,900	$1,688,542,300	$1,800,075,100	$1,970,775,800
CMH Non-Medicaid Line	$311,678,600	$310,519,100	$301,034,300	$311,952,400	$311,199,000	$318,072,300	$317,961,400	$312,027,700	$287,468,000
CMH QAAP Revenues (1)	NA	NA	NA	$15,223,100	$95,705,000	$98,391,700	$94,994,000	$108,004,500	$118,246,500
Selected "Other" CMH Lines (2)	$188,515,700	$178,205,700	$142,331,900	$176,925,100	$198,445,300	$200,613,100	$200,869,000	$201,653,700	$183,032,100
Total Expenditures	**$1,784,004,600**	**$1,906,690,300**	**$1,800,258,900**	**$1,897,439,600**	**$1,985,592,800**	**$2,058,239,600**	**$2,112,378,700**	**$2,205,752,000**	**$2,323,029,400**
Annual % Change		6.88%	-5.58%	5.40%	4.65%	3.66%	2.63%	4.42%	5.32%
Cumulative % Change									30.21%

SOURCE: Michigan Senate Fiscal Agency.
*Based on the initial appropriations included in PA 131 of 2009.The Medicaid consensus agreement included an increase in the CMH Medicaid line of $9,224,200.
(1) The CMH quality assurance assessment program (QAAP) went into effect in FY 2004–05. The tax on community mental health service programs (CMHSPs) was originally 6% of total revenues, but beginning in FY 2007–08 the tax was reduced to 5.5% to comply with revised federal law, then was replaced with the Use Tax in FY 2008–09.
(2) This includes other lines that fund community mental health services, including the CMHSP Purchase of State Services Contracts line; the Federal Mental Health Block Grant line; and the Respite Services line.

Mental Health Funding Distribution and Mechanisms

Historically, mental health services were funded by the state to pay for care in institutions. However, with the decentralization of service provision from state-run facilities to community programs, funding for those facilities has been systematically transferred to local CMHSPs as facilities closed and residents were transitioned into the community. CMHSPs use the funding they receive to provide services and supports in the community, as well as purchasing services from facilities and community residential services. The most common services provided by CMHSPs are outpatient therapy, physician medication reviews, treatment planning sessions, and treatment in public and private psychiatric and private general hospitals.[94] In FY 2007–08, the most recent year with data available, CMHSPs purchased a total of 234,342 state hospital inpatient days and 31,178 community inpatient days.[95] In FY 2008–09, expenditures of CMHSPs totaled $854 million, with an average statewide per capita cost of $112 and an average per person cost of $5,374.

Medicaid

Medicaid mental health funding is paid through capitation rates to PIHPs. As a result of the Medicaid mental health waiver the state obtained in 1997, which allowed the provision and payment of mental health services through a managed care model, CMHSPs consolidated for the provision of waiver services to establish 18 PIHPs. A stipulation for the waiver made by the Centers for Medicare and Medicaid Services (CMS) was that each Medicaid reimbursable mental health organization serves at least 20,000 clients. Because of the minimum client requirement, larger urban areas may be both a CMHSP and a PIHP. The formation of the PIHPs did not alter service delivery from CMHSPs; it simply altered the payment mechanism through which those agencies were reimbursed. Because Medicaid mental health funding is linked to federal match funding, it has traditionally been "safer" when the budget is cut. In 2003, when the managed care waiver was up for renewal, the federal government required that Medicaid rates be actuarially sound. This means that all managed care Medicaid reimbursement rates receive some sort of increase each year. Medicaid payments to PIHPs for mental health services are determined by caseload estimation. Based on these estimates, the state appropriates enough funding to receive federal Medicaid matching dollars.

[94] PA 131 of 2009, Section 404 report; available online at: *http://www.michigan.gov/mdch/0,1607,7-132-2946_5080-14214--,00.html* (accessed 6/15/10).
[95] PA 131 of 2009, Section 604(1)(a) and (b) report; available online at *http://www.michigan.gov/mdch/0,1607,7-132-2946_5080-14214--,00.html* (accessed 6/15/10).

Non-Medicaid

Non-Medicaid mental health dollars are significantly more vulnerable to reductions because they are funded solely by state general fund/general purpose (GF/GP) dollars, which are spent entirely at the state's discretion. Distribution of these funds has also been traditionally controversial, with no set formula used for allocation. Communities that had state institutions generally receive greater amounts of non-Medicaid CMH funds, because of the need to provide services and supports for facility residents that were moved back into the community. In FY 1996–97, the Citizens Research Council developed a funding factor strategy that weighted the number of all Medicaid eligibles, estimates for the uninsured, and estimates for adults with serious mental disorders in each region. In addition to applying the formula, some funding was redirected to the four lowest funded CMHSPs. Today, non-Medicaid mental health funding is distributed proportionally to previous year funding.

This funding formula was revisited in FY 2009–2010, when the $40-million reduction was incorporated into the budget. Section 462 of PA 131 of 2009 required the MDCH to report to the legislature on the formula that would be used to implement the reductions, including the factors used in the formula. The formula developed by the department incorporated the original factors developed in 1997 and added four additional factors. First, pro-rata reductions were included, so all entities received an equally proportionate reduction. Second, funding to purchase services from state facilities was altered to remove person enrolled in Medicaid. Finally, homelessness and unemployment rates in each region were considered. As a result of this new formula, CMHSPs across the state received reductions ranging from 1.4 percent to 18.1 percent of their total GF/GP allocations. The additional factors were included to protect some of the larger CMHSPs from more severe reductions.

Adult Benefits Waiver

The Adult Benefits Waiver (ABW) has also affected CMHSP funding. The ABW program is another waiver granted by the federal government that allows the state to deliver services to a population not traditionally allowable under Medicaid using Medicaid funding. ABW participants are single adults with no dependents who are extremely poor. In FY 2008–09, $40 million was appropriated for ABW mental health services.

QAAP

Another interesting financing mechanism employed by CMHSPs to maximize federal Medicaid match dollars is the quality assurance assessment program (QAAP). This program creates an assessment for each CMHSP that the state collects and uses as eligible Medicaid match dollars. This, in turn, generates increased federal revenue that can then be redirected to CMHSPs at increased reimbursement rates. The state also retains a share of the assessment to help offset other GF/GP expenses. The QAAP is also utilized by hospitals, nursing homes and, in the past, Medicaid HMOs.

Children with Serious Emotional Disturbance

The home- and community-based waiver for children with serious emotional disturbances (SEDW) is funded by both federal Medicaid match dollars and local CMHSP funds. CMHSPs provide the amount of money required to receive federal match dollars. In FY 2008–09, $570,000 of federal money was appropriated for this waiver program.

Mental Health Funding in the Justice System

Corrections

In Michigan, approximately $100 million was allocated in FY 2008–09 to provide mental health services to those in the state corrections system. The MDCH provided $60 million for the Forensic Center, located in Ann Arbor, which provides treatment for criminal defendants who are either incompetent to stand trial or have been acquitted by reason of insanity. The center may also provide specialized mental health services for transferred prisoners and examination and diagnostic services on an outpatient basis for prisoners not housed in the Forensic Center.

Additionally, the Michigan Department of Corrections (MDOC) provided $40 million to the MDCH to provide mental health services in all other corrections facilities. The Mental Health Code requires the MDOC to operate a mental health program to provide services to the mentally ill. The MDOC contracts with the MDCH to administer the Corrections Mental Health Program (CMHP). The program provides both inpatient services and outpatient clinical operations.

Inpatient services are located at the Huron Valley Complex in Ypsilanti and have two subdivisions: acute care and rehabilitation treatment services. Outpatient clinical operations include residential treatment programs and outpatient mental health program located in corrections facilities throughout the state.

County Jails

Both the corrections code and the Mental Health Code require that inmates in county jails receive mental health services, if necessary. County jails are responsible for performing an initial mental health screening to new inmates to determine if they can be housed with the general population, and within 14 days of the screening must provide a more detailed health appraisal by a trained health professional. The Mental Health Code, which regulates CMHSPs, requires that the appropriate CMHSP provide mental health services to county jail inmates.

Payment for county jail mental health services varies from county to county. Some counties contract with the local CMHSP and the county pays for all services; some counties have partnered with their CMHSP so services are jointly funded by both the county and CMHSP; and some CMHSPs have taken full responsibility for service provision. In May of 2009, however, the Attorney General issued Opinion No. 7231, which stipulates that the county is responsible for paying for all mental health services provided to inmates, and that CMHSPs are responsible for providing the services. However, CMHSPs can attempt to obtain reimbursement for mental health services provided to inmates from a third party, such as a private insurer, before attempting to

obtain payment from the county. The MDCH followed this opinion with a memorandum to CMHSPs to ensure that they have entered into contracts with local counties by October 1, 2010.

Adequately funding mental health services continues to serve as a primary barrier for those seeking treatment, because the level of funds available is used primarily for persons with serious mental illness who are in crisis. While the costs of treatment are not rising as much as other kinds of health care costs, the willingness to fund that treatment has been lacking. Pressing economic factors are placing continued strain on the public sector's ability to fund safety net services.

Future Policy Directions

MENTAL HEALTH COMMISSION RECOMMENDATIONS

In February 2004, Gov. Jennifer Granholm appointed 29 members to a special Mental Health Commission. Citing a mental health system that was "broken," the governor charged commission members with comprehensively reviewing the current system and providing recommendations for improvement. In October 2004, the commission presented the governor with recommendations for improvement in seven key areas of the system. Following is a summary of the progress made toward implementing those recommendations.

Recommendation 1: Improving public awareness through public/private partnerships that advance proven health promotion strategies to address mental health issues.

During FY 2009–10, the MDCH convened a statewide anti stigma steering committee with the goal of providing leadership in the following areas:

- Examining current efforts and activities connected to other parties already engaged in anti-stigma work
- Learning more about efforts and directions in other states and countries
- Gauging the extent of the outcomes achieved.

The first monthly meeting of the committee was in June 2009. The focus of the committee's efforts is on creating a resource guide for CMHSPs to address stigma in their communities. The guide will assist in identifying stigma locally, providing examples of interventions that have proved effective to address stigma, and measuring the effectiveness of those interventions. The steering committee will also include mechanisms to hold CMHSPs accountable for using this tool to combat stigma.

The MDCH has also taken steps to educate the public on suicide prevention, with efforts ranging from promotional activities to holding workshops in communities with the purpose of developing youth suicide prevention plans. The department held its first statewide suicide prevention conference in 2008, and is planning a second statewide conference for the fall of 2010.

Recommendation 2: Clearly defining the mental health system and its consumers and addressing the needs of that population uniformly and as early as possible.

One of the most controversial recommendations the commission made was to reduce the number of CMHSPs and make each organization responsible for both Medicaid and non-Medicaid service provision. Neither the executive nor the legislative branch has made any effort to implement this recommendation.

The MDCH has been instructed by the legislature to conduct a cost-benefit analysis of serving some adults with mental illness through small, secure residential programs, in addition to existing state hospitals. These would be facilities with 16 or fewer beds,

making them eligible for Medicaid reimbursement. While the department issues an annual report as required by appropriations bills, the reports simply outline the barriers to implementing such programs without detailed cost-benefit analysis.

Finally, the MDCH, in conjunction with the Michigan Association of Community Mental Health Boards, has established The Standards Group (TSG), which has been charged with developing a uniform set of statewide standards for screening and assessment. While some standards have been developed and training has been conducted for CMHSPs, nothing has been put in place to require uniform use of these standards. Legislation has been introduced to address the following issues, but no action has been taken on those bills to date.

- Requiring CMHSPs to use MDCH-approved standardized instruments for assessment
- Placing many of the commission's recommendations into the Mental Health Code
- Addressing the need to continue service to priority consumers ready to step-down to less intensive care that remains necessary for recovery

Recommendation 3: Ensuring that a full array of high-quality mental health treatment, services, and supports is accessible.

As of October 1, 2009, family psychoeducation and integrated treatment for persons with dual mental health and substance abuse disorders are required evidence-based practices that providers must offer. Additionally, Assertive Community Treatment (ACT) has also become widely used across the state. Two evidence-based practices for children include PMT—Parent Management Training—Oregon Model (PMTO) and trauma-focused cognitive behavior therapy. Currently, efforts are focused on the sustainability and fidelity to the model of the practices being implemented.

Recommendation 4: Diverting people with mental illness out of the juvenile and criminal justice system.

The executive and legislative branches, along with CMHSPs, have actively implemented a number of programs and strategies to facilitate diversion. Funding to pilot mental health courts in nine communities was included in the FY 2008–09 budget. In FY 2009–10, this funding was continued using federal grant funds instead of state general fund dollars. Medicaid status for incarcerated individuals is now suspended, instead of terminated, so that those individuals are eligible for treatment immediately upon release, which facilitates continuity in treatment. The Michigan Prisoner Re-entry Initiative continues to grow and works to facilitate prisoner transition into the community.

Recommendation 5: Funding of and structure of the mental health system is adequate to maintain high-quality care delivery.

Funding for mental health services, particularly services not supported by Medicaid funds, remains inadequate. No improvement has been made on this recommendation. Regardless of funding, however, the MDCH continues to work with local providers to maintain quality standards through TSG and through standards developed by the Quality Improvement Council.

Addressing the need to protect recipient rights, legislation was enacted in 2006 that requires the state-level recipient rights office report directly to the director of the MDCH. While this enhances the accountability of recipient rights programs, more work needs to be done at the local level to provide education, training, and assistance in rights protection processes to consumers and family members.

Recommendation 6: Integrating mental and physical health care and housing, education, and employment services.

A mental health advisory committee, comprised of medical directors from PIHPs and Medicaid health plans, meets to improve the coordination of mental and physical health care. Collaborative models for electronic medical record sharing and clearly defining identified responsibilities for primary and mental health care of recipients have emerged from these meetings. Additionally, ten CMHSPs received federal Mental Health Block Grant funds in FY 2008–09 to implement models for integrating mental health services with primary care in service areas.

The MDCH also works with the Michigan State Housing Development Authority (MSHDA) to promote housing programs to meet the needs of the homeless population, many of whom are homeless because of the inability to manage their mental illness. Significant progress on service integration in other areas such as education and employment services has not been made.

Recommendation 7: Actively involving consumers and their families in service planning, delivery, and monitoring at all levels of the mental health system.

The public mental health system in Michigan was designed to work based on the input and participation of its consumers. The MDCH and local programs take advantage of this participation through a number of programs, including peer specialists, consumer-run drop-in centers, anti-stigma committees, and person-centered planning processes. In 2004, legislation was enacted to legally recognize psychiatric advanced directives. The legislation was developed with input from mental health consumers and a number of trainings have been conducted around the state to educate people on the process of developing an advanced directive.

The Mental Health Commission recommendations continue to serve as a blueprint for planning in the mental health system. Four years after the recommendations were brought forth, much work is still needed to accomplish their goals.

FEDERAL HEALTH CARE REFORM

The Impact of Health Care Reform on Individuals with Mental Illness

Prior to the signing of the Patient Protection and Affordable Care Act (PPACA) in March 2010, a large number of people with serious mental illness were unable to afford health insurance for two main reasons: they did not receive health benefits from an employer or they did not qualify for Medicaid. The PPACA will give those with serious mental illness access to mental health services either by (a) requiring most individuals to purchase health insurance and qualifying a significant subset of these people for tax subsidies to

purchase their own health insurance through the state's health insurance exchange, or (b) qualifying individuals for Medicaid through the expanded eligibility requirements.

The new Medicaid eligibility requirements will include individuals in families with incomes up to 133 percent of the federal poverty level without a second eligibility requirement (such as disability). This opens the door to Medicaid for many low-income adults with serious mental illness who do not have children and do not receive disability benefits (Supplemental Security Income, or SSI). The law also expands Medicaid coverage for foster children up to age 26, thereby filling a gap for young adults who otherwise would not be eligible for Medicaid or may not be able to afford individual insurance. In addition to the expansion of Medicaid eligibility, the enrollment process may be simplified, which would reduce some of the barriers that prevent individuals with serious mental illness from applying for and receiving benefits.

Still under question is exactly what mental health services (for example, outpatient services, hospitalization, drug coverage) will be covered in both the Medicaid and the private health insurance exchanges, and the frequency of those services (e.g., 20 or 30 visits per year). Medicaid will be required to offer a "benchmark plan"—a plan in which the most basic of services (physical and mental) will be decided upon by each state. In contrast, the private insurers in the health insurance exchanges[96] will be required to offer an "essential benefit plan," which will offer different benefits at different levels of coverage (for example, bronze, silver, and gold).

Other aspects of the law that affect individuals with serious mental illness include the following provisions:

- Improvements in home- and community-based services for Medicaid recipients by expanding eligibility for and the range of services provided under the adult benefit waivers; removing the cap on the number of individuals whom states can serve under the waivers; allowing states to target these services to individuals with mental illness; and expanding Medicaid benefits to those who are currently receiving home- and community-based services.
- As of January 2014, expanded Medicaid prescription drug coverage will include medications used in mental health treatment (such as smoking cessation medications, barbiturates, benzodiazepines) that were not previously supported by the federal Medicaid match.
- Improvements to services for dual Medicare and Medicaid enrollees include providing beneficiaries with multiple co-morbidities better coordinated care through a pilot program, and decreasing the prescription drug benefit "doughnut hole" by raising the current 50 percent discount on brand-name medications to 100 percent coverage on brand-name medications by 2019.
- Improvements in the quality of Medicaid services provided in community mental health are possible under the Medicaid Quality Measures and Improvements provision of the law. The Department of Health and Human Services is now required

[96] A health insurance exchange will be organized by the state (or non-profit as designated by the state) as a "one-stop shop" for consumers and small businesses to compare a variety of private insurance carriers for cost and coverage of health care.

to recommend evidence-based health quality measures for adult Medicaid beneficiaries (similar to existing requirements for children receiving Medicaid).

- Within the health and wellness provisions of the law, Medicaid beneficiaries will be offered incentives (specific incentives are yet to be determined) to implement healthier lifestyles. Treatment of depression is included within the list of co-morbid conditions that will be targeted for prevention and treatment by the Department of Health and Human Services as it develops various initiatives supported by the new law.

The Impact of Health Care Reform on Mental Health Services

There are a number of ways in which the law promotes innovative methods for treating individuals with mental illness by incorporating mental health treatment in models for collaborative care. For example, the patient-centered medical home model provides consumers with care coordination and disease management under the supervision of health professional teams. Community health centers are eligible to qualify for designation as a medical home to provide comprehensive care to individuals with serious mental illness, which includes primary and specialty care. Another model recommends the co-location of primary care providers and behavioral health providers to offer easier access to mental health services for individuals with co-occurring disorders (such as diabetes and depression).

The PPACA also includes a maternal and child health early childhood home visitation program that will expand the implementation of needs assessments to determine at-risk communities and evaluate the capacity of these communities to provide appropriate services to improve maternal and child health outcomes. The Bazelon Center for Mental Health Law reports that "home visiting programs have demonstrated positive results by lessening the effects of maternal depression and child maltreatment, by improving mother-infant relationships and by increasing infant scores on cognitive tests and measures of social functioning."[97] In addition to the home visitation program, the law provides funds for research and provision of services to address postpartum depression. The research will include a nationwide longitudinal study of the consequences of postpartum conditions.

The law also authorizes[98] additional funding for mental and behavioral health workforce training, including educational grants for social work, interdisciplinary training, child/adolescent mental health, and paraprofessional training, as well as loan repayment for practitioners who go into a pediatric specialty. Funding has also been authorized to (1) train mental and behavioral health specialists in emergency care during public

[97] Judge David L Bazelon Center for Mental Health Law, *Medicaid Reforms in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act* (Washington, D.C.: May 4, 2010).

[98] The PPACA law authorizes funding for a number of opportunities to build workforce capacity, although it does not currently appropriate money at this time.

disasters, and (2) train practitioners on the new care models, as described above, to provide patients with coordinated care.[99]

While the expansion of service coverage through federal reform is promising, it may have some unintended, negative consequences for consumers. First, some areas of the state already have a shortage of mental health professionals to provide services. Expanding the number of people who will be able to obtain those services may place additional hardship on already strained providers, thereby limiting access. The areas currently experiencing shortfalls in professionals are southeast Michigan and rural areas in Northern Michigan.

Although the provisions in the new health reform law are promising for consumers and practitioners alike, the Bazelon Center for Mental Health Law encourages advocates to continue working toward greater mental health parity by becoming involved with the design of the health insurance exchange benefit packages and Medicaid benchmark plans, as well as revisions to the state option home- and community-based services, in order to expand the range of services available to those with mental illness. The Bazelon Center also encourages advocates to urge the state to cover all individuals with incomes under 133 percent of the federal poverty level immediately, while waiting for the federal match to begin in January 2014.[100] The ability of all states to adopt these service coverage expansions may be difficult, however. Many states are already experiencing economic hardships and funding programs under the current rules has been challenging, at best. Asking states to find additional funds for expanded services under reform could result in actions that would further limit access to the safety net, such as reducing reimbursements to providers who, at the same time, are being asked to provide services to more people.

PRIVATE INSURANCE PARITY

One of the most pressing problems facing the nation today is the uninsured. The newly enacted PPACA of 2010 attempts to resolve many of the barriers people have to access health insurance coverage. The U.S. Census Bureau reported in 2007 that the number of Americans without health insurance was 47 million, 15.8 percent of the population. This represented a four-percent increase over the number of uninsured reported in 2005.[101] This is not surprising given that the unemployment rate was increasing and many people were losing employer-sponsored health insurance along with their jobs. Between May 2007 and July 2009, the percentage of the nonelderly population with employer-based insurance fell from 61.3 percent to 58.2 percent.[102] Along with people losing their jobs, many employers opted to reduce health care coverage in order to keep workers.

Michigan residents have felt the pain brought by the economic decline. Since 1999, more than 727,000 residents have lost private insurance coverage that had been provided by an

[99] National Conference of State Legislators, *Summary of the Health Workforce Provisions in the Patient Protection and Affordable Care Act HR 3590* (Washington, D.C., March 2010); available online at: *http://www.ncsl.org/documents/health/HlthWrkfrceProvHR3590.pdf* (accessed 6/18/10).
[100] Bazelon Center for Mental Health Law, *Medicaid Reforms.*
[101] Teddi Dineley Johnson, "Census Bureau: Number of U.S. Uninsured Rises to 47 Million," *The Nation's Health* 37, no. 8 (2007).
[102] Paul Fronstein, *Issue Brief: The Impact of the Recession on Employment-Based Health Coverage No. 342* (Washington, D.C.: Employee Benefit Research Institute, May 2010).

employer.[103] The number of Michigan residents without insurance is estimated at 1.2 million people. Not surprisingly, this has resulted in a drastic increase in the number of Medicaid beneficiaries in the state. In 2001, 1.2 million people received Medicaid benefits; today, 1.7 million Michigan residents are enrolled in Medicaid.

While it is important to understand the landscape of who is paying for health care benefits in Michigan, the effect on the mentally ill is difficult to ascertain. Though the majority of people with mental illness obtain services paid by the public sector, many people can only access services through private insurance. Traditionally, private insurers have not been willing to cover mental health services as comprehensively as medical/surgical benefits. In 2003, 77 percent of employees were subject to limits on inpatient mental health care, and 74 percent were limited on outpatient mental health care.[104] The imposition of limits on both inpatient and outpatient care days increased between 1988 and 1997, from 38 percent to 57 percent of inpatient benefits and 26 to 48 percent of outpatient benefits. The Hay Group estimated that these limits decreased the value of the behavioral health portion of plans from 6.1 percent to 3.1 percent of the total health benefit.[105]

Additionally, a number of private insurers have opted not to cover mental health services at all. The Household Survey on Drug Abuse reported that among people who had private health insurance, only 59 percent indicated that their plan included mental health benefits. Furthermore, 32 percent reported not knowing if mental health services were covered in their plans.[106]

Equality in insurance coverage between medical/surgical services and mental health services is commonly called parity. The federal government enacted the Mental Health Parity Act (MHPA) of 1996 to address the chasm between mental health coverage and medical/surgical coverage. It requires insurers to provide the same level of benefit, including visit limits, deductibles, copays, and lifetime and annual limits. This law applies to employment-based group health plans, including private-sector self-insured plans that are not subject to state regulations. The federal parity law was permanently enacted in 2008. This appears to be a victory for advocates of mental health coverage equality. Unfortunately, MHPA has limits that prevent true parity. The law does not apply to companies with 50 or fewer employees that offer no mental health benefits; it exempts disability plans that provide benefits to people who are disabled because of mental illness; it allows insurers to apply for an exemption if they experience more than a 1 percent increase in premiums as a result of parity; and it does not apply to individual, or nongroup, insurance plans.[107] This means that state-regulated small group plans and individual insurance policies are not held to the same standard as large group plans. Additionally, it does not require these large plans to offer mental health benefits; it

[103] *Medical News Today*, "EO Medicaid Cuts Would Harm People," May 5, 2009; available online at: *http://www.medicalnewstoday.com/printerfriendlynews.php?newsid=148742* (accessed 6/18/10).
[104] Employee Benefits Research Institute, *Fundamentals of Employee Benefits* (Washington, D.C.: Employee Benefits research Institute, 2009).
[105] Ibid.
[106] L. Wu and W. Schlenger, "Private Health Insurance Coverage for Substance Abuse and Mental Health Services, 1995 to 1998," *Psychiatric Services* 55, no. 2 (February 2004):180–182.
[107] Employee Benefits Research Institute, *Fundamentals of Employee Benefits*.

merely requires the benefit be equal to other health coverage benefits should they choose to offer them. With passage of the PPACA, determining how parity will be affected is difficult. It may become unnecessary to adopt parity laws if mental health services and coverage levels are mandated through federal and state regulations.

A number of states have recognized the inequity between mental health and medical coverage and enacted parity laws of their own. Currently, 29 states have full parity laws in effect, and all but 7 have some sort of parity requirement, though many exceptions may be available. Michigan has no parity law, and the issue has been hotly contested recently. Many private companies argue that mandating parity would result in increased premiums for everyone. An actuarial analysis by PricewaterhouseCoopers suggests that premium increases would be minimal, at less than 1 percent.[108] Other states that have implemented parity report little to no effect on current premiums: Maine implemented parity laws in 1996 and reported less than 1 percent increases to premiums; Vermont's 1998 implementation reported no effect on rates; and Pennsylvania instituted parity in 1998 and in 2001 reported a 0.43 percent premium increase.[109]

CORRECTIONS

Early Treatment: Involuntary Treatment

The thesis of many mental health advocates is that a good deal of crime could be prevented if more persons suffering from mental illness had access to timely treatment. In part this is because, under the laws of Michigan and other states, the rules governing involuntary treatment are different for persons with mental illness than they are for persons with other illnesses. One of the more penetrating analyses of the problem has been provided by Judge Milton Mack, a widely respected probate judge in Wayne County and a member of the Mental Health Commission. Mack observes:

> Our jails and prisons are filled with people whose only real crime was their inability to get timely treatment for their mental illnesses. If timely treatment was provided, many of these individuals would have been able to avoid the conduct that led to their incarceration and any damage or injury they caused. With every passing day, the magnitude of this travesty continues to grow. Yet, this tragic outcome could be avoided if mental illnesses were treated like all other types of illnesses. For all other illnesses, if the individual does not have the capacity to make an informed decision about treating his or her illness, a third party can be given the power to consent to timely treatment. However, this is not the case for mental illnesses. In Michigan, like in most states, the current Mental Health Code will not permit involuntary treatment for mental illnesses, even if the individual lacks the capacity to make an informed decision about treatment of his or her illness, unless that person is also a danger to self or others.[110]

[108] Judy Kovach, "The Impact of Inadequate Mental Health Care in Michigan," presentation, Council of State Governments: Michigan Policy Summit on the Emerging Trends in Mental Health, Lansing, Mich., June 2008.
[109] Ibid.
[110] Hon. Milton L. Mack, Jr. "Involuntary Treatment for the Twenty-first Century," *Quinnipiac Probate Law Journal* 21, nos. 3&4 (June 2008): 294.

Mack sees the current law as an anachronism—a holdover from a time when "involuntary treatment" for mental illness was synonymous with "involuntary commitment" to a mental health institution. Mack's view is that in an age when the treatment of mental illness is predominantly done on an outpatient basis, such extraordinary protections need not apply. As he put it, "the current Mental Health Code is an inpatient model in an outpatient world."[111]

Mack's recommendations, which have been endorsed by the Michigan Probate Judges Association, are as follows:

- The statutory criteria for involuntary treatment should be changed to apply to "[a]n individual who has mental illness and lacks sufficient understanding or capacity to make or communicate informed decisions concerning his or her mental illness."
- The legislature should give courts the authority to appoint a guardian who is statutorily authorized to consent to the involuntary treatment of the incapacitated individual.
- Michigan's Mental Health Code should be amended to statutorily require that the court order for involuntary treatment be 180 days.

Mack further suggests that the code be amended to require that treatment be directed by an independent psychiatrist who would oversee coordination of outpatient/inpatient care.

In April 2010, Rep. Ellen Cogen Lipton introduced House Bill 6046, a proposed amendment to the Mental Health Code. The most important provision of Representative Lipton's bill is its revision of the definition of a "person requiring treatment" to include persons whose

> . . . .judgment is so impaired that he or she is unable to understand his or her need for treatment and whose continued behavior as the result of mental illness can reasonably be expected, on the basis of competent clinical opinion, to result in harm to himself, herself, or others.[112]

The existing definition was more restrictive, defining a person who required treatment as someone who might reasonably be expected to do serious *physical* harm to himself or others.

Sen. Alan Cropsey introduced Senate Bill 1305, which amends the same section of the Mental Health Code as does HB 6046. Senator Cropsey's bill defines a "person requiring treatment" as anyone who is deemed to need treatment on the "basis of competent clinical opinion." SB 1305 does not define "competent clinical opinion," nor does it identify factors that must be considered in requiring that a person requires treatment

House Bill 6046 has been referred to the House Committee on Health Policy. Senate Bill 1305 has been referred to the Committee on Judiciary. To date, no legislation has been offered that would deal with court-appointed guardians or a maximum time for involuntary commitment.

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[111] Mack, Involuntary Treatment, 295.

[112] Text of House Bill No. 6046, available online at: *http://www.legislature.mi.gov/documents/2009-2010/billintroduced/House/htm/2010-HIB-6046.htm* (accessed 6/23/10).

Diversion: Mental Health Courts

The most desirable outcome is to treat mentally ill persons before they commit crimes. When that is not possible, the diversion to the mental health system of persons who have committed less serious offenses is still a valid policy goal. In theory, diversion may occur at any time in the criminal justice process up to the time of sentencing. Yet, as the authors of a recent report on improving prisoner mental health note, pre-arraignment diversions present certain practical problems:

> For relatively minor offenses, police officers can refer offenders immediately to treatment, but this presupposes that (1) the police officer has had training in identifying persons with mental illness; (2) there are alternative resources available; (3) access to resources is reasonably convenient not only for the offender, but also for the police officer; (4) the clinical presentation overcomes legal barriers to compulsory treatment; and (5) the responsible mental health clinicians are willing and able to assume responsibility for care of the offender.[113]

Rather than relying on the judgment of individual officers, a better approach may be the creation of "mental health courts." The establishment of these new courts—modeled after the successful drug courts—was an action explicitly recommended in the Mental Health Commission report. Drug courts treat minor drug offenses as substance abuse problems, not criminal problems. Mental health courts are based upon the premise that some "crimes" are expressions of mental illness. Diversion in mental health courts is "post arraignment" and requires the cooperation of both the legal and the mental health delivery systems.

As of May 2010 there were a total of nine pilot adult mental health courts in Michigan. There are no mental health courts for juvenile offenders at this time. The mental health courts are administered by the State Court Administrative Office (SCAO), with mental health services being provided through the MDCH and local CMHSPs. The pilot programs are funded by federal funds provided through the American Recovery and Reinvestment Act (ARRA) and a grant program administered through the Michigan State Police. Mental health courts are currently operating in the following counties:

- Wayne County (3rd Circuit Court)
- Oakland County (6th Circuit Court)
- Jackson County (4th Circuit Court and 12th District Court)
- Genesee County Probate Court
- Berrien County Trial Court
- Grand Traverse (86th District Court)
- Livingston County (53rd District Court)
- St. Clair County (72nd District Court)
- Otsego County (24th Circuit Court & 87A District Court)

[113] MDOC and MDCH, A Blueprint for Transforming Prisoner Mental Health Care, pp. 19–20. This report contains the findings and recommendations of an interagency work group on mental health care that included representatives of the Michigan Department of Community Health and the Michigan Department of Corrections with assistance from the Michigan Public Health Institute.

In FY 2008–09, the SCAO and the MDCH received funds to establish mental health courts, with the SCAO appropriating $550,000 and the MDCH appropriating $1,200,000 from the general fund.[114] Between 2009 and the end of the grant period in 2012, the total expenditures will be $1.65 million and $3.4 million, respectively.[115] In FY 2009–10, the general fund dollars were replaced with federal Byrne grant funds.

Data from the SCAO show that during FY 2008–09, 247 individuals were referred to mental health court programs statewide, with 67 not admitted. In more than 50 percent of cases, individuals were not admitted because they were not part of the target population or because they refused to participate. Of the 180 persons accepted, 102 (56.7 percent) were referred by the court or judicial system. Key facts concerning the 180 participants include:

- One hundred forty-two of the 180 participants (78.8 percent) suffered from schizophrenia, bipolar disorder, and depression. Eighty-seven of these (61.3 percent) were from three counties: Genesee, Wayne, and St. Clair.
- One hundred fourteen participants (63 percent) were Caucasian; an additional 60 participants (33 percent) were African American.
- Eighty-nine participants (49.4 percent) had an 11th grade education or less; an additional 48 participants (26.7 percent) had a high school education but nothing beyond.
- One hundred forty-four participants (80 percent) were unemployed, and another 24 participants (13.3 percent) were not in the labor force. Only 3 participants (1.7 percent) were employed full time.[116]

While mental health advocates and state policy makers are hopeful that mental health courts will improve treatment, and decrease both crime and costs, these programs are still in their infancy. At this point only process evaluation data are available. A full evaluation of the effectiveness of these programs is planned but has yet to be done.

[114] *Michigan Mental Health Court Grant Program Process Evaluation: October 1, 2008–September 30, 2009*, prepared by the State Court Administrative Office (undated).
[115] The Michigan State Police as forwarded to the Michigan Senate Fiscal Agency in an e-mail dated May 6, 2010 (on file). In FY 2009–2010, the MDCH received funding for all nine courts. The SCAO received funding for all courts but the one in Otsego County.
[116] *Michigan Mental Health Court Grant Program Process Evaluation.* Data summarized from several exhibits.

Conclusion

The mental health system in Michigan has undergone significant transformation since the middle of the last century. Conscious efforts have been made to move persons with mental illness out of institutions back to the community, while trying to develop and maintain programs and services to support them. Changes in treatment, including the evolution of anti-psychotic medications, have facilitated a greater level of success for people to manage illness in community settings. However, efforts toward prevention and early intervention are almost non-existent, which means that people receive treatment only when their illnesses have progressed to a debilitating level.

In the past ten years, dramatic changes to payment and insurance mechanisms have helped to slow spending growth in mental health treatment. Unfortunately, the savings from those techniques are no longer sustainable, and with an economy undergoing severe decline, funding for programs and services is in jeopardy. With the implementation of federal health care reform, changes to that funding may be positive, with a greater number of people benefitting from insurance, both public and private.

Challenges in the field remain. Continuing to battle the stigma associated with mental illness is essential to expanding programs and services, as well as placing more emphasis on prevention and early intervention, especially for children. The criminal justice system is rife with persons whose mental illnesses have gone untreated, and the people in that system receive less than adequate support upon re-entry to society. Finally, the disjointed system of programs and services does not guarantee uniform programs and services across the state. Efforts must be continued to create a uniform system of quality prevention and treatment programs that have sufficient funding mechanisms in order to further improve the quality of life for persons with mental illness.

Appendix 1
Private Hospitals by County

Partial hospitalization programs are programs where patients participate in day long sessions in a hospital setting but return home at night. These are indicated in italics.

County	Facility	Number of beds	
		Adult	Minor
Alpena	Alpena General Hospital	15	0
Bay	Bay Regional Medical Center	28	0
Berrien	Lakeland Hospital, St. Joseph	26	0
Branch	Community Health enter of Branch County	15	0
Calhoun	Battle Creek Health System – Fieldstone Center	39	0
	Oaklawn Hospital	17	0
	Oaklawn Bear Creek Campus Partial Hospitalization	*20*	*0*
Chippewa	Chippewa County War Memorial Hospital	20	0
Emmett	Northern Michigan Hospital	14	0
Genesee	Hurley Medical Center	60	0
	Regional Behavioral Center PHP	*40*	*0*
	McLaren Regional Medical Center	36	0
Grand Traverse	Munson Medical Center	14	0
	Partial Hospitalization Program – Munson Hospital	*15*	*0*
Gratiot	Gratiot Medical Center	12	0
	Partial Hospitalization Program – Gratiot Medical Center	*15*	*0*
Hillsdale	Hillsdale Community Health Center	10	0
Ingham	Ingham Regional Medical Center – Pennsylvania Campus	26	0
	Adult Treatment Center and Partial Hospitalization Program	*20*	*0*
	Edward W. Sparrow Hospital Association – St. Lawrence Campus	59	0
Jackson	Allegiance Health	40	0
	Adult Day Treatment Program	*15*	*0*
Kalamazoo	Borgess Medical Center	44	6
	Adolescent PHP –Borgess Medical Center	*0*	*20*
Kent	Forest View Psychiatric Hospital	40	22
	Forest View Psychiatric Hospital PHP	*20*	*10*
	Pine Rest Christian Mental Health Services	20	36
	Child & Adolescent PHP	*30*	*40*
	Saint Mary's Health Care – Psychiatric Medical Unit	20	0
	Saint Mary's Health Care Partial Program	*30*	*0*
	Saint Mary's Health Care – Mulder West/Van Andel Adult Units	94	0
Lapeer	Lapeer Regional Medical Center	20	0
Lenawee	Herrick Memorial Hospital	10	0

County	Facility	Number of beds	
		Adult	Minor
Macomb	Behavioral Center of Michigan	42	0
	Behavioral Health Center of Michigan	*30*	*0*
	Harbor Oaks Hospital	31	16
	Harbor Oaks Hospital PHP	*14*	*15*
	Henry Ford Macomb Hospital	85	0
	Henry Ford Macomb Hospital PHP	*30*	*0*
	New Oakland Child-Adolescent & Family Center	*10*	*25*
	St. John Macomb – Oakland Hospital – Macomb Center	28	0
	St. John Macomb – Oakland Hospital – Macomb Center PHP	*56*	*0*
Marquette	Marquette General Hospital	37	6
Mason	Memorial Medical Center of West Michigan	14	0
Midland	Mid Michigan Medical Center – Midland (	20	0
Monroe	Mercy Memorial Hospital System	21	0
Montcalm	Carson City Hospital	16	0
Muskegon	Mercy Health Partners – Hackley Campus	27	0
	Psychiatric Partial Hospital Program	*17*	*0*
Oakland	Beaumont Hospital	30	0
	Psychiatric Partial Hospital Program	*20*	*0*
	Botsford General Hospital	25	0
	Crittenton Hospital Medical Center	20	0
	Havenwyck Hospital	65	55
	Havenwyck Day Hospital	*24*	*24*
	Henry Ford Kingswood Hospital	70	30
	Kingswood Hospital PHP	*30*	*20*
	Harper Hutzel Hospital dba Madison Behavioral Health Services	31	0
	Oakland Physicians Medical Center LLC dba Doctor's Hospital of Michigan	30	0
	New Oakland Child-Adolescent & Family Center	*11*	*38*
	POH Medical Center	20	0
	Providence Hospital & Medical Center	25	0
	Providence Hospital Psychiatric – PHP	*32*	*0*
	St. John Macomb – Oakland Hospital – Oakland Center	26	0
	St. John Macomb – Oakland Hospital – Oakland Center PHP	*30*	*0*
	St. Joseph Mercy – Oakland	33	0
	St. Joseph Mercy Hospital – Oakland	*30*	*0*
Ottawa	Holland Community Hospital	16	0
Saginaw	HealthSource Saginaw	47	14
Shiawassee	Memorial Healthcare	16	0
St. Clair	Port Huron Hospital	23	0
Van Buren	Bronson Lake View Hospital	23	0

County	Facility	Number of beds	
		Adult	Minor
Washtenaw	Chelsea Community Hospital	30	0
	Chelsea Community Hospital PHP	*28*	*0*
	St. Joseph Mercy Hospital	24	0
	Adolescent & Adult Psychiatric PHP	*30*	*15*
	University of Michigan Health System	33	32
Wayne	BCA Stonecrest Center	25	16
	Detroit Receiving Hospital	25	0
	Henry Ford Cottage Hospital PHP	*20*	*0*
	Henry Ford Wyandotte Hospital	56	0
	New Oakland Child-Adolescent & Family Center	*18*	*0*
	Oakwood Heritage Hospital	70	0
	Oakwood Hospital Heritage Center – PHP	*45*	*0*
	Sinai Grace Hospital	927	0
	St. John Hospital and Medical Center	35	0
	St. Mary Mercy Hospital	31	0

Appendix 2

Medicaid Health Plans and Pre-Paid Inpatient Health Plans by County

County	Prepaid Inpatient Health Plan	Affiliated with the PIHP
Alcona	Northern Affiliation	Northeast CMH
Alger	NorthCare	Pathways CMH
Allegan	Southwest MI Urban & Rural Cons	Allegan CMH
Alpena	Northern Affiliation	Northeast CMH
Antrim	Northern Affiliation	North Country CMH
Arenac	Access Alliance of MI	Bay-Arenac CMH
Baraga	NorthCare	Copper Country CMH
Barry	Venture Behavioral Health	Barry CMH
Bay	Access Alliance of MI	Bay-Arenac CMH
Benzie	CMH Affiliation of Mid-MI	Manistee-Benzie CMH
Berrien	Venture Behavioral Health	Riverwood Center
Branch	Venture Behavioral Health	Pines Behavioral Health Services
Calhoun	Venture Behavioral Health	Summit Pointe CMH
Cass	Southwest MI Urban & Rural Cons	Woodlands CMH
Charlevoix	Northern Affiliation	North Country CMH
Cheboygan	Northern Affiliation	North Country CMH
Chippewa	NorthCare	Hiawatha CMH
Clare	CMH Central MI	CMH for Central MI
Clinton	CMH Affiliation of Mid-MI	CEI CMH
Crawford	Northwest CMH Affiliation	Northern Lakes CMH
Delta	NorthCare	Pathways CMH
Dickinson	NorthCare	Northpointe CMH
Eaton	CMH Affiliation of Mid-MI	CEI CMH
Emmet	Northern Affiliation	North Country CMH
Genesee	Genesee County CMH Services	Genesee County CMH Services
Gladwin	CMH Central MI	CMH for Central MI
Gogebic	NorthCare	Gogebic CMH
Gr. Traverse	Northwest CMH Affiliation	Northern Lakes CMH
Gratiot	CMH Affiliation of Mid-MI	Gratiot CMH
Hillsdale	Lifeways	Lifeways CMH
Houghton	NorthCare	Copper Country CMH
Huron	Access Alliance of MI	Huron CMH
Ingham	CMH Affiliation of Mid-MI	CEI CMH
Ionia	CMH Affiliation of Mid-MI	Ionia CMH
Iosco	Northern Affiliation	AuSable CMH
Iron	NorthCare	Northpointe CMH

County	Prepaid Inpatient Health Plan	Affiliated with the PIHP
Isabella	CMH Central MI	CMH for Central MI
Jackson	Lifeways	Lifeways CMH
Kalamazoo	Southwest MI Urban & Rural Cons	Kalamazoo CMH
Kalkaska	Northern Affiliation	North Country CMH
Kent	Network 180	Network 180
Keweenaw	NorthCare	Copper Country CMH
Lake	Northwest CMH Affiliation	West MI CMH
Lapeer	Thumb Alliance PIHP	Lapeer CMH
Leelanau	Northwest CMH Affiliation	Northern Lakes CMH
Lenawee	CMH Partnership of SE MI	Lenawee CMH
Livingston	CMH Partnership of SE MI	Livingston CMH
Luce	NorthCare	Pathways CMH
Mackinac	NorthCare	Hiawatha CMH
Macomb	Macomb Co CMH Services	Macomb Co CMH Services
Manistee	CMH Affiliation of Mid-MI	Manistee-Benzie CMH
Marquette	NorthCare	Pathways CMH
Mason	Northwest CMH Affiliation	West MI CMH
Mecosta	CMH Central MI	CMH for Central MI
Menominee	NorthCare	Northpointe CMH
Midland	CMH Central MI	CMH for Central MI
Missaukee	Northwest CMH Affiliation	Northern Lakes CMH
Monroe	CMH Partnership of SE MI	Monroe CMH
Montcalm	Access Alliance of MI	Montcalm CCM
Montmorency	Northern Affiliation	Northeast CMH
Muskegon	Lakeshore Behavioral Health Alliance	Muskegon CMH
Newaygo	CMH Affiliation of Mid-MI	Newaygo CMH
Oakland	Oakland Co CMH Authority	Oakland Co CMH Authority
Oceana	Northwest CMH Affiliation	West MI CMH
Ogemaw	Northern Affiliation	AuSable CMH
Ontonagon	NorthCare	Copper Country CMH
Osceola	CMH Central MI	CMH for Central MI
Oscoda	Northern Affiliation	AuSable CMH
Otsego	Northern Affiliation	North Country CMH
Ottawa	Lakeshore Behavioral Health Alliance	Ottawa CMH
Presque Isle	Northern Affiliation	Northeast CMH
Roscommon	Northwest CMH Affiliation	Northern Lakes CMH
Saginaw	Saginaw Co CMH Authority	Saginaw Co CMH Authority
Sanilac	Thumb Alliance PIHP	Sanilac CMH
Schoolcraft	NorthCare	Hiawatha CMH
Shiawassee	Access Alliance of MI	Shiawassee CMH
St. Clair	Thumb Alliance PIHP	St. Clair CMH

County	Prepaid Inpatient Health Plan	Affiliated with the PIHP
St. Joseph	Southwest MI Urban & Rural Cstm	St. Joseph CMH
Tuscola	Access Alliance of MI	Tuscola CMH
Van Buren	Venture Behavioral Health	Van Buren CMH
Washtenaw	CMH Partnership of SE MI	Washtenaw CMH
Wayne	Detroit Wayne Co CMH Authority	Detroit Wayne Co CMH Authority
Wexford	Northwest CMH Affiliation	Northern Lakes CMH

Appendix 3
Calculations Methodology

Footnote 25: This is the percentage of physicians who responded to surveys of licensed physicians conducted in 2007, 2008, and 2009 who are actively practicing medicine in Michigan who indicated adult psychiatry is their primary specialty.

Footnote 26: Since 2005, the Michigan Department of Community Health has surveyed licensed physicians in conjunction with the license renewal process to collect data on their employment characteristics, practice specialty, etc. Physicians indicate both a primary and secondary specialty, if applicable. Physicians renew their license every three years, so the responses from the 2007 through 2009 surveys can be used to approximate a sample of all licensed physicians in Michigan. Nearly 13,000 physicians responded to the survey over that three-year period. Of these, 8,627 (or 66.5 percent) were identified as *active* physicians; that is, they work as a physician in Michigan. As of April 2010, there are currently 39,069 fully licensed physicians in Michigan. To identify the approximate number of *active* physicians in the state, we multiplied this by 66.5 to arrive at 25,785. The percentages of physicians who indicated either adult or child and adolescent psychiatry (4 percent and 1 percent, respectively) as their primary practice specialties were then applied to this number to identify an approximate total number of psychiatrists in Michigan.

Footnote 27: Since 2004, the Michigan Center for Nursing has surveyed licensed nurses in conjunction with the license renewal process to collect data on their employment status, work setting, practice area, etc. Registered nurses who provide direct care services are asked to identify their main practice area. In 2009, the survey showed that approximately 62 percent of registered nurses provide direct patient care services in Michigan. Applying this percentage to the current total of licensed registered nurses (132,738) suggests that approximately 82,222 registered nurses provide direct patient care in Michigan. In 2009, 3.4 percent of registered nurses who provide direct patient care indicated “psychiatric/mental health” as their main practice area. If we apply this percentage to our estimate of registered nurses providing direct patient care in Michigan we arrive at 2,796 nurses working in mental health.