

*This paper provides, in two sections, the history of Michigan's public mental health system and the history of the Community Mental Health Association of Michigan (CMHA) up through the date of this report.*

*Note that this document only scratches the surface of these histories, covering only a few points along the lifespan of the system and the Association. Each stakeholder, leader, and observer of the system and the Association will have their own views on key highlights of that history.*

*The appendix to this paper links readers with other sound sources of information on the history of the nation's and Michigan's public mental health systems. Additionally, links to a series of reports and recommendations, made by Mental Health Commissions and similar groups, are found within the body of this paper.*

## Part 1: History of Michigan's public mental health system

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While the history of community mental health in Michigan and the Community Mental Health Association of Michigan (CMH Association) began during the 1960's, the early roots of community care in the United States date back to colonial New England.

In 1773 the first hospital for persons with mental illnesses was established in Williamsburg, Virginia. Advocates for appropriate care and treatment were pioneers such as Dr. Benjamin Rush, the father of American psychiatry in the late 1770s, Dorothea Dix, who crusaded for the establishment of more mental hospitals in the mid 1880s, and Clifford Beers, a consumer of mental health services, who brought the "mental hygiene" movement into being in 1900 when he shocked readers with a graphic account of hospital conditions in his famous book, "The Mind That Found Itself."

**Groundbreaking actions by state and federal governments:** In September of 1959, the Michigan Society for Mental Health established a study committee to review the efforts of other states which had established community mental health programs. In May of 1961, the Michigan Senate established a special committee to study community mental health services. Based on the recommendation of the Senate special committee and with the support of the Mental Health Society, identical bills were introduced in both the House and Senate in February of 1963 to establish a community mental health services act in Michigan.

On April 29, 1963, Governor George Romney signed into law Act 54 of the Public Acts of 1963 - Michigan's Community Mental Health Services Act. Sections 190-192 of the Act describe its scope and purpose:

*"Increasing numbers of persons afflicted with psychiatric disorders require care and treatment in mental institutions. The human suffering and social and economic losses caused by these costly infirmities are a matter of grave concern to the people of the state. This act is designed to encourage the development of preventative, rehabilitative and treatment services through new community mental health programs and*

*the improvement and expansion of existing community services."*

On October 31, 1963, President John F. Kennedy signed into law the Community Mental Health Act (also known as the Mental Retardation and Community Mental Health Centers Construction Act of 1963), which drastically altered the delivery of mental health services and inspired a new era of optimism in mental healthcare. This law led to the establishment of comprehensive community mental health centers throughout the country. It helped people with mental illnesses who were "warehoused" in hospitals and institutions move back into their communities.

The Michigan Mental Health Society and the Department of Mental Health convened the first meeting of the county CMH boards in September of 1964. Issues to be reviewed were administrative rules to implement Act 54, relationships between Act 54 boards and the Department of Mental Health, relationships between CMH boards and their county boards of commissioners, and problems and questions relating to financing of CMH services.

By the end of 1964, the following counties had established community mental health programs under Act 54: Bay, Calhoun, Copper Country, Detroit-Wayne, Dickinson-Iron, Genesee, Ingham, Monroe, Muskegon, Oakland, Shiawassee, and Washtenaw. Counties having established formal committees to study their participation in PA 54 were Berrien, Ionia, Kalamazoo, Macomb, Midland, Montcalm, and Kent.

The Mental Health Society established an ongoing committee on community mental health services which convened periodic meetings of CMH board members.

**Michigan Mental Health Code adopted;** Public Act 54 was replaced with the enactment of the Mental Health Code, Act 258 of the Public Acts of 1974. This act was signed into law by Governor William Milliken and became effective on August 6, 1975. Its scope and purpose was described as:

*"An act to codify, revise, consolidate, and classify the laws relating to mental health; to prescribe the powers and duties of certain state and local agencies and officials and certain private agencies and individuals; to regulate certain agencies and facilities providing mental health services; to provide for certain charges and fees; to establish civil admission procedures for individuals with mental illness or developmental disability; to establish procedures regarding individuals with mental illness or developmental disability who are in the criminal justice system; to provide for penalties and remedies; and to repeal acts and parts of acts."*

In 1979, Governor William Milliken appointed a committee to study and make recommendations on how to better coordinate and integrate state operated and CMH services. The Committee on Unification of the Public Mental Health System issued its report in January of 1980. The report, entitled "Into the 80's," described the principles and features of a model mental health system and included 80 recommendations for change. The report recommended a single point of responsibility for entry into and exit from the public mental health system. It further recommended that local mental health authorities made up of one or more counties be established to act as that single point of responsibility and to manage and deliver services. The report recommended that there be a sharing in system governance between the Department of Mental Health and the local community mental health authorities, that shared responsibility be extended, via a contract, to the operation of state psychiatric facilities and centers for developmental disabilities, and that increased control over direct services personnel and fiscal resources be recommended for CMH boards.

Representing the community mental health system on the Governor's unification committee were Ann White (Berrien), Chairperson of the Subcommittee on Administration and Finance, James Haveman (Kent), William McShane (St. Clair), Thomas Presnell (Detroit-Wayne), and Roger VanderSchie (North Central).

**Mental Health Code Mandates Transfer of Responsibility to CMH system:** Encouraged by the Unification Report and recommendations, new ways were sought to accelerate the transfer of responsibility for direct delivery of mental health services from the state to county CMH boards as mandated by Section 116 of the Mental Health Code. In 1980, the Alger-Marquette, Kent, St. Clair and Washtenaw boards were selected to pilot a new method of contracting with the Department of Mental Health. This became known as "full management" contracting and provided flexibility within a CMH board's budget to purchase inpatient care or develop community-based alternative services. After a successful pilot experience, the opportunity to enter into full management contracts was available to the entire system. Eventually all CMH boards sought and achieved full management status.

Through the flexibility of full management contracting, a major expansion of community-based, alternative services began throughout Michigan. Full management became a model for changing the mix of institutional and community-based care which received national recognition and has since been replicated in other states. As a result, Michigan became a leader in assertive community treatment, psychosocial rehabilitation and other services and supports which provide clinically appropriate community-based services and supports which are alternatives to hospitalization.

**Medicaid becomes chief funding source for system:** Medicaid became the major source of funding for mental health services during the 1980s and 1990s as Michigan added clinic, home and community-based, children's model II, habilitation, and rehabilitation coverages to its Medicaid state plan.

The growth of community-based, alternative services made possible by full management contracting and new sources of Medicaid revenue have resulted in the major expansion of community-based services and the significant decline in census at state operated psychiatric hospitals which have occurred throughout the 80's and 90's. Since 1965, thirty six (36) hospitals serving adults with mental illnesses, centers serving persons with developmental disabilities and programs serving emotionally disturbed children have been closed by the State of Michigan. CMH boards have become the primary providers of long-term care for persons with severe and persistent mental illness and developmental disabilities.

The growth of the CMH system may best be illustrated by the increase in the amount of funds, both state General Fund, Medicaid, Healthy Michigan Plan (Medicaid expansion), PA2, and Federal Block Grant dollars, appropriated annually for CMH services.

1970	\$13.1 million
1980	\$104.2 million
1990	\$626.7 million
2000	\$1.1 billion
2010	\$2.5 billion
2020	\$3.5 billion

An economic analysis of the conversion of Michigan's mental health system from one in which the bulk of the public dollars were spent on state psychiatric hospitals and state developmental disability centers to one in which the bulk of the dollars were spent to support community-based services is striking.

If the dollars currently spent by Michigan's community-based public mental system \$3.469 billion, were spent solely on the provision of traditionally long-term inpatient care at the state's psychiatric hospital and developmental disability centers, those dollars would serve 9,500 persons per year. In contrast, those dollars, used to fund community-based services and supports, as they are now used, allows the public system to serve over 350,000 persons per year.

The impact of this transition is staggering. **Michigan's community based mental health system meeting the mental health needs of 37 times more persons, in the community, than would be served if those same dollars were used to provide long term inpatient care in the state's psychiatric hospitals and developmental disability centers.**

**Mental Health Code Revised:** With a changing health care environment, a community mental health system taking more responsibility for management of public mental health services and Medicaid services, and new approaches to clinical and administrative practice, it became apparent that changes to the Mental Health Code were needed. While there had been amendments from time to time, no comprehensive rewrite of the Mental Health Code had taken place since it was enacted in 1974. In January of 1993, the Association and the Department of Community Health began meeting to discuss a Mental Health Code rewrite. After a lengthy period of comment and input from a broad spectrum of stakeholders including consumers and family members, identical bills were introduced in the House and Senate on May 10, 1995. The legislation was extensively discussed and debated. Work groups representing a wide range of mental health stakeholders met throughout the summer of 1995.

The bill passed the Senate on October 11, 1995. During House consideration of the bill, more than 400 amendments to the legislation were considered with 113 amendments offered on the floor of the House of Representatives. After a day long debate which ended shortly before midnight, the House of Representatives adopted the bill by a vote of 70-31 on December 5, 1995. The Senate concurred in the House amendments by a vote of 30-4. The bill was signed into law by Governor Engler on January 9, 1996 and became Act 290 of the Public Acts of 1995.

This landmark legislation created an option for counties and community mental health boards to create a mental health authority, empowered consumers and family members by mandating their representation on CMH boards, strengthened recipient rights protections, allowed CMH boards to carry forward up to 5% of their state allocation, and improved accountability by requiring that CMH boards be certified. Perhaps most significantly, the act created the requirement that person-centered planning processes be utilized to ensure choice and consumer direction of his/her plan of service. The provisions of this historic legislation became effective on March 28, 1996.

**Move to managed care:** Noting the move to managed care by private sector health care during most of the 1980s, the Association convened a committee to explore the impact of managed care on the delivery of public mental health services and began to negotiate with the Department of Mental Health and the Medical Services Administration regarding an expanded role for CMH boards in managing Medicaid mental health and substance abuse services.

In August of 1995, CMHs began serving as gatekeeper for psychiatric admissions of persons enrolled in Medicaid and not members of qualified health plans. On June 18, 1996, the Michigan Department of Community Health (DCH) announced that it intended to move to managed care and to "carve out" Medicaid specialty services and supports for persons with mental illnesses, substance use disorders and

developmental disabilities (behavioral health and intellectual/developmental disability services; BHIDD) from Medicaid physical health care. DCH submitted a set of Medicaid waiver applications [1915 (b) and (c)] to the Health Care Financing Administration (HCFA), now known as the Centers for Medicare and Medicaid Services (CMS), requesting the ability to move to a Medicaid managed care system and to have the Medicaid Specialty (BHIDD) benefit carved out, with the CMHSPs responsible for service coordination and system management. The waivers, if granted, would allow Michigan to replace the state's Medicaid fee for service payment system with a capitated risk-based funding mechanism.

A set of federal Medicaid waivers [1915 (b) and (c) waivers] were approved by CMS and **all of Michigan's CMHSPs became managers of the specialty services benefit, as Prepaid Inpatient Health Plans (PIHPs) with the plan taking effect on October 1, 1998.**

The waiver approval from HCFA stipulated that the state had to submit a plan for competitive procurement of management of those services. As a result, in September of 1999, DCH announced its plans to competitively bid out management of the Medicaid specialty services benefit. After a series of public hearings, input from stakeholders, and the impact of a procurement plan put forth by State Senators Bev Hammerstrom and Shirley Johnson, the DCH document submitted to CMS in October of 2000 requested a continuation of management by CMHSPs, as PIHPs, who met revised qualification and performance requirements. The waiver renewal request included a rigorous application process, and requirements that prospective CMH applicants have a geographic area with a minimum of 20,000 covered lives.

To accommodate these requirements, in 2004, **46 CMH programs organized themselves into either stand-alone or regional affiliations**, each with a "hub" CMHSP board, which would serve as the regional PIHP, and would hold the contract with the state for Medicaid financed services. The PIHP then, in turn, contracted with the "spoke" CMHSPs within their region. Not all of the state's CMHs were in hub-and-spoke arrangements, with 8 PIHPs made up of single CMHSPs which met the minimum covered life requirement. Applications were reviewed by the Department of Community Health and submitted to a specialty services panel appointed by the Governor. All 18 applicant prepaid health plans were approved by the panel.

The revised waiver program began on October 1, 2002. In September of 2003, the Department of Community Health submitted a request for another renewal of the CMS waiver which authorizes Michigan's specialty services program. DCH continued to submit waiver renewal requests with CMS as required and has maintained the essential "carve out" model for specialty services.

In 2014, the PIHP system was redesigned to **reduce the number of PIHPs from 18 to 10 and to create, across the state with the exception of Macomb, Oakland, and Wayne counties, regional PIHPs.** These regional PIHPs are quasi-public and were formed and governed by the CMHSPs in the region, with each CMHSP in the region appointing members to the regional PIHP board of directors. As in the past, these PIHPs hold the shared risk Medicaid managed care contract with the state and make Medicaid payments, to the CMHSPs within their region. The CMHSPs then provide or purchase Medicaid services to the Medicaid enrollees in their communities.

As part of the federal Affordable Care Act (ACA), Michigan expanded, in 2014, its Medicaid program through the Healthy Michigan Plan (HMP), providing healthcare coverage to over 600,000 Michigan residents. As a result, a wide range of BHIDD services became available to persons to whom such care had been, up until that point, hard to access.

**Substance Use Disorder Funding and Services Integration:** While a number of CMHSPs, in the role of PIHPs, began to merge with and/or take on the role formerly played by the Substance Abuse Coordinating Agencies (CAs), prior to its passage, with the passage of PA 500 of 2012, this pace of this process accelerated. PA 500 mandated that CMH entities take on the coordination and regional funding and oversight role for the publicly funded regional substance use disorder system – the role formerly held by the CAs. The CMH entities that assumed this role were the PIHPs in each region, managing Medicaid, PA2, and Federal Block Grant dollars, through the network of SUD prevention and treatment providers in each community. With the formation of the newly structured PIHPs, in 2014, these CA responsibilities moved to these PIHPs.

With this integration of local/regional SUD management into the PIHP/CMH system, the efforts to clinically integrate SUD services with the mental health, intellectual/developmental services system, while taking place, for decades, in communities across the state, received greater attention and support. While much is still needed to integrate these services, without losing the system’s ability to meet the unique needs of persons without co-occurring conditions nor losing the integrity of the SUD system, long underfunded and under-represented in policy discussion.

**Integrated Care:** Following passage of the Affordable Care Act, Michigan began to examine opportunities to reform its healthcare delivery systems. One of the first opportunities pursued was a planning grant in 2011 to make changes in the organization, management, and financing of care for persons with both Medicare and Medicaid eligibility. The Association and its members were very active in providing input and, with other important consumer stakeholders, influencing the direction of the state’s planning. In the spring of 2016, the Association’s Center for Healthcare Research and Innovation (a policy analysis center formed by the Association) conducted a study of the healthcare integration initiatives led by Michigan’s Community Mental Health Services Programs, the state’s public Prepaid Inpatient Health Plans (PIHPs), and providers within the CMH system. The study examined varying efforts aimed at integrating behavioral health and intellectual/developmental disability services with physical health care services. Results showed that more than 750 healthcare integration efforts, led by these public sector parties, were in operation in Michigan. Of this number, work in bi-directional co-location, integration of electronic health records, and high/super-utilizer initiatives underscored the variety and maturity of these efforts.

**Mental Health Commissions and Task Forces:** Over the years, a number of mental health commissions or similar efforts have been formed, by the Michigan Governor, the State Legislature, or MDMH/ MDCH/MDHHS. These commissions are listed below with links to the reports and recommendations developed by these groups:

- Governor Granholm’s Mental Health Commission; 2004; Commission report can be found at: [https://www.michigan.gov/documents/mdch/Final\\_MHC\\_Report\\_Part\\_1\\_375106\\_7.pdf](https://www.michigan.gov/documents/mdch/Final_MHC_Report_Part_1_375106_7.pdf)  
Appendix to this report can be found at: <https://publicsectorconsultants.com/wp-content/uploads/2017/01/FINAL-MHC-REPORT-PART-2.pdf>  
Plan for implementing recommendations of the Granholm. Mental Health Commission; 2005; Plan can be found at: [https://www.michigan.gov/documents/mdch/Transforming\\_Mental\\_Health\\_Care\\_in\\_Michigan\\_375062\\_7.pdf](https://www.michigan.gov/documents/mdch/Transforming_Mental_Health_Care_in_Michigan_375062_7.pdf)
- Behavioral Health Section 298 Workgroup; 2016; Workgroup report can be found at: [https://www.michigan.gov/documents/mdhhs/Behavioral\\_Health\\_Section\\_298\\_Final\\_Report\\_7-](https://www.michigan.gov/documents/mdhhs/Behavioral_Health_Section_298_Final_Report_7-)

[15-16\\_531073\\_7.pdf](#)

- o Governor Snyder's State of Michigan Mental Health and Wellness Commission; 2013; Commission report available at:  
[https://www.michigan.gov/documents/mentalhealth/CommissionReportFinal1212014\\_445161\\_7.pdf](https://www.michigan.gov/documents/mentalhealth/CommissionReportFinal1212014_445161_7.pdf)
- o Community, Access, Resources, Education, and Safety (CARES) Task Force formed by the Michigan House of Representatives; 2018; Task Force report can be found at: [http://gophouse.org/wp-content/uploads/2018/01/HouseCARES\\_Report.pdf](http://gophouse.org/wp-content/uploads/2018/01/HouseCARES_Report.pdf) ).

**Changes in state department:** The state department responsible for the design, funding, and oversight of the state's public mental health system has undergone a number of changes in make-up, name, and leadership since the 1940s. The Michigan Department of Mental Health, formed in 1945, was merged, in the 1990s, with the Michigan Department of Public Health to form the Michigan Department of Community Health. In the 2010s, this department was merged with the Michigan Department of Human Services to form the Michigan Department of Health and Human Services.

The Directors of the state department responsible for the design, funding, and oversight of the state's public mental health system, since its early days are provided below:

Charles F. Wagg ..... September 1945 to March 1946  
Charles F. Zeller, M.D. .... April 1946 to July 1947  
Charles F. Wagg ..... August 1947 to December 1947  
R.L. Dixon, M.D. .... January 1948 to May 1949  
Charles F. Wagg ..... June 1949 to June 1964  
Robert A. Kimmick M.D. .... July 1964 to November 1966  
Vernon A. Stehman, M.D. (*Acting Director*) .... December 1966 to June 1967  
William W. Anderson, M.D. .... July 1967 to June 1970  
E. Gordon Yudashkin, M.D. .... July 1970 to May 1974  
Donald C. Smith, M.D. .... June 1974 to February 1978  
Vernon A. Stehman, M.D. (*Acting Director*) ..... March 1978 to July 1979  
Frank M. Ochberg, M.D. .... August 1979 to August 1981  
C. Patrick Babcock ..... September 1980 to December 1986  
Thomas Watkins ..... January 1987 to December 1990  
James K. Haveman, Jr. .... January 1991 to December 2002  
Janet Olszewski ..... January 2003 to December 2009  
Olga Dazzo ..... February 2010 to September 2012  
James K. Haveman, Jr. .... September 2012 to April 2015  
Nick Lyon. .... April 2015 to December 2018  
Robert Gordon ..... January 2019 to present

## Part 2: History of the Community Mental Health Association of Michigan

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As noted in the history of the system, above, The Michigan Mental Health Society and the Department of Mental Health convened the first meeting of the county CMH boards in September of 1964. Issues to be reviewed were administrative rules to implement Act 54, relationships between Act 54 boards and the Department of Mental Health, relationships between CMH boards and their county boards of commissioners, and problems and questions relating to financing of CMH services.

The Mental Health Society established an ongoing committee on community mental health services which convened periodic meetings of CMH board members.

**Michigan State Association of Community Mental Health Services Boards formed:** Throughout 1967, interest grew among the Act 54 boards to establish their own association. An organizational meeting took place on May 25, 1967, at the Capitol Park Hotel in Lansing. A call for membership was issued and on October 20, 1967, representatives of Act 54 boards agreed to the organization of the "Michigan State Association of Community Mental Health Services Boards" and adopted a constitution and By-Laws. Each member board was asked to appoint two delegates to the Association. Officers elected were:

Harold Brigham (Kent) President  
Leon Schneider (Midland) Vice President  
George Kallos (Shiawassee) Secretary  
William Wagner (Oakland) Treasurer

The first Act 54 boards to join the Association were Bay, Berrien, Copper Country, Ingham, Kalamazoo, Kent, Livingston, Macomb, Midland, Monroe, Muskegon, Oakland, Saginaw and Shiawassee. By June of 1968, and with the addition of the Alger/Marquette, Calhoun/Branch, Detroit-Wayne, Genesee, Montcalm, St. Clair, and Washtenaw boards, twenty-one of thirty-two Act 54 boards were members in good standing of the new Association. Eventually, all 83 Michigan counties established CMH Services Programs. The number of boards has varied over the years with the largest number being 55. Currently there are 46. The Association achieved 100% membership for the first time during 1985. Membership has been at or near 100% for most subsequent fiscal years.

The first annual meeting of the Michigan State Association of Community Mental Health Services Boards was held on October 10, 1968, in Northland. The Association identified the areas of financial planning, budget building, contractual relationships, program development, program evaluation, community relations, personnel practices and recruiting and staff training as topics to discuss at the first annual meeting. In early 1969, Association President Harold Brigham wrote:

"Greetings to our directors, board chairmen, and others interested in community mental health. Of overriding interest at this point, is the consideration by the legislature of the budget requests for mental health. The amount in the Governor's recommendation for PA 54 was \$14.1 million, an increase of \$3.1 million from 68-69. This amount would allow for only the most modest increase over the expenditure of this fiscal year because of increased personnel costs and because many of this year's programs were funded for less than a full year. Because of the total budget picture, however, there is some indication that this amount of \$14.1 million will be reduced in order to add to other items in the budget of the Department of Mental Health. The department has not indicated yet that



they would oppose this. Support for the PA 54 funds will apparently have to come from other sources, such as your Association and the Michigan Society for Mental Health."

**Association of Community Mental Health Directors formed:** An association of community mental health directors was formed during the mid 1970's. Presidents of that association included Mel Ravitz (Detroit-Wayne; 1974-76), Thomas Ennis (Clinton-Eaton-Ingham; 1977-79), Saul Cooper (Washtenaw; 1980), William McShane (St. Clair; 1981), and James Haveman Jr. (Kent; 1982-85).

During 1979, both the associations of CMH Boards and Directors agreed to appoint a "Joint Action Committee" to explore matters of common interest. Co-chairpersons of the committee were Ralph Collins (Allegan) representing board members and Thomas Ennis (Clinton-Eaton-Ingham) representing directors.

**Boards and Directors Associations merge:** In October of 1982, both associations agreed to undertake a study to consider the feasibility of consolidating the two groups. The committee was co-chaired by Harriet Kenworthy (Genesee) representing board members and Larry Grinwis (Ottawa) representing directors. The committee produced a report in April of 1983 which described the assets and liabilities of consolidation, proposed a process for further study and drafted a set of by-laws for review and comment. In June of 1983 both associations debated the proposal to merge and in October both approved the consolidation plan.

This new organization was established for a two-year trial period. The first meeting took place on January 13, 1984. The membership of both organizations was again convened on October 4, 1985, and at that time approved the continuation of the consolidated organization on a permanent basis. The permanently consolidated organization held its first general membership meeting on January 27, 1986.

The Association hired its first full time executive director, David LaLumia, in July of 1985. In 1988 the Association purchased the former headquarters of the Michigan Association of Counties at 319 West Lenawee in downtown Lansing. This strategic location was ideal in supporting the mission of the Association and its interaction with the Executive and Legislative branches, the Department of Community Health, the infrastructure of state government and other stakeholder organizations interested in mental health and human services.

Unfortunately, this building was destroyed by fire on April 8, 1998. The Association purchased a building at 426 S. Walnut in downtown Lansing – an equally strategic location – in November of 1998. MACMHB staff moved into the new headquarters in April of 1999. This building contains meeting and conference space which supports the Association's interest in training and technical assistance.

David LaLumia left as the Association's executive director in 2008, having served as its Executive Director since 1985. In 2009, Michael Vizena was hired as the executive director. In 2015, Robert Sheehan followed Mike Vizena as the Association's executive director.

**Affiliate Members and PIHPs added to Association membership:** In 1997, the MACMHB executive board approved affiliate membership for organizations whose purpose is consistent with that of MACMHB. As of 2017, affiliate membership was at nearly one hundred (100) members, adding an important voice and ability and strength to MACMHB in achieving its goals. In 2011, MACMHB amended its bylaws to provide four (4) designated provider representatives with full voting privileges at MACMHB's Member Assembly, Executive Board, and Standing Committee meetings.

In 2015, soon after the creation of regional PIHPs as distinct organizations from the state's CMHs, four seats at the CMH Association Executive Board and Steering Committee were added for PIHP representatives. Additionally, the Association's by-laws were revised to allow PIHP representatives to serve as officers and committee members.

**ALSAO joins Association:** Early in the 21<sup>st</sup> century, the members of ALSAO (Alliance of Licensed Substance Abuse Organizations) joined the CMH Association, with the ALSAO members becoming affiliate members, as part of the Association's Provider Alliance. With the addition of ALSAO members to the Association, the Association brought on the multi-client lobbying firm formerly used by ALSAO, with an eye toward substance use disorder issues, especially those issues impacting SUD providers.

**Name changes for Association:** During 1972, the name of the association was changed to the Michigan Association of Community Mental Health Boards.

In 2017, the name of the Association was changed to the Community Mental Health Association of Michigan. The new name retained the words "community mental health" to represent the association's link to the community mental health movement that, fifty years since its genesis, is in robust and continual development. However, the name no longer contains the word "Boards". While the Association is still led by the members of the Boards of Directors of the state's public Community Mental Health centers (CMHs) and public Prepaid Inpatient Health Plans (PIHPs) – with Board members making up 2/3 of the Association's Member Assembly – the Michigan Mental Health Code has not, for years, used the term "Board" to describe the local and regional organizations that make up the public BHIDD system. Additionally, none of the Association's members use the word "Board" in their names.

The Association's new name underscored that, in the midst of the innovation required for the public system to respond to an ever changing environment (both opportunities and challenges), the system and the Association have never forgotten their roots in the community mental health movement – a civil rights movement in every sense of the word. A movement that is grounded in the commitment to the dignity of the person and to each person's right, regardless of ability or disability, to self-determination, full citizenship, community inclusion, and equality of opportunity.

**Partnerships:** The Association has longstanding and deep partnerships with state-wide advocacy groups and associations. While too numerous to name, some of the advocacy groups with which the Association regularly works include: Arc Michigan, NAMI-Michigan, Mental Health Association in Michigan, Association for Children's Mental Health, Michigan Disability Rights Organization, Michigan Protection and Advocacy, Autism Alliance of Michigan, Epilepsy Foundation of Michigan, Incompass Michigan, Michigan Assisted Living Association, Area Agencies on Aging Association of Michigan, Michigan League for Public Policy, and Michigan Health Policy Forum.

The Association and its members have also been active participants and partners in advocacy on the national level through its membership in several national associations, including the National Council for Community Behavioral Healthcare (NCCBH), the National Association of County Behavioral Health and Developmental Disabilities Directors (NACBHDD).

Core to the work of the Association is its partnerships with the Michigan Department of Mental Health (MDMH) and its successor organizations, the Michigan Department of Community Health (MDCH) and the Michigan Department of Health and Human Services (MDHHS).



## Appendix:

### Other sources of information on the history of the nation's and Michigan's public mental health systems

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Mental Health in Michigan, Prepared for the Flinn Foundation by Public Sector Consultants, December 1997; <http://www.flinnfoundation.org/wp-content/uploads/2011/03/Mental-Health-in-Michigan-Dec-1997.pdf>

Mental Health Funding and Services, Public Sector Consultants, April 2017; <https://publicsectorconsultants.com/wp-content/uploads/2017/04/issue-46.pdf>

Infographic on the Community Mental Health Act 50<sup>th</sup> Anniversary Timeline, National Council for Behavioral Health, 2017; [https://www.thenationalcouncil.org/about/national-mental-health-association/overview/community-mental-health-act/50th-anniversary-timeline\\_final\\_for\\_mag-2/#foobox-1/0/50th-Anniversary-Timeline\\_final\\_for\\_mag.jpg](https://www.thenationalcouncil.org/about/national-mental-health-association/overview/community-mental-health-act/50th-anniversary-timeline_final_for_mag-2/#foobox-1/0/50th-Anniversary-Timeline_final_for_mag.jpg)

The Federal and State Role in Mental Health; Mental Health America; <https://www.mhanational.org/issues/federal-and-state-role-mental-health>