

Mental Health Association in Michigan
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The ADVOCATE

Mental Health Association in Michigan



Mental Health Matters Every Day

Over One-Half of Babies in Poverty Raised by Mothers Living with Depression

The Urban Institute recently released a report examining the characteristics, access to services and parenting approaches for infants living in poverty whose mothers are experiencing depression. The study examined these variables among 8,550 study respondents.

The report noted that initial recent estimates provided by the National Research Council and Institute of Medicine suggest that 15 million children (1 out of every 5) live with an adult experiencing major depression. Depression can hurt adult educational attainment, income and employment. Depression often occurs with substance abuse, other mental health problems, chronic medical conditions and social disadvantage. What was unknown until recently was the impact of depression among an adult on infants. Key findings of the report were:

- Eleven percent of infants living in poverty have a mother suffering from severe depression.
- Evidence suggests that depression can interfere with parenting, potentially leading to poor child development.
- Compared with their peers who have non-depressed mothers, infants living in poverty with severely depressed mothers are more likely to have mothers who also struggle with domestic violence and substance abuse, and who report being only in fair health.
- Infants living in poverty with depressed mothers receive similar prenatal care as their peers whose mothers are not depressed, but they are breast-fed for shorter periods of time.
- Even though depression is treatable, many severely depressed mothers do not receive care.
- Many depressed mothers living in poverty are already connected to services such as Women, Infants and Children (WIC), other health care, food stamps and Temporary Assistance for Needy Families (TANF). Every contact is an opportunity to identify depression

and help parents seek treatment.

Additional findings from the report noted that infants living in poverty with severely depressed mothers are more likely to have white mothers (44 percent) and less likely to have Hispanic mothers (21 percent), compared with infants living in poverty with non-depressed mothers. Infants of severely depressed mothers are about the same age as the non-depressed mothers. However, all infants in poverty have relatively young mothers. More than half of both groups have mothers 24 years of age or younger.

Infants living in poverty whose mothers suffer from severe depression are more often exposed to additional serious risks. Infants are more likely to have mothers who also struggle with domestic violence and substance abuse. In 16 percent of cases where infants were living in poverty with severely depressed mothers, the mothers reported being physically abused between the 9-24 month span of interviews, nearly eight times the share of their peers from non-depression families. Further, for 14 percent of cases where infants were living in poverty with severely depressed mothers, the mothers reported binge drinking in the last month of interviews for the study, versus only six percent of mothers from non-depression families.

About a quarter (24 percent) of infants in poverty with severely depressed mothers have mothers who also report being in fair health. This was a significantly higher rate than among non-depressed mothers. Conversely, poor infants' mothers with severe depression reported being in excellent health at half the rate of poor infants' mothers without symptoms of depression.

In 30 percent of cases, severely depressed mothers spoke with a psychiatrist, psychologist, doctor, counselor or other health care professional within the last year about an emotional or psychological problem. Alternatively, approximately five percent of peers from

non-depression families spoke with a health care professional. The report noted that while it was encouraging that some severely depressed mothers were seeking treatment, many were not. In nearly 67 percent of cases where poor 9-month-olds lived with severely depressed mothers, their mothers did not speak with a mental health practitioner.

Also noteworthy were findings that related to severely depressed mothers receiving similar prenatal care as their peers who were not depressed. The timing of care was about the same for infants of severely depressed mothers and those of non-depressed mothers. Nearly three-quarters of infants in poverty have mothers who received prenatal care during their first trimester; about a fifth received care in the second trimester; and 6 percent received care in the last trimester.

The findings of the report suggest many infants living in poverty are exposed to the potentially damaging effects of a mother's depression during a critical development period in their lives. The report calls for an increased role for the public sector in identifying struggling mothers and helping them obtain the mental health services they need. The report calls for the idea of looking at this problem in a strategic sense by which health, social service and early childhood professionals can recognize and treat parental depression. The report noted in conclusion that given the recent changes in health care reform; additional emphasis needs to be placed on all entry points into the public health system to determine depression either through CHIP (Child Health Insurance Program), TANF or WIC programs in order to address help for those experiencing severe depression and mental illness.

***Depression:
Get Screened,
Get Treated,
Get Better.***

Thanks to 2010 Golf Outing Sponsors 16th Annual MHAM Golf Outing

The 16th Annual golf outing of Michigan AFSCME Council 25, to benefit MHAM was held on August 20, 2010 at the Swartz Creek Golf Course in Flint, with 78 golfers participating. Over \$28,000 were raised for MHAM. This brings the sixteen-year event total income generated by our friends at AFSCME to over \$521,000. The MHAM family wishes to thank AFSCME President Albert Garrett, Secretary-Treasurer Lawrence Roehrig and all the AFSCME Council 25 members for their outstanding support of MHAM over the years. This support has been a critical point of assistance to our public policy, advocacy, educational and other work. We also thank the many organizations and individuals who sponsored the event; all of those who did supportive volunteer work; and MHAM Board golf event captains: Phil Mastin, Joanne Sheldon and Ollie Cameron.

Thanks to 2010 Golf Outing Sponsors !

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AS SEEN BY THE CEO

Mark Reinstein, Ph.D., President & CEO

Changing of the Guard

Michigan is saying good-bye to Jennifer Granholm and hello to Rick Snyder as the state's Governor.

What kind of mental health legacy has Ms. Granholm left? A rather poor one. She always talked a good game, but of course actions speak louder than words.

Ms. Granholm raised the hopes of many when, in her first year as Governor, she committed to create a special Mental Health Commission for the state. Our Association had been pushing for that since her November 2002 campaign victory. The Governor announced her commitment during the midst of a Detroit News "expose" series on mental health in Michigan.

Whether the Commission would have happened without that series is not known to us. But the Commission was formed, beginning its work in February 2004 and giving the Governor a report in October of that year. The Governor told the Commission at its onset that Michigan's mental health system was "broken." She then proceeded to ignore virtually all of the Commission's recommendations. The system she inherited was in dire straits; it remains that way today.

Ms. Granholm never used the power of her office to advance mental health insurance parity law in Michigan. In fact, members of her staff lobbied the Mental Health Commission (unsuccessfully) to exclude any parity law recommendation from the Commission report. Michigan today is one of only seven states without its own parity law, as we continue shamefully to tell consumers and families that it's OK to discriminate against brain disorders.

Governor Granholm presided over some significant reductions in Community Mental Health non-Medicaid funding. You can tell me about hard times, overall budget situations and the state's need to potentially fund hundreds of different items. But this is a column on mental health, and in the course of making hundreds of state funding decisions, Governor Granholm did not prioritize CMH non-Medicaid funding to the point where the modest amount already there would be maintained (at the expense of something else in the vast state budget).

Ms. Granholm did sign a small number of positive mental health bills. But these were not initiatives she sought or worked toward. In fact, in the case of one of them (protecting most mental health medications from Medicaid prior authorization), her

administration began violating it within weeks of its enactment in 2004, and it took us four months and, ultimately, some aggressive public action to assure the law would be followed. More recently, in 2009, the Granholm administration sought to have the law repealed, but it was not.

What will Governor-elect Snyder inherit on the mental health scene?

*A publicly funded system that lacks resources to meet need and demand, especially when it comes to intermediate or long-term protected intensive care for actively severe cases.

*A private sector that doesn't have to pull its full fair share and can discriminate against coverage of brain disorders. Yes, the federal improvement parity law of 2008 should help many Michiganders, but that law leaves out employers with less than 51 employees. And yes, the health exchanges envisioned for 2014 (under this year's federal health care reform law) will help some additional people. But come 2014 that law may not look the same, and even if it does, there's no way to know how many privately insured Michiganders who presently lack parity will wind up in the exchanges.

*A publicly funded sector that is two-tiered, offering the hope of service to those enrolled in Medicaid and the likelihood of nothing for those who are not.

*A publicly funded sector that lacks accountability, uniformity, appropriate standards and deliverance on the many "rights" Michigan law and rule promise to those applying for or receiving service from that sector.

*An epidemic of persons with mental illness and emotional disorder in the adult and juvenile justice systems.

On the campaign trail, Mr. Snyder made some very positive statements (as did his opponent) about the importance of mental health. Here are two examples, both from the GONGWER legislative news service:

* "We used to sort of put mental health in a closet. By not helping that person, what happens? They end up on one of two paths: They end up on the path toward acute care hospitalization, going to multiple ER visits for health, potentially being hospitalized in that system or potential homelessness. The other path they get dropped on by not getting assistance at the early stage ... they're now put on a path to corrections. When you say it costs more money [to improve services], it actually saves us money. By doing frontline

mental health services, that's the focus, it's not a net cost, it's a net reduction to society and at the same time we're providing better services to our citizens." (September 17)

* "I actually piloted that [improved support for mental health] in the town halls. There's been no other issue that I've had more positive feedback on than that single issue. And it just started with simple body language. When I brought it up, it was amazing. And this goes back to very early on. I would get heads going up and down with like half or more of the audience in a positive way." (October 25)

Of course, Mr. Snyder also said during the campaign that we need new, innovative ways of governing, and that people should vote for him as an outsider not wedded to the failed ways of government as we know it. He then turned around and in his first five announced post-election appointments (through November 8) has tabbed former government officials for those spots. President Obama made the mistake of campaigning as a change agent and then filling his administration with former government officials who don't know how to (and perhaps don't want to) break from the past. Is Mr. Snyder going to make the same mistake? Time will tell, but we have to be cognizant that what's said before an election and what happens after are often two different things.

Mr. Snyder has further said that he wants to use the "price of government" concept in Michigan. This approach, which all Michigan legislators were trained in several years ago and then proceeded to ignore, holds that in allocating resources government must decide what issues are most important and then do everything possible to support those issues - regardless of state department compartmentalization and the relative consequences to lower-priority initiatives. If the Governor-elect really believes in this; can sell the Legislature on it; and values mental health as much as his campaign comments indicate, he could do much to make matters better in the mental health arena.

We congratulate Mr. Snyder and wish him all the best. He faces daunting challenges, both overall and with respect to mental health. We will begin his administration with guarded optimism that mental health is truly important to him - because he said it was - and that we can help him, his administration and the next Legislature to improve mental health outreach, care and treatment in Michigan.

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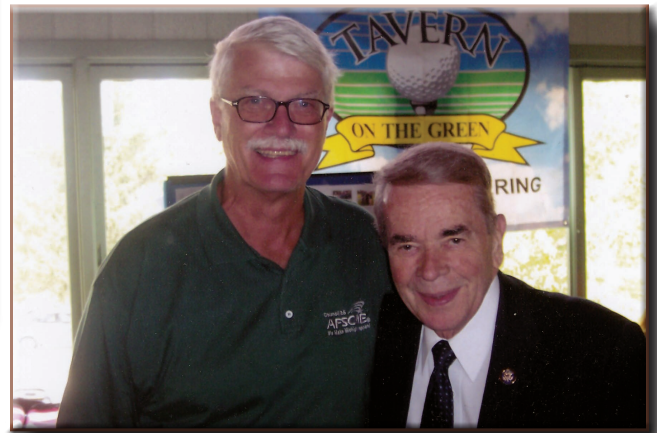
2010 Michigan AFSCME Council 25 Golf Outing



Golfers warm up before tee-off at the 16th Annual Golf Outing



(L - R) AFSCME Council 25 retiree Ken Stovall, Tom Greyerbiehl, Arthur Wood, Lori Hamilton from AFSCME Council 25 Flint Office



AFSCME Council 25 Secretary-Treasurer Lawrence Roehrig (left) with U.S. Congressman Dale Kildee, D-Flint



16th Annual Golf Outing tournament Winners (from left to right) Paul Ford, Marc Meloff, Chris Grzybowski, and Scott Jensen. With them is (back center) AFSCME Council 25 Secretary-Treasurer Lawrence Roehrig.

Recommendations to Foster System Reform for Adults with Serious Mental Illness

A new report, developed by a group of 65 prominent figures representing all aspects of the behavioral health care field, calls on government agencies to implement five recommendations to drive ongoing health system reforms essential for serving adults with serious mental illness (SMI). According to the report, adults with SMI, who comprise six percent of the U.S. population, rank among the highest-cost Medicaid beneficiaries and die an average of 25 years sooner than the general population, often from preventable, co-occurring disease including asthma, diabetes, cancer and heart disease.

The report grew out of a November 2009 forum, the National Action Meeting on Fostering System Reform for Adults with Serious Mental Illness in conjunction with the National Association of County Behavioral Health and Developmental Disabilities Directors (NACBHDD). The meeting was funded by Janssen Pharmaceutica, which under federal law had no input on the planning, conduct or conclusions of the forum.

The goal of the meeting was simple. On the eve of health care reform, participants sought to unite around strategies that could reshape the nation's approach to mental health service delivery, improve system and service efficiency and greatly improve individual outcomes. There were five recommendations that the participants concluded were important. These recommendations were:

One, The U.S. Department of Health and Human Services (DHHS) must design and implement a robust set of performance measures, with risk-adjusted financial incentives to facilitate a system that financially supports the best consumer outcomes. These actions would change mental health treatment from a series of trial-and-error tests to a data-driven decision process. Standard outcome and performance measures would allow managers and policy makers to make better resource allocation decisions and offer appropriate incentives to improve outcomes.

Two, the U.S. Congress and DHHS should designate people with serious mental illness as a health disparities group in order to close the 25-year gap in life expectancy. This designation would facilitate tracking and measuring of health disparities experienced by persons with serious mental illnesses, thereby providing the opportunity to

focus resources on addressing these disparities.

Three, Congress and DHHS should support health information technology (HIT) for community behavioral health care systems as organizations as well as for mental health and substance use services. All federal HIT initiatives including Health Information Technology for Economic and Clinical Health (HITECH) should be required to have substantial involvement from behavioral health stakeholders. Any technology systems development in the future must be capable of supporting behavioral health content and operational needs. Ensuring full inclusion of all behavioral health care providers along with general health care providers in HIT implementation will improve efficiency and outcomes across the health care spectrum, including persons with serious mental illnesses and those with any health condition displaying behavioral health symptoms.

Four, obstacles should be removed from integration of mental health and general medical care by ensuring that all person-centered medical homes (PCMH) and person-centered health care homes (PCHH) include ready access to behavioral health services as a core element. The benefit of these actions would increase access to and capacity for behavioral health treatment services and would make possible coordination/integration of primary care and behavioral health care, resulting in less fragmentation and duplication of services, as well as improved outcomes for the individuals served. Also, overall health care costs would likely decline, as studies consistently show this impact when behavioral health treatment is provided in conjunction with treatment for many physical conditions.

Lastly, DHHS, in particular the Centers for Medicare and Medicaid Services (CMS), should develop a national definition of "medical necessity." The definition should include the range of services needed by persons with serious mental illness. This will provide an important standard for payers to follow.

These recommendations call for federal leadership in the development and support of policy that will improve services for adults with serious mental illnesses. With enactment of national health reform legislation, the nation is at a watershed moment in which much of

its health care system will be realigned. Serious mental illness is the medical condition with the largest social burden. Health care reform cannot succeed in its goals of improving access to care, containing costs and improving the quality of health care in America unless it addresses the health care policy issues specific to serious mental illnesses.



Mark Reinstein, President and CEO of MHAM, models the latest fashion at a recent fundraiser for the **MINDS** school-based education program

Mental Health Matters Every Day!

MHAM Membership Categories

MHAM relies on the generosity of members to help us serve people in our communities. Listed below are the Association's membership categories and benefits. If you are already a member of MHAM, please take a moment to review the categories and consider upgrading to a higher level of support under these options. If you are not yet a member of MHAM please consider joining by choosing the category best suited to your interest. Please see page 6 for a membership form. Please note on the form that we're now offering memberships of one and two years (with the latter discounted). If you have any questions about our membership, please contact our office at (248) 647-1711.

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- MHAM e-mail updates
- Legislative Alerts, News Releases, Call to Action

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- Certificate of Membership
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