Community Mental Health and Corrections:

A Sequential Intercept Model Survey of Michigan CMHSPs

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I. Executive Summary

Mental health and corrections has become a significant topic at the national level, especially in the light of recent gun violence. Historically, empirical data on mental health and corrections in the State of Michigan has been very limited. This project gathered information on mental health and corrections initiatives at the state and local level to increase understanding of current programming in order to identify gaps of care and service and to make recommendations moving forward. With the support of the Community Mental Health Association of Michigan, a self-reporting study was conducted involving each of the 46 Community Mental Health Service Programs (CMHSPs) in Michigan from November 2017 to January 2018. A questionnaire was developed using the Substance Abuse and Mental Health Services Administration's (SAMSHA) adaptation of Patricia Griffin's Sequential Intercept Model (SIM) as a baseline rubric. Each CMHSP used the Sequential Intercept Model as a guide to report their current initiatives and programs at each of the six Intercepts. A remarkable 100% of the 46 CMHSPs completed the questionnaire and their completed responses were then analyzed using a basic coding matrix to examine status, gaps, and trends in local mental health and corrections initiatives.

II. Introduction

When Michigan Speaker of the House, Tom Leonard, announced the formation of the Community, Access, Resources, Education and Safety Task Force (C.A.R.E.S.) in July 2017 he stated its purpose was "Reforming our broken mental health system". His voice joined the chorus of critics and some advocates who believe that Michigan's Mental Health System is failing communities and many of our most vulnerable citizens. However, others who have been part of a massive expansion of community-based mental health programs over the past 40 years, now serving tens of thousands of Michigan citizens and their families, were disheartened by the Speaker's words.

There is a national disconnect between what communities want in its mental health system, what it is willing to pay for, and what it gets in the end. Adequacy, efficiency and effectiveness in the mental health system is fundamentally what critics and supporters agree to be the end goals of the mental health system. Regardless of whether we define the mental health system as "broken" or not, we all agree that it falls short of what it could be and that we want more from it.

The Community Mental Health Association of Michigan (CMHA), in response to Speaker Leonard's formation of the C.A.R.E.S. Task Force, formed a Mental Health and Corrections workgroup to address the Task Force and to make recommendations regarding how to best improve the Michigan CMHSPs system regarding mental health and corrections. This report is a summary of the work group's efforts to date. Specifically, a system-wide inventory of all the initiatives its members are engaged in locally to address mental health and corrections.

III. Purpose of the Project

- Proactively describe the substantial efforts by the Michigan Community Mental Health system to address mental health and corrections.
- Identify and compile all the current initiatives.
- Identify where gaps in care exist.
- Develop a resource guide for advocates and policy makers.

IV. A Brief History of Mental Health and Corrections

The issue of mental health and corrections has deep historical roots. Criminologist Gwynn Nettler provides insight into the issue in his 1974 book, *Explaining Crime*. Nettler describes an 1843 rule promulgated from an English trial, The M'Naughten Rule, which attempts to distinguish what is and is not to be considered when a person commits a crime but is suspected to be mentally incapacitated. In the United States, when 31 States followed the M'Naughten Rule, a 1954 Court case in the District of Columbia, Durham v. United States, led to Durham's rule further extended the consideration of psychiatric influence in the commitment of a crime.

In the late 19th and early 20th Century, Dorothea Dix, perhaps the most visible humanitarian of her generation, became aware of a significant number of individuals suffering from mental illness in jails. This inspired her to focus on the need for moral treatment of persons with mental illness and through her ensuing work and advocacy led to the creation of the first generation of American mental hospitals. Most all of the Psychiatric facilities in Michigan were built in the late 1800's. They were quickly filled with societies most vulnerable and disabled citizens.

In 1963, President John F. Kennedy signed into law the Community Mental Health Act of 1963. This was the beginning of the public Community Mental Health system as we now know it. For the first 20 years, the system was designed and developed in every Michigan County, in partnership with locally elected County Boards of Commissioners, who helped fund and established local Community Mental Health governance boards. This CMH Act of 1963 was a harbinger of deinstitutionalization.

The closing of most State Hospitals and the return of patients to their communities, in the 1980's and 1990's, left many critics blaming a host of societal and community problems onto the mental health system, in spite of the fact that most of these institutions had become human warehouses, filled with abandoned people who were functionally incarcerated for no other reason than having severe disabilities and being abandoned by their communities to the State. The fact that a lack of adequate housing, employment, transportation and appropriate health care are more causal determinants of societal and community wellbeing for persons of mental illness or developmental disabilities is inexplicably minimized in the discussion.

Today, whether a person has a mental disability that may contribute to an intervention by law enforcement and the legal system, is a topic of considerable weight and consequence when determining the efficacy of our current mental health system. The proliferation of specialty courts is one significant effort aimed at making such determination and advocating for appropriate interventions. The role of local Community Mental Health in serving persons

involved in the legal system is continuing to emerge and evolve. Legal boundaries as well as additional funding for mental health services are major issues that require further resolution. Nonetheless, as the following report will document, communities are attempting to move forward to address the topic of mental health and corrections, at various levels, in every single county in the State.

V. Contemporary Issues

Presently, there is a great deal of emphasis and development regarding mental health and corrections. The current major initiatives in Michigan include the following:

- **Governor's Mental Health Diversion Council** was established via Executive Order in 2013 with the overarching commitment to "de-criminalize mental illness" through the implementation of pilot programs in identified counties lead by Governor's Liaison Steven Mays, in conjuncture with a MSU research team lead by Dr. Sheryl Kubiak and project Technical Advisor Dr. Debra Pinals. The current pilots are in Barry, Berrien, Detroit Central City, Detroit SW Community Court, Kalamazoo, Kent, Livingston, Marquette, Monroe, Oakland, and St. Joseph counties. Additional pilot counties are currently being identified.
- **The Stepping Up Initiative** is a national initiative started by the National Association of Counties, the Council of State Governments Justice Center and the American Psychiatric Association Foundation in May of 2015. This initiative has the general goal of reducing the number of people with mental illnesses in jails. The current counties participating in Michigan include Dickinson, Marquette, Charlevoix, Alpena, Huron, Genesee, Gratiot, Oakland, Macomb, Wayne, Monroe, Lenawee, Jackson, Washtenaw, Kalamazoo, Barry, Kent, and Muskegon.
- **House C.A.R.E.S. Task Force** is a bipartisan task force announced by Speaker Leonard in July 2017 to investigate the needs of the most vulnerable populations and compile a list of recommendations. Public meetings and testimonies were held in Livingston, Grand Rapids, Oakland, Lansing, Detroit, and Mid-Michigan. A final report with over 40 identified recommendations was published in January of 2018.

VI. Methodology:

The base of the project was established through research and discussion with a number of key informants in the field. The fundamental research included review of a 2007 publication by SAMSHA, "10 Years of Learnings on Jail Diversion from the CMHS National GAINS Center"; Dr. Munetz's and Dr. Griffin's 2006 article, "Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness"; and their resulting 2015 book, *The Sequential Intercept Model and Criminal Justice: Promoting community alternatives for individuals with serious mental illness*. Extensive research by Dr. Debra Pinals, MDHHS medical director of Behavior Health and Forensic Programs since 2016, provided further insight into the subject. Discussions with individuals in the field including phone consultations with researchers Vera Hollen and Amanda Wik from the National Institute of Research; statistician

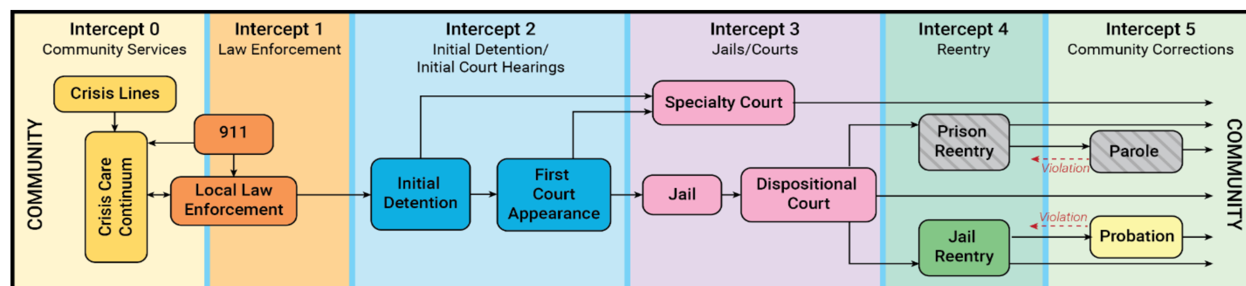
Jennifer Bronson from the Bureau of Justice Statistics; and Ross Buitendorp of Network 180 (Kent County) proved to be pivotal in guiding the project development.

After reviewing the research described above and discussing strategies of how to measure current initiatives with key informants in the field, a decision was made to use the existing Sequential Intercept Model first developed by Patricia Griffin et. al in 2015, as a rubric to guide CMHSP self-reporting. The Sequential Intercept Model is a nationally recognized framework that depicts jail diversion as a continuum of activities divided into five separate "Intercepts". As Griffin explains,

> *The Sequential Intercept Model provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems as they address concerns about criminalization of people with mental illness. The model envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system. (Griffen & Munetz, 2006)*

While attending the November "Stepping Up Summit" facilitated by Dr. Debra Pinals, it became apparent that it was necessary to include Intercept Zero. Intercept Zero was not part of Griffen's original model, but was adapted by SAMSHAs GAINS Center. Intercept Zero broadens the continuum to include programs and initiatives that serve as crisis care in the community prior to formal law enforcement intervention. The finalized questionnaire listed the following six intercepts of the Sequential Intercept Model.

Intercept 0 – Community Services
Intercept 1 – Law Enforcement
Intercept 2 – Initial Detention/Initial Court Hearings
Intercept 3 – Jails/Courts
Intercept 4 – Reentry
Intercept 5– Community Correction



Under each intercept, CMHSPs were requested to report on every initiative their agency was currently participating in. For each initiative identified, the CMHSP was asked to provide the following information: program description, date initiated, community partners, lead personnel, funding source, and tools used (if applicable). *See below for questionnaire format:*

Intercept	Initiatives	Date	Community	Lead	Funding	Tools

		Initiated	Partners	Personnel	Source	Used
0						
1						
2						
3						
4						
5						

In November 2017, CMHA of Michigan, through Executive Director Robert Sheehan, sent a RFI email to every CMHSP Director. Each director was asked to assure their CMHSP responded to Elizabeth Tompkins, the project manager, identifying the individual at their CMHSP who primarily works in jail diversion or mental health and corrections, and who would be responsible for completing the questionnaire. Each Director responded with an identified point person who was then sent two articles that defined and gave examples of the Sequential Intercept Model as well as a blank questionnaire. Following completion and return of the questionnaire, the project manager followed up with each respondent to ask clarifying questions as necessary.

The information provided in each questionnaire was recorded into a response matrix and analyzed through basic thematic coding of each reported initiative. Utilizing the key best practices of each intercept as identified through the GAINS Center, specific initiatives were quantified at each intercept for each completing CMHSP. The essential intitiatives for each intercept of the Sequential Intercept Model included the following: Intercept Zero (0) identified mobile crisis outreach teams, afterhours access centers, a 24-hour crisis phone line, and ongoing Crisis Intervention Training (CIT) as essential programs. Intercept One (1) included mental health training for police, police friendly drop offs to hospitals, crisis units, or triage centers, follow up and linkage to appropriate services, and communication between agencies. Intercept Two (2) focused on screening tools implemented for mental health and substance use disorders at the earliest opportunity, pretrial diversion programming, and care coordination with CMHSPs and other identified agencies. Intercept Three (3) looked for specialty court (mental health, veterans, substance use/drug/sobriety coordination) coordination, communication and coordination between courts and involved agencies, and jail-based programing and services. Intercept Four (4) included transitional planning before time of release from the jail, and warm hand-offs coordinated at the time of release between the jail and involved agencies. Lastly, Intercept Five (5) included a developed community of care including support for medical care, housing, and employment along with continued case management and supervision. For the purposes of this project, only the best practice initiatives of each intercept were tallied in order to provide a focused and concrete comparison state wide. *See below for visual depiction of the identified essential programs of each intercept, as identified by SAMSHA.*

VII. Data:

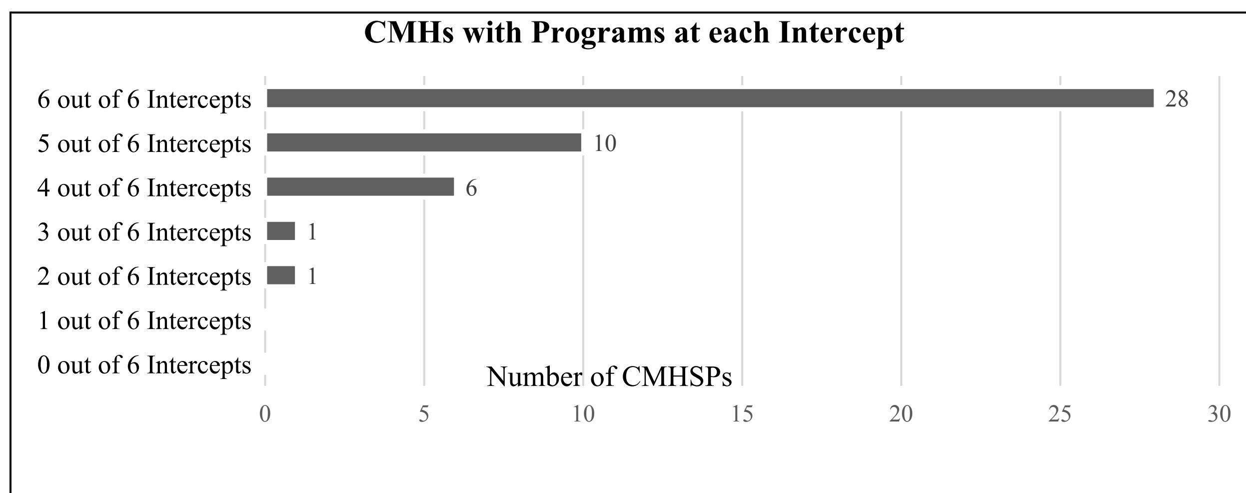
At the implementation of this project, it was our belief that if we could get a 70% response rate (32 boards), that we would be able to have relatively reliable data in order to generalize findings regarding the status of mental health and corrections initiatives across the state of Michigan. It took persistence and tenacity but at the end of three months a 100% response rate was achieved.

The fact that all 46 agencies completed the request is remarkable and demonstrates that the entire community mental health system in Michigan is working to resolve mental health and corrections issues.

The questionnaires were returned at varying degrees of completion and detail, depending largely on the complexity of the jail diversion programing at each agency, personnel available to respond to specific questions, and importance placed on the questionnaire completion request. While the majority of CMHSPs completing the questionnaires could provide answers to each of the prompts for every initiative (program description, date initiated, community partners, lead personnel, funding source, and tools used), some CMHSPs were unable to provide specific information for each initiative.

VIII. Preliminary Analysis:

Every Michigan CMHSP was able to identify at least one primary point person in their agency with specific knowledge in the subject of jail diversion or mental health and corrections programming. All 46 were able to identify current jail diversion initiatives on at least 2 intercepts of the Sequential Intercept Model. The preliminary results of the completed questionnaires demonstrate that 61% (28 CMHSPs) currently have essential jail diversion and mental health initiatives at each of the 6 intercepts. 21% (10 CMHSPs) have initiatives identified in 5 of the 6 intercepts. 13% (6 CMHSPs) have initiatives identified at 4 of the 6 intercepts. One CMHSP has programming identified in 3 of the 6 initiatives, and one CMHSP identified programing at 2 of the 6 intercepts. There are no CMHSPs unable to identify at least two initiatives on the Sequential Intercept Model. Some form of jail diversion or mental health and corrections programming is reported as an essential service at every CMHSP. *See below for further representation of the results.*



To further examine the degree to which each agency has provided the identified essential programing at every intercept, the information provided by the CMHSPs on their current programing and initiatives for each intercept responses were coded and labeled with the corresponding essential programing. The chart below depicts the essential Sequential Intercept Model reportedly occurring at each intercept for every CMHSP. For agencies who did not have

any of the essential programing in an intercept, the cell is left blank/white. For agencies who reported having some, but not all, of the essential initiatives active at the intercept, the cell is shaded grey. For each CMHSP that reported they currently provide each of the essential initiatives that defines the intercept, the cell is shaded black. This depiction enables the viewer to quickly gain a sense for which CMHSPs self-report that they are providing the essential jail diversion or mental health and corrections programming at every intercept.

Intercept 0
MCOT - Mobile Crisis Outreach Teams respond individually or with police officers
AC - After-hours ACCESS Centers
CL - 24-hr Crisis Phone Lines
CIT - Ongoing Crisis Intervention Training (CIT) Programs

Intercept 1
T - Mental Health Training for Police
DO - Police-Friendly drop offs to hospitals, crisis units, or triage centers
FU - Follow-up and linkage to appropriate services
C - Communication between agencies

Intercept 2
ST - Screening tools implemented for mental health and substance use disorders at the earliest opportunity
PtD - Pretrial Diversion Programs
CC - Care coordination with CMHs and other identified agencies

Intercept 3
SC-MH/V/D - Specialty court coordination (mental health, drug, and veteran treatment courts)
C&C - Communication and coordination between courts and involved agencies
JBP - Jail-based programming and

Intercept 4
TP - Transitional planning begins before release by the jail or by in-reach providers
WHO - Warm hand-offs coordinated at the time of release between jail and involved agencies

Intercept 5
S (M, H, E) - Community of care is facilitated (support for medical, housing and employment needs)
CM - Continued case management and supervision

Response Color Key	
Meaning	**Color of Cell**
No essential programing taking place in the intercept	
Partial programming identified in the intercept (i.e. two of the four essential programming is taking place)	
All essential programing is currently active	

CMHSP	Int. 0	Int. 1	Int. 2	Int. 3	Int. 4	Int. 5
Allegan County CMH Services						
AuSable Valley CMH Authority						
Barry County CMH Authority						
Bay-Arenac Behavioral Health Authority						
Riverwood						
Centra Wellness Network						
CMH Authority of Clinton-Eaton-Ingham County						
CMH of Ottawa County						
CMH & SA Services of St. Joseph County						
CMH of Central Michigan						
Copper County CMH Services						

Detroit Wayne Mental Health Authority						
Genesee Health System						
Gogebic CMH Authority						
Gratiot Integrated Health Authority						
HealthWest						
Hiawatha Behavioral Health						
Huron Behavioral Health						
Kalamazoo CMH & Substance Abuse Services						
Lapeer County CMH Services						
Lenawee CMH Authority						
LifeWays CMH						
Livingston County CMH Authority						
Macomb County CMH Services						
Monroe CMH Authority						
Montcalm Care Network						
Network180						
Newaygo County Mental Health Center						
North Country CMH						
Northeast Michigan CMH Authority						
Northern Lakes CMH Authority						
Northpointe Behavioral Healthcare Systems						
Oakland Community Health Network						
Pathways CMH						
Pines Behavioral Mental Health						
Saginaw County CMH Authority						
Sanilac County CMH						
Shiawassee County CMH Authority						
St. Clair County CMH Services						
Summit Pointe						
The Right Door for Hope, Recovery and Wellness						
Tuscola Behavioral Health Systems						

VanBuren CMH Authority						
Washtenaw County CMH						
West Michigan CMH System						
Woodlands Behavioral Healthcare Network						

For the complete coded response matrix of what essential programs were identified for each CMHSP by intercept, see Appendix.

By examining the chart above, it becomes clear that the majority of essential initiatives of the Sequential Intercept Model consistently occur in Intercepts 2 and 3. The most limited programming is reported at Intercept 0 and at Intercept 5. It can be said that the majority of the current jail diversion programing and initiatives take place within the middle of the Sequential Intercept Model. Programming is more underdeveloped at both ends of the continuum. For a further breakdown of responses by intercept, see below:

Intercept 0 (Community Services): 40 of the 46 CMHSPs (87%) reported essential initiatives taking place in Intercept 0 in their communities. 16 CMHSPs stated that they have active Mobile Crisis Outreach Teams (MCOT) who respond individually or with police. 14 CMHSPs report that they have afterhours ACCESS centers currently functioning within their communities. Only 26 CMHSPs identified that they currently have an active 24-hour crisis phone line. 15 CMHSPs reported that they currently have ongoing CIT training programs.

Intercept 1 (Law Enforcement): 98% (45 of 46) of CMHSPs reported initiatives currently active within Intercept 1. Ongoing mental health trainings for police and dispatch officers is currently available in 36 CMHSPs. 31agencies identified that police friendly drop offs can occur to hospitals, crisis units, or triage centers in their communities. 63% (29 of 46) of the CMHSPs state that follow-up and linkage to appropriate services is provided, and 38 CMHSPs report significant communication between agencies.

Intercept 2 (Initial Detention/Initial Court Hearings): 45 out of 46 (98%) CMHSPs identified programing within Intercept 2. 89% (41) of CMHSPs state that they are implementing screening tools for mental health and substance use disorders at the earliest opportunity. 34 of the 46 agencies report active pretrial diversion programs in the jail and 89% (41 out of 46) CMHSPs cite care coordination with other agencies.

Intercept 3 (Jails/Courts): 100% of CMHSPs reported at least some essential programing within Intercept 3 in their communities. Specialty court coordination (in general) was reported to be taking place at 28 (61%) of CMHSPs. Specifically, 23 CMHSPs reported an active Mental Health Court, 2 agencies reported an active Veterans Court, and 13 CMHSPs stated that they were currently participating in Drug/Sobriety Court. Communication and coordination between courts and involved agencies was listed as an essential initiative at 40 (87%) CMHSPs. 33 agencies report that they currently have active jail-based mental health and substance use programing and services.

Intercept 4 (Reentry): 39 agencies (89%) reported programing within Intercept 4. 38 CMHSPs state that transitional planning begins before release by the jail or is coordinated by in-reach providers. Only 12 CMHSPs identified that their agency coordinates a warm hand off at the time of release from jail between the jail and the involved agencies.

Intercept 5 (Community Correction): 32 CMHSPs (67%) reported current initiatives taking place within Intercept 4. 22 agencies state that a community of care is facilitated though support provided for medical, housing, and employment needs. 22 agencies also reported that their CMHSP provides continued case management and supervision.

IX. Limitation of the Project

There are a number of limitations with this project. Primarily, the questionnaire was created as a self-reporting tool and relied entirely on the individual staff completing the questionnaire to understand the terms and subjects discussed. While there was an individual identified at each agency, not every agency identified a sole particular individual for each specific initiative, which may affect the information each CMHSP reported. Additionally, this survey did not include the responses or point of view of other stake holders (court, corrections, law enforcement). This survey also did not verify the depth and adequacy of the reported services provided at each intercept by the reporting CMHSP.

It is obvious from the breadth of programming and responses that there is an integration of initiatives by community mental health organizations and state agencies that reaches far beyond the scope of what we were able to capture in our limited time. This project was unfunded and completed by volunteer project coordinators, who are the principal authors of this report.

This project was not intended to measure success or failure, it was intended to examine the evolutionary process of each organization in the area of mental health and corrections. The results should be viewed as an examination into where better practices can be evolved and developed. In fact, a number of CMHSPs reported that they are in the process of implementing additional initiatives along the Sequential Intercept Model in the time after completing the questionnaire. Therefore, it is important to acknowledge that this report captures a particular moment in time of mental health and corrections programming in the state of Michigan.

X. Next Steps

1) Moving forward in the area of mental health and corrections initiatives, it is important to continue to create a common language and understanding, through the use of the Sequential Incept Model, of what jail diversion means and continue to examine how to measure what programs are currently taking place and what areas are lacking in development.
2) It will be important to adopt the Sequential Intercept Model as the principle framework against which to identify, build, and measure success.
3) Each CMHSP should reflect on areas of need and program development and seek funding to fill in each of the intercepts for their community.

4) The most important variable that does not appear to be addressed in mental health and corrections initiatives at this time is Substance Use Disorder. This must be given a higher priority and integrated in all mental health and corrections initiatives.
5) A permanent committee/workgroup should be established by CMHAM to identify and implement best practices; problem solve cases and situations; and to build an adequate, integrated funding model for mental health and corrections.

IIV. Appendix

Complete Response Matrix

Intercept 0
MCOT - Mobile Crisis Outreach Teams respond individually or with police officers
AC - After-hours ACCESS Centers
CL - 24-hr Crisis Phone Lines
CIT - Ongoing Crisis Intervention Training (CIT) Programs

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WHO - Warm hand-offs coordinated at the time of release between jail and involved agencies

Intercept 5
S (M, H, E) - Community of care is facilitated (support for medical, housing and employment needs)
CM - Continued case management and supervision

CMHSP	Intercept 0	Intercept 1	Intercept 2	Intercept 3	Intercept 4	Intercept 5
Allegan County CMH Services	MCOT*, CL, CIT	DO, C, FU				
AuSable Valley CMH Authority	CL	DO, FU, C		C&C	TP	
Barry County CMH Authority	CL	T	ST, PtD		TP	
Bay-Arenac Behavioral Health Authority		T, FU, C		C&C, JBP		
Riverwood	CIT	DO, FU, C		C&C, JBP	WHO	S (M, H, E)
Centra Wellness Network	MCOT, CL	T, FU, C			TP	
CMH Authority of Clinton-Eaton-Ingham County	AC, CIT					CM
CMH of Ottawa County	CL	T, C, FU		SC-MH/D, C&C	TP	CM
CMH & SA Services of St. Joseph County	AC, CL, CIT			C&C, JBP		
CMH of Central Michigan	MCOT	T, DO, C		C&C, JBP	TP	
Copper County CMH Services	CL			C&C, JBP	TP	

Detroit Wayne Mental Health Authority		T, FU, C			TP	
Genesee Health System	MCOT, CL				TP	S, CM
Gogebic CMH Authority	CL	T, C		C&C, JBP		S
Gratiot Integrated Health Authority	CL	DO	PtD	SC-MH		
HealthWest	MCOT				TP	
Hiawatha Behavioral Health			ST, CC	SC-MH	TP	S (E, H)
Huron Behavioral Health	MCOT, AC		ST, CC	C&C	TP	S
Kalamazoo CMH & Substance Abuse Services	MCOT, CIT	T, DO, C	CC	SC-MH/D/V	TP	
Lapeer County CMH Services	AC, CL	T, C	ST, CC	SC-MH, C&C	TP	S (M, E)
Lenawee CMH Authority			ST, CC	SC-MH/D		
LifeWays CMH	CIT	DO	CC	SC-MH	TP	
Livingston County CMH Authority	CIT*	T, DO, C	ST, CC	C&C		
Macomb County CMH Services	CL, AC	FU, C		C&C, JBP		
Monroe CMH Authority	MCOT, AC, CIT					
Montcalm Care Network	CL				TD	CM
Network180	AC, CL, CIT					CM
Newaygo County Mental Health Center		T, DO, C	ST	C&C, JBP	TP	S (M, H)
North Country CMH		T, DO	ST, PtD,	C&C, JBP	TP	CM
Northeast Michigan CMH Authority	CL			C&C	TP	S (M, H)
Northern	MCOT, CL	T, FU, C		C&C, JBP		

Lakes CMH Authority						
Northpointe Behavioral Healthcare Systems				C&C, JBP	TP	
Oakland Community Health Network	CL, CIT	T	ST, CC	SC-MH/D, JBP		CM
Pathways CMH	CIT	T, FU, C			TP	CM
Pines Behavioral Mental Health	MCOT	C	ST, CC	JBP, C&C	TP	
Saginaw County CMH Authority	MCOT				TP	CM
Sanilac County CMH	CL, AC	T, DO, C		C&C	TP	
Shiawassee County CMH Authority	CL					
St. Clair County CMH Services	MCOT, AC			SC-MH, C&C		
Summit Pointe		T, DO, C	PtD, CC			S
The Right Door for Hope, Recovery and Wellness	MCOT, CL					S
Tuscola Behavioral Health Systems	AC, CL, CIT				TP	CM
VanBuren CMH Authority	MCOT, CL, AC	DO, C			TP	S
Washtenaw County CMH	MCOT, CL	T, FU, C			TP	
West Michigan CMH System	AC, CL	DO		C&C, JBP	TP	CM
Woodlands Behavioral Healthcare Network	CL, CIT	DO, FU, T	ST, CC			

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