

Access to Youth Mental Health Care in a Rural Setting: Michigan's Upper Peninsula

Isabelle R. Nebel and Brian D. Cherry

Department of Political Science, Northern Michigan University

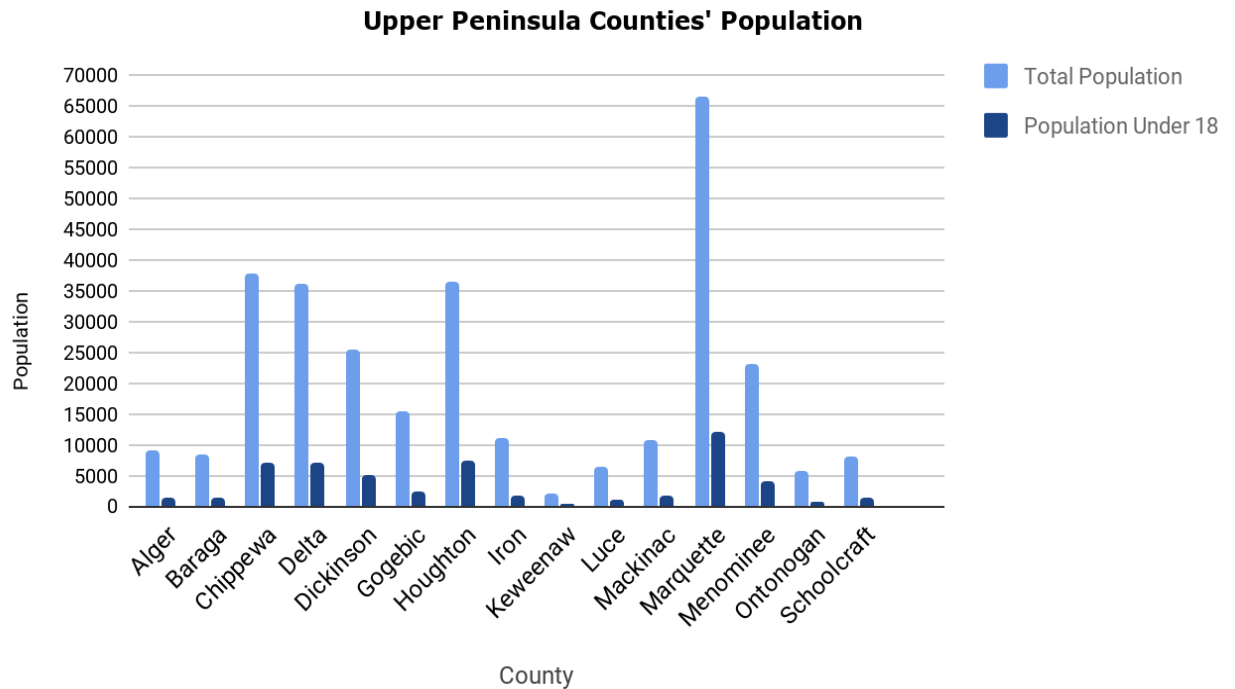
Abstract

The number of children and youth committing or attempting suicide is on the rise in a dramatic and disturbing way. Officially, suicide is the second leading cause of death among youth age 15-24, and for every suicide death among this population, there may be as many as 100 to 200 suicide attempts (Youth.gov). Depression and anxiety is commonplace for people under 18, and is often a stepping stone for more severe mental health diagnoses continuing on into adulthood if left unaddressed. Although it is common for individuals to experience temporary emotional distress as they progress through childhood, rates of mental health diagnoses are alarming and for a variety of reasons, children are not receiving the mental health services that they need in order to live healthy and productive lives. In the case of the Upper Peninsula of Michigan, known as the “U.P.,” the problem is only intensified by geography. Its rural nature creates added barriers to accessing mental health care, exacerbating a national shortage of physicians and psychiatrists further, where only one child psychiatrist serves the entire Upper Peninsula. There are no inpatient beds for children who experience serious mental illnesses, and instead, they are driven up to 9 hours away from home to a facility either in Grand Rapids or Green Bay. The financial costs of mental health care can prove to be too heavy a burden for Medicaid carriers, private insurance carriers, and especially the uninsured.

According to the Office of Adolescent Health (2018), access to care generally includes three components; (1) gaining entry into the healthcare system, usually through insurance coverage (2) accessing a location where needed health care services are provided, based on geographic availability, and (3) finding a health care provider whom the patient trusts and can communicate with. As examined in this report, Michigan’s Upper Peninsula lacks adequacy in all 3 areas of access.

Poor mental health and mental illness have profound effects on communities, families, and the individual. As citizens and neighbors, the Upper Peninsula must take action towards improving the lives of those who are the future of this country. Mental health has been difficult to quantify as compared to physical health, but its effects are felt increasingly and with more regularity in youth populations. If we demand an equal opportunity to seek care for visible illnesses, we must also address the invisible ones that take the lives of children daily. Health care providers and the State of Michigan must take steps to alleviate the burden of accessing mental health care for youth, as mental health is linked to overall happiness and prosperity within a society. If we allow our youth to fail, our society will fail; we must step up for our children.

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The total population of Michigan's Upper Peninsula, according to the 2019 County Health Rankings, is 302,077 people. 17.2% of these individuals are under the age of 18 (Robert Wood Johnson Foundation & University of Wisconsin Population Health, 2019). These figures suggest that there are approximately 52,000 people under 18 in the Upper Peninsula. The Upper Peninsula's youth population and their access to mental health services will be the primary focus of this report.

On average, Michigan's mental health-related problems in children is higher than the national. About 37% of Michigan high school students reported feeling sad or hopeless almost every day for 2 or more weeks so they stopped doing their usual activities, where the national rate is 31% of students. The percentage of attempted suicides is bleakly correlated to these feelings, with 9% of Michigan high school students reporting they attempted suicide, 2% higher

than the national average (Office of Adolescent Health, 2018). Although it is common to associate mental health with these mentioned negative occurrences, it is important to note that mental health also encompasses much, much more. “It includes emotional well-being, psychological well-being, and social well-being and involves being able to... navigate successfully the complexities of life, develop fulfilling relationships, and adapt to change...” (Youth.gov). When youth are offered services in these crucial areas of mental health, they acquire the tools necessary to live productive lives, deal with challenges as they are presented, and pass these lessons then on to their children. Unfortunately, the Upper Peninsula lacks basic mental health care for its youth, and the consequences are borne by all.

Capacity for Upper Peninsula Counties to Deal with Youth Mental Health

In the graphic found below, we compiled rankings and measured data provided by the Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute in 2019, from all of Michigan's 83 counties. These rankings include the percentage of uninsured children, the ratio of mental health providers to residents, and the percentage of individuals living in a rural area. Assigning a point value from 1 to 10 for each of these factors, 10 being the “worst” and 1 being the “best,” an overall score was assigned to each county in the State of Michigan. Note that due to the extremely low population in Keweenaw County, no data was provided for the three factors, thus it is unable to receive a score. Otherwise, these basic measures provide a fairly accurate reflection of adolescents' ability to access mental health care in Michigan, based on the ability to gain entry into the healthcare system, access a location where mental health care is provided, and find a health care provider whom patients can communicate with and trust.

that tribal populations have faced centuries of forces that have annihilated their ways of life. The lasting effects of abuses against the Native American people include disproportionately high levels of joblessness, poverty, substance abuse, mental health disorders, broken homes and violence, and low levels of educational attainment (Sarche & Spicer, 2008).

In addition to these scored factors, there are numerous additional barriers to youth access referenced consistently in the youth mental healthcare field. Some of these restrictive factors include transportation and lack of nearby inpatient beds, Medicaid, high costs of care, stigma, primary care physicians' lack of comfort with mental health, and homelessness and foster care.

Percentage of Uninsured Children

Insurance coverage plays a critical role in accessible mental healthcare for children. Those families who cannot afford insurance for themselves or their children, or who are not enrolled for government insurance programs such as Medicaid, are highly unlikely to be able to afford the services upfront.

Without health insurance, many patients may opt to not get the preventative care they need, and may not seek care until their condition is more difficult and complicated to treat. These patients could incur large medical bills or seek treatment in an Emergency Room, which is far more expensive than a primary care setting. After initial treatment, the patient may not get the follow-up care they need and end up back in the Emergency Room. This continuous cycle can place a heavy burden on the health care system, especially in cases of uncompensated care (Michigan Dept. of Community Health, 2008, p. 30).

Low income families without insurance may not be able to recognize what poor mental health looks like in their children, so they may never be diagnosed or suspected to have poor mental health in the first place. Mental illnesses are left to advance and then treated only upon reaching a crisis point, such as in a severe mental break or an attempted suicide. Oftentimes, the only treatment sought out for such occurrences is within an ER setting, which do not hire professionals to deal with youth mental health. In addition, these low income and uninsured

families with historically high rates of mental illness and substance abuse pass down the life lessons from their own upbringing, which have direct consequences on the mental health of their children. In essence, poor mental health can be passed down through the generations by lack of recognition of mental health problems and years of ignoring the possible signs. Being uninsured as a child in the Upper Peninsula doesn't only prohibit accessing care for financial reasons, it is also a sign that you may be in a generational loop of poor mental health, which is difficult to break without an initial diagnosis, counseling, and proper mental healthcare.

Ratio of Mental Health Providers to Residents

All fifteen counties in the U.P. have multiple federal designations for health professional shortages, known as Health Professional Shortage Areas, or HPSAs. Federal HPSA designations in the Upper Peninsula's mental healthcare sector include geographic HSPAs, high needs geographic HSPAs, and low income population HSPAs (Health Resources & Services Administration). To figure the severity of the HPSA, each county is assigned a score from 0-25 based on population to provider ratio, percentage of the population below 100% of the Federal Poverty Level, travel time to the nearest source of care outside the HPSA designation, among several other factors. Upper Peninsula counties score between 13 and 18 in mental healthcare, where 25 is the "worst", not counting state correctional facilities (Health Resources & Services Administration, 2016). According to Michigan State University study Examining Access to Psychiatric Care in Michigan's Upper Peninsula, the number one barrier to care is long waitlists in psychiatry offices. Other operational psychiatric offices weren't taking new patients or did not have another professional nearby to refer them to. This highlights the need to increase the amount of mental healthcare providers in order to mitigate long waitlists and reduce the need to look out of county, or out of the Upper Peninsula, for care.

It is important to note that the ratio of mental health providers to residents in our graphic combined both adult and youth mental health providers, and does not take into account the heightened difficulty for children to access care compared to adults in the U.P. Across the entire state of Michigan, there were just 293 adolescent's and children's psychiatrists in 2017, equating to about 1 psychiatrist for every 9,100 children (Van Buren, 2019). According to the Office of Adolescent Health, 65 Michigan counties have no child psychiatrist, and Michigan's average ratio of mental health providers to young people is 404:1 (2018). In the Upper Peninsula, there is only one child psychiatrist employed through Pathways, a community mental health, causing that ratio to amplify to 1 psychiatrist per approximately every 52,000 children. According to Brittany Pietsch from NorthCare Network, the central intake for Community Mental Health in the Upper Peninsula, during fiscal year 2018, they served 1,231 children with serious emotional disturbances under the age of 18 through Community Mental Health's in the U.P. (B. Pietsch, personal communication, September 23, 2019). This number is relatively small compared to the apparent demand and population. Youth across the Upper Peninsula must travel hours to Dr. Klamerus in Marquette and face months-long waitlists for their initial consultation, if they are accepted in the first place. In addition, it takes an average of 19 phone calls to find an inpatient psychiatric bed in Michigan, while there's an average of 180 people on the wait-list for 770 beds in State-Run Hospitals (Mack, Hiner, & Robinson, 2019). It is difficult to know the true consequences of children waiting this long for care. One psychiatrist to serve 52,000 children is unacceptable and offensive to rural communities who have high rates of mental illness and suicide, and likewise, the U.P. should be at the forefront of national health concern.

Percentage Living in Rural Communities

Our final ranked data in the graphic affecting access to mental health care for youth is the percentage of the population in each county living in a rural area. The concept of “rurality” is not novel for those families who must find mental healthcare services for their children urgently. “The United States' workforce shortages in mental healthcare are greatest in rural and low-income areas. These provider shortages may lead to rural patients being put on long waitlists in order to receive necessary care” (Rural Health Information Hub). Additional impediments to care that ruralness adds, according to the Rural Health Information Hub, is lack of anonymity when seeking treatment, lack of culturally competent care, affordability of care, shortages of mental health workforce professionals, and transportation to care. Affordability of care, shortages of mental health workforce professionals and transportation to care will be discussed in detail in subsequent pages of this report.

Anonymity and privacy is extremely important in mental healthcare, and stigma around mental health causes embarrassment and creates reluctance for individuals to accept care from people in their town. Doubts about confidentiality can dictate whether a person accepts care or suffers from a mental health diagnosis. Lack of culturally competent care is a fairly unique problem attributed to rural areas, because more than 20% of rural residents identify as Native Americans or people of color. With few mental healthcare options, it is difficult for these individuals to find services from individuals who share and understand their culture. Fortunately for the Upper Peninsula’s Native American Population, there are several available Tribal Health Centers that offer some mental health services: Bay Mills Health Center, Hannahville Indian Community Health Center, Sault Tribe Health Center, Keweenaw Bay Indian Community, and the Lac Vieux Desert Band of Lake Superior Chippewa Indians. These Tribal Health Centers

often have offshoots in small communities with tribal populations, but despite this, rates of suicide and mental illness remain shockingly high in Native American populations.

There is no clear or universally accepted definition of rural. The Office of Management and Budget defines rural as areas not classified as either metropolitan or micropolitan. The United States Census Bureau defines rural as, "All territory, population and housing units located outside of urban areas and clusters... Urban areas have a population of at least 50,000 and urban clusters include areas with populations between 2,500 and 50,000" (Michigan Dept. of Community Health, 2008, p. 4). According to these definitions, the U.P. is rural in regards to both measures; population and distance from urban centers, and approximately 66.4% of the Upper Peninsula's population is rural (Office of Adolescent Health, 2018).

Distance to Travel to Facilities and Transportation

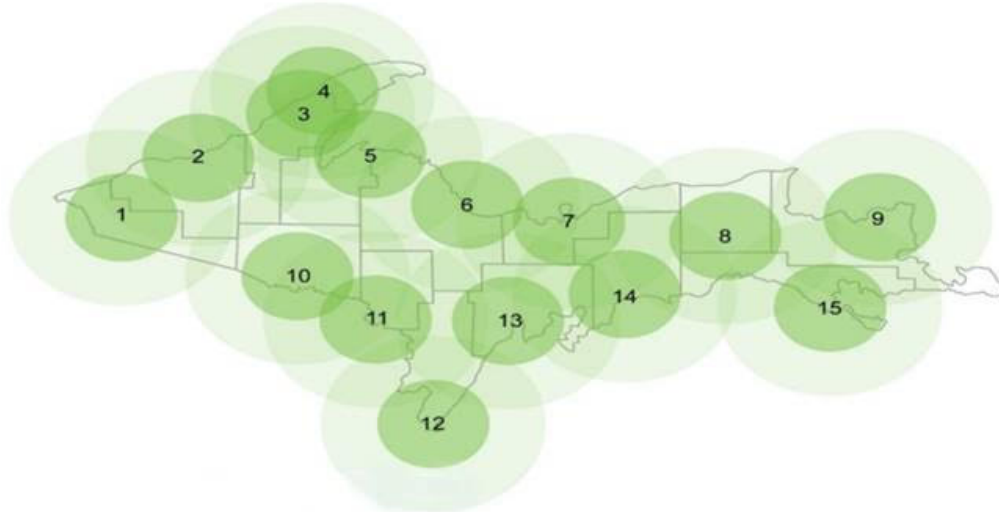
There are no pediatric inpatient beds in the Upper Peninsula, so children experiencing severe psychiatric ailments are usually held in emergency rooms until they are placed in an inpatient bed elsewhere or released. Children who find themselves in the ER for mental health require immediate care and psychiatric evaluation, but instead, their experience is traumatic and stressful. Jennifer Santer, CEO of Teaching Family Homes, recounted instances of children remaining in the emergency room for three to five days until finally being released despite receiving no mental health treatment. Many children say what they think they have to in order to be released from the ER, and underplay the severity of their symptoms. Their issues usually never subside and their mental health isn't treated during their stay (J. Santer, personal communication, September 4, 2019). If a child is considered to have a severe enough diagnosis, they may be placed in an inpatient bed, which is up to a 9-hour drive for some U.P. residents.

The nearest pediatric inpatient facilities are located in Grand Rapids, either Pine Rest or Forest View, and Green Bay's Willow Creek. Usually, family members or connected parties are responsible for arranging travel and oftentimes take days off work to drive their child to the facility. Mary Swift is the CEO of Pathways, an Upper Peninsula Community Mental Health, and cites transportation as one of their barriers in securing inpatient care for children. In the past, Pathways has received grants to put towards covering the costs of transportation, but these have recently run out so there is no assistance for families who must make travel arrangements for their children's inpatient care (M. Swift, personal communication, September 30, 2019). This is especially problematic for single-parent households and for those who live in poverty who may not have access to reliable transportation.

Transportation barriers also lead to mental health appointment "no-shows." Once a child is enrolled for some mental health service, the expectation is that for the program to be successful, they must attend meetings regularly and at scheduled times. If a parent or connected party is unable to arrange transportation, that child will miss their appointment and go without care until their next meeting. Considering the difficulty of entering the mental health system in the first place, many patients cannot afford to miss appointments and no one should go without treatment for longer than recommended. Additionally, extreme winter weather events in the U.P. are unavoidable difficulties for transportation; high winds, thunderstorms, snow, slush, and ice all deter travel. Bob Mellin of Great Lakes Recovery explains that no-shows are a lose-lose for both the child and the mental health provider. Insurance programs in the state like Medicaid currently operate under a fee-for-service model, meaning providers do not get compensated for missed appointments. This is despite having time set aside for the child that could have otherwise been filled by another patient (B. Mellin, personal communication, October 2, 2019). Finally,

school mental health clinics around the U.P., which will be discussed in greater detail in this report, accept children from any school district; but lack of transportation and missing school prohibits many children from utilizing the resource.

The map below was provided by North Care Network. Here, the dark green area represents the urban rule of 30-minutes/30-miles from each Community Mental Health office. The light green area represents the 60-minutes/ 60-mile radius from each Community Mental Health office. Note that Menominee County has two offices, one is located by #12 on the map (B. Pietsch, personal communication, September 23, 2019).



Difficulty Accessing Mental Healthcare for Medicaid Recipients

Medicaid provides insurance coverage for 64.5 million people in the United States, including low-income adults, children, pregnant women, elderly adults, and people with disabilities. Financial eligibility is determined by taxable income. It is provided by states under federal guidelines, and is funded jointly by the two (United States Government). States can also choose to cover children who are in foster care and would not be otherwise eligible; Michigan is a state whose foster children are automatically eligible. “State Medicaid programs are the largest

payers of both mental health and substance abuse related hospitalizations: 28% of mental health stays and 26% of substance abuse stays are for Medicaid beneficiaries” (Piper, 2012).

A drawback to any health insurance program, but especially state programs like Medicaid, is that private psychiatrists and mental healthcare providers are much less likely to accept any patients who are insured. Comparatively, “55 percent of psychiatrists accept patients covered by Medicare, against 86 percent of other doctors. And 43 percent of psychiatrists accept Medicaid... while 73 percent of other doctors do” (Pear, 2013). Possible reasons for this lack of acceptance is that private psychiatrists have such a high demand as it is that they do not need to accept insurance, and because it takes more time to administer therapy than other types of healthcare. Since Medicaid carriers and private insurance carriers alike are turned away by private care, they are forced to resort to underfunded and highly demanded resources such as community mental health. This bogs down an already bogged down system. Mental healthcare providers are also reluctant to accept Medicaid because it utilizes fee-for-service, meaning the provider is compensated for care administered. The fee-for-service method presents drawbacks that will be discussed later in this report.

High Cost of Care

Accessing mental healthcare is an extremely costly and time-consuming endeavor. There are also costs of transportation and lost time at work, which may not be a feasible expense for low income families who do not have insurance. First, consider the cost of receiving care in the ER, a common destination for many low income families who have children with mental health related occurrences. Due to a federal law passed in 1986 called the Emergency Medical Treatment and Active Labor Act, the upside of emergency rooms is that they treat a patient whether they are insured or not, and the downside is that you will be charged whether you can

pay the bill or not. It applies to all hospitals that accept Medicare, and nearly all do, so most emergency rooms adhere to this rule. “The decision to receive treatment at an emergency room is one of the many reasons Americans spent \$3.65 trillion on healthcare in 2018. It’s also a factor for why more than 75 million people complained they were having problems paying off medical debt, which happens to be the No. 1 cause of bankruptcy in the U.S.” (Debt.org). The average cost of an emergency room visit in 2017 was \$1,389, and if poor individuals cannot afford the costs, the hospitals typically remain uncompensated for the care administered.

The preferred route to mental health care is to seek specialized care for children who have received a diagnosis. This typically takes form in counseling and consultations with a psychiatrist. Therapy ranges from \$65 dollars per hour to \$250 or more, but most often is \$100 to \$200 dollars per hour. That cost is affected by the therapist’s level of training, location, insurance coverage, length of sessions, and specialization. Additionally, “many therapists work with a sliding scale fee schedule, which means their fee will depend on your income level” (GoodTherapy, 2019). The cost of consulting with a child psychiatrist varies based on the specific diagnosis and price point of that psychiatrist. You or your insurance are charged for the evaluation, talk-therapy sessions, and for any medications prescribed. Typical psychiatrist costs are \$120 to \$200 for an hour appointment (Heuberger, 2015). It is easy to see how the costs of emergency room visits and specialized care can quickly add up and become overwhelming. Kip Piper estimates that the average cost of hospitalization for mental health reasons is \$5,700 per stay, and \$4,600 per substance abuse related stay.

On the other end of the spectrum is the fiscal infeasibility of maintaining a psychiatric inpatient unit in a rural area. Reimbursement rates for psychiatric inpatient care are a fraction of what a hospital could receive for an acute-care bed. This lack of revenue makes it practically

impossible to staff full-time specialists or to keep them in rural areas long-term. Costs of mental healthcare are too high for both the patients and care providers, causing a void in access to care.

Stigma

The stigma surrounding mental health has long been understood as a main deterring factor for those considering getting treatment. In general, societal stigma causes reluctance or refusal to seek care or to admit that a problem exists in the first place. It's no secret that mental health has a long history of being criminalized and misunderstood, which does not encourage individuals suffering from poor mental health to reach out for care. The desire for confidentiality is amplified in mental healthcare, and in a rural area this is an especially prominent concern. There are not many therapists in small towns across the Upper Peninsula, which presents several problems, but especially for those concerned about confidentiality. If an individual knows the mental healthcare provider, they may be especially worried about judgement and their information remaining secret. Students who have access to mental health clinics in school may be reluctant to go to the counselor for fear of their classmates finding out or in fear of their information being leaked to their peers. If children experiencing problems with their mental health do not feel safe revealing their condition, they will not seek care.

With the emergence of telehealth and telephone assessments, fear of judgment prohibits these individuals from benefiting from these emerging and helpful services. Telehealth requires that patients and doctors disclose deeply personal information over the phone regarding the child's mental condition. In addition, for most Medicaid claims, patients go through an initial phone assessment to determine severity. In both instances, parents and children may feel reluctant to disclose the most severe aspects of the case for fear of judgment. Details crucial to the wellbeing of the child are unaddressed, and as a result, the assessment may show the case as

less severe than it really is. This can prohibit Medicaid insurance carriers from receiving coverage. For the case of Community Mental Health, which accepts Medicaid, they only accept patients with severe mental health diagnoses, and may deny patients who don't meet their criteria. In conjunction with insurance being affected, quality and appropriateness of care is warped due to omitted information and some of the most troubling aspects of a child's life may never be discussed. Stigma ultimately affects the comfortability of a child to seek care from a professional who they feel able to communicate freely with.

Primary Care Physicians Lack Comfortableness with Mental Health

Primary care physicians (PCPs) could bridge the gap between youth mental health diagnosis and psychiatrist intervention. According to Turner, "Three-quarters of all children eventually diagnosed with a mental health condition are initially seen in primary care" (2013). Turner classifies children as having a mental health diagnosis if they are determined to have, "a schizophrenic, affective, neurotic, personality or conduct disorder; emotional disturbance; or hyperkinetic syndrome." PCPs have adequate training to handle and diagnose some of these mental health diagnoses in children, and are generally comfortable providing care for youth with less severe diagnoses, like depression and anxiety. They can prescribe medication and conduct basic counseling in moderate cases, and due to the shortage of child psychiatrists, most PCPs who work with youth report that they are spending about 40 percent of their time on mental health cases (Van Buren, 2019).

Primary care physicians may not be comfortable, however, with handling more severe instances of youth mental health, such as bipolar disorder, substance abuse, or schizophrenia, which are more complex and time consuming to treat. Most PCPs are not trained to deal with and are not offered continued training that would allow them to treat severe mental health cases in

primary care within the youth population, partially due to the expenses that these diagnoses tend to incur. As a result, PCPs usually refer these youth elsewhere, despite the cited issue of not having a local provider that they can refer to in rural Upper Peninsula counties. Consequently, PCPs are an underutilized, underfunded, and undertrained resource for families of children with severe mental health diagnoses.

Homelessness and Foster Care

Homelessness and foster care create inescapable barriers for children with mental health issues. Currently, 16% of Michigan residents deal with severe housing problems, and for the youth within this population, access to a consistent and safe shelter is merely a concept. Houghton County leads the Upper Peninsula in severe housing problems, hovering at the State average of 16% (Office of Adolescent Health, 2018). Most often, homeless shelters and foster families do not have the adequate means to deal with severe cases of mental illness. Teaching Family Homes of Upper Michigan, a facility that houses children with occasional suicidal ideation, is required to take expensive and tedious measures that are not available in most foster or homeless situations; triangle doorknobs, dressers built into walls, and strict control of objects with strings or cords. Besides the inability to take such measures, foster families and homeless shelters that house children are not usually trained to handle manifestations of mental health issues. “Youth expressions of distress ensue that foster parents and other supportive adults may not be equipped to manage” (Bertram, 2018). Finally, foster families and homeless shelters operate on too narrow of a budget to adequately care for and secure treatment for a child with severe mental health issues, even if the child has Medicaid insurance coverage.

Mental health issues existing during a child’s time in foster care or homelessness persist into adulthood, and present severe societal issues. “Quality of life outcomes of youth who have

lived in foster care are bleak... many struggled with securing and maintaining housing, obtaining stable employment, and attaining education achievement. They have also suffered disproportionately with health problems and legal system involvement” (Bertram, 2018). This outcome is brought on in part by the traumatic experiences and mental health problems that most youth have prior to entering the foster system. According to Bertram, over 95% of youth entering foster care have experienced at least one traumatic event, and up to 80% of all youth in care experience severe emotional problems. Despite this, psychiatrists, psychologists and therapists are usually not present at family support team meetings, held regularly to address a child’s care and mental health status. The issue of care is exacerbated because children are typically not placed permanently, and bounce from home to home. This general absence of medical oversight and lack of continuity has resulted in many of these children slipping through the societal cracks, and now, “the over-medication of foster youth has reached alarming proportions as evidenced by public press reports, a national audit of the foster care system, changing legislation to tighten oversight; and several class action lawsuits” (Bertram, 2018). Youth who face homelessness are also at a distinct disadvantage in the way of their future; according to Greenberg and Rosenheck, severe mental health issues are more prevalent among the homeless population than the general public. In addition, homeless individuals are more likely to enter the criminal justice system, particularly for violent crimes, to have substance abuse problems, and to commit crimes that are manifestations of their mental illness and their lack of ability to cope with homelessness. A staggering 20.1% of people experiencing homelessness in the U.S. have a serious mental health condition (National Alliance on Mental Illness). In a rural area such as the Upper Peninsula where mental health care is already difficult to attain, youth homelessness and foster care poses challenges that are nearly impossible to overcome without increased funding for mental health.

Recommendations

Eliminate Fee-for-Service

A common concern amongst mental health specialists and professionals is the fee-for-service model that Medicaid currently has in place to pay for care that is not otherwise paid for by other means. This model is consistently and constantly referred to as broken.

Fee-for-service (FFS) is health care's most traditional payment model where physicians and healthcare providers are paid by government agencies and insurance companies (third-party payers), or individuals, based on the number of services provided, or the number of procedures ordered. Payments are unbundled, so services are billed and paid for separately. In other words, every time a patient has a doctor's appointment, a surgical consultation, or a hospital stay, providers bill for each visit, test, procedure, and treatment independently (Hodgin, 2018).

The model is logical, but its shortcomings have been highlighted especially in mental healthcare. It is understood as one of the main factors pushing up the cost of healthcare and encourages wasteful spending. Simply, it pays for the procedure rather than value. There are more incentives for providers to maximize their clients rather than provide cost-efficient, quality care. This is problematic for mental health, as administering care for children is not a fast process, thus the volume of patients seen in other areas of healthcare cannot be seen in mental healthcare. If appointment times are too short in order to maximize patients, the child does not get substantive or effective care. If a child misses an appointment that could have otherwise been filled by another child, that time is uncompensated and places a heavy financial burden on mental healthcare providers. In addition, as explained by Turner, "Physicians may also respond to limited reimbursement for mental health-related visits by reclassifying mental health diagnoses as other covered conditions. Although in this case, patients will still receive mental health care, misclassification may be detrimental to their future mental health outcomes" (2003).

Limited reimbursement for mental health visits incentivizes physicians to misdiagnose and underreport the frequency of such visits.

Some alternatives to the fee-for-service model, as posited by Bob Mellin of Great Lakes Recovery, include the establishment of outcome-based incentive models, setting fixed costs per number of clients, and capitation (personal communication, October 2, 2019). Fee-for-service reform will need to take place on the federal and state level, and will likely only be accomplished through legislation.

Expand Mental Health Services into School Districts

To address mental health issues in children daily, one avenue is to introduce more mental health programs into schools. Jerry Messana, a Health Officer with the Marquette County Health Department, explained how mental health clinics in schools can provide access to mental healthcare for youth who would normally not have such an opportunity. These programs are funded by the state and primarily run by social workers who have an office within the school. The clinics offered by Marquette County Schools are open to any child aged 5 to 21, even if they do not attend Marquette area schools. Children over 14 may be seen by a counselor without parental oversight for about 12 visits, which is especially important for those experiencing issues within the home. The counselor can make recommendations based on the visits, and set up a mental health program for the child moving forward. (J. Messana, personal communication, September 4, 2019). The major issue for children who wish to travel to a different school district for counseling becomes a lack of transportation and missing days of school.

School mental health clinics are valuable in rural areas, where some of the only institutions in the small towns are schools. If more government funding became available to

schools in the U.P. for the creation of mental health clinics, initial mental health care could finally be available to all children and they would less likely encounter transportation barriers.

The value of significant investments in school-based mental health programs is the right thing to do, and its efficacy is also borne out by prevailing research and data. As a 2017 research review in the *Harvard Review of Psychiatry* asserted, there is a growing body of evidence that supports the effectiveness of mental health programs in schools and their ability to reach large numbers of children (National Association of Secondary School Principals, 2019).

Although small school districts don't have the number of children to sustain a program, one clinic could be established within each county and have its services expanded to reach smaller schools within that county. There would be less distance to travel and access to daily care.

Increase Mental Health Comfortability for Primary Care Providers with Telehealth

Primary care providers could assist in the momentous caseloads of mental health providers if they had the tools to deal with more severe cases of mental illness. Since they are not equipped to deal with such issues, alternate measures must be taken by health care providers and the State of Michigan to supply the demand for mental health services. Technological advances make it increasingly possible to provide youth mental healthcare in the most remote areas. This emerging field of medicine, known as telehealth, allows doctors and patients to discuss a case in real-time with a doctor across the state, or even the nation. Although telehealth is a tremendous resource, hospitals are reluctant to utilize the services, as are patients who value face-to-face contact. As one of the most readily available and affordable avenues of mental health care improvement though, hospitals should adopt telehealth as an asset to their care.

An example of one effective and proactive program that has existed since 2012 is the Michigan Child Collaborative Care program (MC3). MC3, implemented by the University of Michigan and grant-funded in cooperation with the Michigan Department of Health and Human Services, is attempting to address the child psychiatry gap by providing psychiatry support to

PCPs who manage patients with behavioral health problems. This telehealth program provides access to University of Michigan psychiatrists who can advise within 24 hours on mental health issues in children, adolescents, young adults through the age of 26, and women who are, have been, or may become pregnant. They offer guidance on diagnoses, medications and certain types of psychotherapy so that PCPs feel more comfortable managing their patients. Their telehealth services are currently present in every region of the state. Should a service similar to MC3 be implemented in all rural areas of the Upper Peninsula, PCPs will be able to assist youth who may have otherwise gone without adequate care.

Set-Up the Profession to be More Attractive

Until the shortage of mental health specialists is addressed, the problem will never truly be solved. The Upper Peninsula is in immense need of more children and youth psychiatrists, psychologists, social workers, PCPs, case workers, therapists and other mental health workers to meet the demand for service. Telehealth is only effective as long as local providers and clients buy into it, and it still cannot take over the crucial role of mental health professionals.

The mental health field must be perceived as an attractive and rewarding career path to aspiring professionals if the situation is to improve. Currently, mental health workers are undervalued and aren't paid nearly what they could be if in a different field of medical services. According to Glassdoor, an online platform that allows employees to anonymously review companies and report yearly salaries, the average national salary for a mental health worker is \$48,905 (Glassdoor). On the other hand is the salary of a physical therapist, for example, whose average salary is \$73,148 (Glassdoor). It is mentally and emotionally taxing for those working in mental health as a profession to see young people suffer from severe trauma and mental health diagnoses. Burn out rates are high, which is not made up for in compensation, and a cloud looms

over the profession. To improve this sentiment and attract more people to the mental health field, loan assistance programs should be implemented, residency programs should be created, salaries must be higher, burnout prevention practices must be in place, and other creative and cooperative means must be undertaken to encourage professionals to practice in the Upper Peninsula.

Conclusion

Mental health is a stigmatized topic often avoided in discourse over health care issues. Historically, those with mental health diagnoses have been ostracized and criminalized. The simple term “mental health” has been thwarted and misunderstood as a negative aspect of people's lives, despite the proven importance of good mental health for all people. There is a stigma that surrounds the mental health profession, one that must be systematically broken down and revealed, then replaced with compassion and understanding. Unfortunately, stigma is only the beginning of the problems faced by children experiencing mental health issues in the rural Upper Peninsula of Michigan, where simply accessing care is astonishingly difficult.

There is every reason to keep our youth safe and happy, for the future of our society and the sake of the children’s wellbeing itself. Having a youth population with rampant suicidal ideation and severe mental health diagnoses is unhealthy on a macro public health level. Moving forward, we must address the crucial issues relating to youth mental healthcare access as a both state and as independent counties of the Upper Peninsula. One child psychiatrist serving the entire U.P. is blatantly unacceptable in the wealthiest nation per capita in the world. Remoteness and ruralness cannot be allowed to seal the fate of children who are unable to travel to appointments, or make the painfully long journey to receive inpatient care away from home. Costs of care are too high and children cannot afford to get the help they desperately need to be happy, healthy, functioning members of society. The issue of mental healthcare in the Upper

Peninsula must be addressed with all urgency before more children's lives are lost to the grip of depression, anxiety, substance abuse, and other treatable mental health diagnoses.

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