Examination of Community Mental Health Services for Persons with Serious Mental Illness: A Descriptive Study of 31 Counties in Michigan

Pamela C. Werner

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EXAMINATION OF COMMUNITY MENTAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS: A DESCRIPTIVE STUDY OF 31 COUNTIES IN MICHIGAN

by

Pamela C. Werner

A Thesis Submitted to the Faculty of The Graduate College in partial fulfillment of the requirements for the Degree of Master of Arts Department of Psychology

Western Michigan University Kalamazoo, Michigan December 1992
Thirty-one out of 55 Community Mental Health Boards participated in a survey conducted by the Alliance for the Mentally Ill of Michigan. This study examined a number of variables in the questionnaire using a product-moment correlational analysis.

Results indicated that family and consumer input is modestly correlated with comprehensive service delivery and staff/consumer education and training. Budget and the active number of mentally ill cases had a low correlation with comprehensive service delivery and staff/consumer education and training. Interagency collaboration was modestly correlated with program evaluation, and comprehensive services available to consumers. Weaknesses were noted in the management structure of CMH Boards regarding their mission and purpose in the treatment of persons with serious mental illness. Discussion of the results and implications for future research are provided.
ACKNOWLEDGEMENTS

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I thank John Bennett, President of AMI/Share in Kalamazoo, for the honor of requesting my involvement and assistance in working on the questionnaire developed by the Alliance for the Mentally Ill in Michigan.

Last, I extend deep gratitude to my husband, Rick, for his support during my course of study and my sister, Anita, for her assistance in the completion of my Thesis.

Pamela C. Werner
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Examination of community mental health services for persons with serious mental illness: A descriptive study of 31 counties in Michigan

Werner, Pamela Carr, M.A.

Western Michigan University, 1992
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>ACKNOWLEDGEMENTS</th>
<th>ii</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIST OF TABLES</td>
<td>v</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>The Michigan Family Movement</td>
<td>17</td>
</tr>
<tr>
<td>Focus of Present Study</td>
<td>18</td>
</tr>
<tr>
<td>Hypotheses</td>
<td>20</td>
</tr>
<tr>
<td>METHOD</td>
<td>23</td>
</tr>
<tr>
<td>Subjects</td>
<td>23</td>
</tr>
<tr>
<td>Instrument</td>
<td>23</td>
</tr>
<tr>
<td>Scoring Criteria</td>
<td>25</td>
</tr>
<tr>
<td>Procedure</td>
<td>26</td>
</tr>
<tr>
<td>Construction of Variables</td>
<td>26</td>
</tr>
<tr>
<td>RESULTS</td>
<td>29</td>
</tr>
<tr>
<td>Demographics</td>
<td>29</td>
</tr>
<tr>
<td>Relationships Between Primary Variables</td>
<td>30</td>
</tr>
<tr>
<td>DISCUSSION</td>
<td>40</td>
</tr>
<tr>
<td>Limitations</td>
<td>45</td>
</tr>
<tr>
<td>CONCLUSION</td>
<td>47</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>49</td>
</tr>
<tr>
<td>A. Survey Instrument</td>
<td>50</td>
</tr>
<tr>
<td>B. Survey Scoring Guide</td>
<td>64</td>
</tr>
<tr>
<td>C. Description of Variables</td>
<td>71</td>
</tr>
</tbody>
</table>
Table of Contents--Continued

D. Exempt Letter From the Human Subjects
   Institutional Review Board ................... 75

BIBLIOGRAPHY ........................................... 77
LIST OF TABLES

1. Relationship Between Active MI Cases and Total Budget. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
List of Tables—Continued

14. Relationship Between Program Evaluation and Specialized Services for the Mentally Ill Population ........................................... 37

15. Relationship Between Management Structure and Specialized Services for the Mentally Ill Population ........................................... 37

16. Relationship Between Management Structure and Comprehensive Service Delivery ..................... 38

17. Correlation Matrix for Variables: $X_1, \ldots, X_n$ .......... 39
INTRODUCTION

A variety of mental health professionals and researchers have reported that the treatment system for community care developed during the process of deinstitutionalization remains inadequate for persons with serious mental illness (Iscoe & Harris, 1984; Shern, Surles, & Waizer, 1989). This view is strongly shared by family members who have a loved one affected with a serious mental illness.

One father writes about his experience in attempting to access community services:

As I attempted to locate help for my son, I found instead of a mental health system, a bewildering, Kafkaesque maze of difficult-to-access programs for which nobody had continuing responsibility or sufficient authority and where standards of quality were non-existent ... psychiatrists, psychologists, and day treatment programs we turned to offered processes that had little relevance to (our son's) raging illness and our confusing circumstance - at least in our judgement (Weisburd, 1990, p. 1245).

This past and current frustration with service availability and integration is well documented in the literature. Community Mental Health Centers have been repeatedly criticized for their inability to provide quality, cost effective services for persons with serious mental illness (Brown, 1978; Iscoe & Harris, 1984; Kubie, 1968; National

Community Mental Health programs were developed to advocate for local autonomy and control. The construction of these mental health centers, was funded by the Federal Government in response to the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (Public Law 88-164). In the following years, an amendment required states to enforce standards, and provide services within a geographical catchment area (Public Law 94-63). In 1980, the Mental Health Systems Act (Public Law 96-398) moved the emphasis from a maintenance philosophy towards less flexibility and more accountability (Faulkner, Cutler, & Middleton, 1982).

Under the leadership of President Carter, the Mental Health Systems Act addressed the lack of services to specific populations by providing grant money for treatment of the chronically mentally ill, children and adolescents, and other underserved populations (Ebben, Bliss, & Perlman, 1991). However, in 1981, a change in federal policy occurred when the Mental Health Systems Act was repealed. This resulted in a major reduction of federal funds creating a block grant concept (Shern et al., 1989). The block grant concept occurred under the direction of
President Reagan purporting that it is each state's responsibility to provide care for their own.

With the responsibility resting on the state, federal funding for alcohol, drug abuse and mental health treatment was cut by one third (Goplerud, Walfish, & Broskowski, 1985). From 1984 to 1986, federal funding of Community Mental Health Centers dropped 30% (Drolen, 1990). The block grant concept provided states with the authority to structure and evaluate programs, but at reduced levels of funding (Faulkner et al., 1982). At this present time, funding for services remains inadequate. Current estimations indicate that funding nationally is less than 50% of what is necessary to care for the seriously mentally ill in the community (Parrish, 1989; Stroul, 1989). Without federal funds, centers are forced into the position of cutting programs and/or recruiting populations who bring in revenue for the services provided.

With a decrease in federal funds, directors of Community Mental Health Centers are implementing programs that generate funds (Drolen, 1990). Drolen (1990) completed a mail survey of Community Mental Health Centers requesting answers to the following questions: (a) Given the bleak financial status of CMHC's, to what extent are center directors changing the configuration of their service delivery pattern from the original conception of community mental health; and (b) Due to the need for increased
revenues, are centers servicing certain populations based on the ability to receive reimbursement, and not serving others? With a return rate of 62%, directors showed a clear preference for programs that generate funds. Directors were asked to project future caseloads in 1990. Individuals who were paying approximately 75% of treatment costs were projected to increase, while those who paid 25% or below for services were expected to decrease by 8%. The author stated that this may have represented a trend to exclude the poor, or those who do not receive reimbursement. These results point to some health care predictions of a system of care where those who cannot pay are increasingly being excluded.

Other authors report many of these same concerns. Iscoe and Harris (1984) examined the community mental health literature from 1979 to 1982. They report that there is a movement toward marketing community mental health services more competitively to consumers in the private sector. In addition, centers appeared to be more dependent on the need for third-party payments. Iscoe and Harris (1984) strongly point out that Community Mental Health Centers are not meeting the needs of the chronically mentally ill, and there is question whether the deinstitutionalized are better off in terms of quality of life and health status.
This concern has led to a variety of studies examining patterns and trends occurring as a result of decreased funding and service integration. Some authors have stated that the lack of funding, and service availability are central factors to homelessness among the mentally ill (Shern et al., 1989), high hospital readmission rates, increased reliance on the penal system, and unemployment (National Institute of Mental Health, 1991). E. Fuller Torrey, a national advocate for improving treatment services for individuals with a serious mental illness, has requested a complete reevaluation of what is being provided. Torrey (1990) states:

After 35 years of deinstitutionalization, ... it is time to go back to the drawing board and re-evaluate the economics of the mental health services system. What is the proper mix of federal, state and local funding? How can various levels of government and different departments be encouraged to cooperate toward the common goal of better services? (p. 530)

With the lack of service coordination, an increase in state mandates, and a shortage of funds necessary to provide services, many authors believe a greater emphasis must be placed on program evaluation to increase accountability (Ebben et al., 1991; Faulkner et al., 1982; Shern et al., 1989).

In 1990, Torrey in partnership with Erdman, Wolfe and Flynn authored the third edition of "Care of the Seriously Mentally Ill: A Rating of State Programs" to address
issues of service coordination, funding and accountability. The publication rated all 50 states, including the District of Columbia, answering the question, "If I or a family member had a serious mental illness in what state would that person be most likely to receive good services?"

Through gathering information and data on a nationwide scale, the authors reported eight current crises leading to a "near-total breakdown in public psychiatric services" (Torrey et al., 1990).

1. There are more than twice as many people with schizophrenia and manic-depressive psychosis living in public shelters and on the streets than there are in public mental hospitals.

2. There are more people with schizophrenia and manic-depressive psychosis in prisons and jails than in public mental hospitals.

3. Increasing episodes of violence by seriously mentally ill individuals are a consequence of not receiving treatment.

4. Mental health professionals have abandoned the public sector and patients with serious mental illness.

5. Most community mental health centers have been abysmal failures.

6. Funding of public services for individuals with serious mental illness is chaotic.
7. An undetermined portion of public funds for services to people with serious mental illnesses is literally being stolen.

8. Guidelines for serving people with mental illnesses are often made at both the federal and state level by administrators who have had no experience in this field.

In response to these crises, the authors provide six proposals to improve services, including:

1. Public mental health programs must serve people with serious mental illness as a priority; if less than 75% of a program's resources are going to this group, its state and federal subsidies should be terminated.

2. All psychiatrists, psychologists, and psychiatric social workers should be required to donate, pro bono, one hour a week of work to public programs. Federal and state supported training programs for such professionals should include an automatic payback obligation.

3. Since psychiatrists have abandoned the public sector, psychologists, physician assistants and nurse practitioners should be given special training and allowed to prescribe psychiatric medication. This program should initially be piloted in three to five states.

4. The chaotic funding of public services for individuals with serious mental illnesses needs a total overhaul.
5. Budgets of public mental illness programs should be examined for possible theft.

6. All administrators of public programs for people with mental illness should spend at least one-half day each week working with mentally ill people.

The Torrey report received national attention from advocacy groups. Many of the recommendations called for radical changes within the mental health system. Included with these criticisms and recommendations, each state was given a rating with a brief description of strengths and weaknesses as noted by the rating team.

Michigan and four other states tied for 26th place out of a total of 51. Torrey et al., (1990) reported Michigan as improving significantly with strengths including Assertive Community Treatment Teams, clubhouse programs, Fairweather Lodges, consumer run drop-in-centers and support groups such as Schizophrenics Anonymous. Weaknesses included the lack of supported and semi-independent living options for housing, lack of system integration, and CMH boards' lack of attention to the state mental health code in prioritizing services for the more severe forms of mental illness. He concluded his report on Michigan with a concern regarding the 1990 passage of a bill mandating that prevention of mental illness be given as high a priority as the treatment of serious mental illness. Given that nobody knows how to "prevent" mental
illness Torrey et al. (1990) report "hopefully Michigan's flakiness will be confined to Kellogg's cereal boxes in Battle Creek" (p. 41).

In addition to the Torrey et al. report, a recent evaluation on programming and planning of mental health services in Michigan was conducted by Hazel, Herman and Mowbray (1991). These researchers reported a need for interagency coordination, cooperation, and planning. Weaknesses in the system were noted by the majority of consumers living well below poverty level, with difficulties reported in performing both self care and community living skills. The authors reported a need for integrating services.

The National Institute of Mental Health (1991) reports that former research and evaluations have not included the preferences of consumers with a serious mental illness and their families. Currently studies from a consumer and family perspective have not occurred within the State of Michigan, or remain unpublished. In the past several years, the idea of family and consumer evaluation of services has received attention and debate.

A variety of arguments against involving consumers in satisfaction surveys have been reported (Lebow, 1982). Awareness of these arguments places perspective on the continued resistance some individuals have for involving persons with serious mental illness in the evaluation.
process. One weakness reported in satisfaction surveys concerns validity. Some researchers have reported a discrepancy between satisfaction and outcome. Although Fiester and Fort (1978), reported an overlap between consumer satisfaction questionnaires and outcome measures, the relationship between outcome measures and satisfaction surveys has been shown to be affected by the timing of the rating during the period the individual is receiving treatment (Edwards, Yarvis, Mueller, & Langsley, 1978). In addition to validity, another argument for the limited use of consumer satisfaction is the idea that the data is of very little functional use (Keppler-Seid, Windle, & Woy, 1980). Still others report that consumers are unable to adequately judge their own treatment (Scheirer, 1978). In addition, Scheirer (1978) claims that satisfaction surveys are not important in the area of treatment. While these areas of reported weaknesses require some consideration, the majority of researchers believe that requesting consumer input to improve services is beneficial.

Many professionals believe that consumers who receive services are equally as important in evaluating and improving the current system. Morrison (1978) states that since consumers are often in the position of receiving ineffective and ethically questionable services, their involvement in satisfaction surveys is important. Carscaddon, George and Wells (1990) report that many
outcome studies of mental health services have been completed, yet research in consumer satisfaction is relatively new and in the early stages. While some researchers have stressed that a crucial element in improving services delivered is to evaluate the consumers opinion of therapy (Lebow, 1982; Uhlenhuth, Lipman, Chassan, Hines, & McNair, 1970), others have reported previous studies demonstrating that consumers can meaningfully evaluate psychiatric services (Denner & Halprin, 1974; Kotin & Schur, 1969; Mayer & Rosenblatt, 1974). Although some professionals may be resistive to consumer evaluations, Mayer and Rosenblatt (1974), completed a study indicating that consumers actually rate a clinic and the services provided more positively than employees of the clinic.

In addition to consumers evaluating services, families also serve an important role in identifying what services are most beneficial. Families have recently become more active in the political process and have learned to impact the mental health system through their advocacy and lobbying efforts. However, in the past, organized efforts have not always existed.

Historically, families have felt stigmatized and blamed by explanations that have listed the family as a source of mental illness (Hatfield, 1981). While many advocates have fought against the negative view of
families, there continues to be a need to educate professionals on the positive influence families provide and the biological nature of serious mental illness. Recent studies on expressed emotion research perpetuates stigma and blame by viewing the role of the family as a negative influence (Vaughn, Snyder, Jones, Freeman, & Falloon, 1984). Fortunately this view is combated by articles appearing in the literature stressing the positive impact family members provide for persons with serious mental illness. The role families play as caregivers is one positive example.

Recent studies show that 40% of consumers live with their families (Lefly, 1988). Other studies have reported that between one half and two thirds of consumers return to their families after discharge (Lamb & Goertzel, 1977; Minkoff, 1977). A Michigan study by Hazel et al. (1991) reported that the majority of consumers receiving community services lived with their families. These findings demonstrate consistency with information regarding the role of the family as caregivers. Providing direct care places a large burden on all members of the family requiring support from others. With family members providing a large amount of direct care and support, their view of mental health services is an integral part of the improvement process.

A variety of individuals have supported the importance of family input by surveying families regarding their view
of the mental health system. Hatfield (1978) surveyed the Schizophrenia Association of Greater Washington finding that although respondents reported a high level of contact with professionals, they indicated a low level of satisfaction with services provided. Nearly half reported that mental health services had no value for them. They stated that families and friends provided more effective support than professionals.

Holden and Lewine (1982), completed a similar study to assess a larger sample of family members. Results showed that 74% of families were dissatisfied with the help received from professionals. Involvement with professionals left them feeling guilty, defensive, confused, ignored, and left out of treatment. They felt a lack of confidence in individuals making decisions which was attributed to their lack of involvement in the treatment planning process. Even though families experienced frustration, they reported that they view mental health professionals as the best source of help when problems develop. Their main source of dissatisfaction was the lack of basic information about serious mental illness and management techniques. Other areas they reported dissatisfaction with were the lack of professional support during the time of re-entry into the community, information on how to access community resources, outreach support, medication reviews, and advice in coping with bizarre behaviors.
Some mental health clinicians are surprised at the feedback family members provide when asked for input. A study completed by Spaniol, Jung, Zipple, and Fitzgerald (1987) reported that families dissatisfaction with family therapy was much greater than the perception held by mental health professionals. This demonstrates the poor communication families and professionals share with each other. Relatives do not appear comfortable in communicating their dissatisfaction with professionals. Professionals do not appear at ease in asking family members for feedback regarding treatment being provided.

A survey of the California Alliance for the Mentally Ill was conducted in 1986 (Williams, Williams, Sommer, & Sommer, 1986). This study reported that 30% of consumers were living at home. When questions were asked regarding what helped their family member most, answers included, in order of priority: medication, family support, psychotherapy, socialization centers, community residential treatment, and locked facilities. The authors noted that when families were questioned regarding what state and local government could do, answers abundantly ran outside the margins and onto additional sheets. Areas such as housing, vocational and social opportunities were written. Research was viewed as the only effective long-term solution to problems of their loved ones. The authors stated that the responses to the questionnaire were written
positively without blaming or scapegoating. Family members saw mental illness, stigma and prejudiced behaviors as the largest obstacles to overcome.

Families frustration with service availability, integration and the inability to effect the treatment planning process has led to the development of the National Alliance for the Mentally Ill (NAMI) in 1979. This movement was energized as a result of the anger of families who felt blamed by health care professionals for the illness of their relative (Bataille, 1990). Hatfield (1981) reports that groups whose main purpose is self-help, result from feelings of not being understood and that their needs will not be met under existing conditions; therefore, change becomes necessary. NAMI, organized as a result of family concern, is a self-help, support and advocacy organization that began at a grass roots level. Their mission is to "eradicate mental illness and to improve the quality of life for those who suffer from these no-fault brain diseases" (NAMI, 1991). Since 1979, membership has doubled with 100 affiliates in 50 states and a membership of 140,000.

The strong presence of NAMI and the push for family involvement has attracted the attention of psychologists nationwide. Baker and Richardson (1989), a psychologist and NAMI member, respectively, state that "family members need all the assistance science and the profession of
psychology can provide." They believe that increasing communication and strengthening the support system for family members benefits psychology as equally as persons with mental illness and their families. This view of clinicians and families working together is becoming a focus of a variety of organizations nationwide.

In 1986, the National Institute of Mental Health (NIMH) and NAMI held a conference on "Educating Mental Health Professionals To Work With Families of the Long Term Mentally Ill". The conference centered on educating clinicians to work with individuals suffering from a mental illness while emphasizing families as an important resource in training, planning, advocacy and service (Lefley, Bernheim, & Goldman, 1989). Individuals who participated in this conference unanimously agreed that clinical and professional training programs have an obligation to educate and train all levels of students regarding research and treatment of persons with a serious mental illness. Collaboration between universities and families can only strengthen service delivery, integration, and availability.

Lefley (1989) reports that a number of historical events have helped build alliances between families and clinicians. Some of these include: biogenetic research findings, recognition of the burden families experience, and the new view of the families role as a result of the deinstitutionalization process. Barbee, Kasten, and
Rosenson (1991) advocate for training psychiatrists to work with families encouraging stronger alliances by becoming interdependent allies in defining the future of service delivery. They describe a program that incorporates family support during residency training. Former first lady, Rosalyn Carter (1989), published an article stressing collaboration and advocacy activities between families, clinicians and consumers can increase mental health funding for research and services. She identified three areas of common ground: research, treatment, and public education. Carter (1989) encouraged that common interests held by families, clinicians and consumers and the ability to establish partnerships will help in the challenge confronting the field of mental health.

In addition to Carter (1989), Johnson (1989) reports that the interest of families can be joined by psychologists for mutual benefit. He reports that the goals of NAMI can be met with the help of psychologists while psychologists need the help of families and consumers in the role of advocacy for increasing funding. The 1990s will show a nontraditional approach in collaboration between various groups of individuals affected by services provided in the mental health field.

The Michigan Family Movement

This nontraditional approach of collaboration is
carried into this study. In 1991, The Alliance for the Mentally Ill of Michigan (AMIM), was challenged by Dr. E. Fuller Torrey at their statewide convention to rate Community Mental Health Centers from a family perspective.

Dr. Torrey reported that AMI has a powerful influence in legislation and now is the time to exercise rights as family members. His challenge was provided in response to the concerns of family members regarding the closure of public hospitals within the State of Michigan. Members of AMIM voiced concern in relation to the ability of Community Mental Health Boards to provide comprehensive, quality and specialized services for their loved ones.

Based on this concern and challenge by Dr. Torrey, the Alliance for the Mentally Ill of Michigan (AMIM), as an organized group, developed a questionnaire and affiliated itself with Western Michigan University, Department of Psychology, to examine the types of services provided in each county in the state. The survey contained a wide range of questions regarding mental health services available in each county.

Focus of Present Study

Currently family surveys of The Michigan Community Mental Health system do not exist or, remain unpublished. Therefore, this study examined family/consumer involvement, program evaluation, management structure, interagency
collaboration, education, training and university collaboration, comprehensive service delivery and availability of services for specialized populations. This study first described, and second examined the relationship of the following multiple item variables.

1. What is the relationship between active MI cases and total budget?

2. What is the relationship between family and consumer input and county population.

3. What is the relationship between family and consumer input and comprehensive service delivery?

4. What is the relationship between total budget and comprehensive service delivery?

5. What is the relationship between active mentally ill adult cases and comprehensive service delivery?

6. What is the relationship between family and consumer input and services for specialized mentally ill populations?

7. What is the relationship between total budget and services for the specialized mentally ill population?

8. What is the relationship between family and consumer input and staff/consumer education, training and university collaboration?

9. What is the relationship between the Board's total budget and staff/consumer education, training and university collaboration?
10. What is the relationship between interagency collaboration and program evaluation?

11. What is the relationship between interagency collaboration and level of sophistication of management structure?

12. What is the relationship between interagency collaboration and comprehensive service delivery?

13. What is the relationship between program evaluation and comprehensive service delivery?

14. What is the relationship between program evaluation and specialized services for the mentally ill population?

15. What is the relationship between level of sophistication of management structure and specialized services for the mentally ill population?

16. What is the relationship between level of sophistication of management structure and comprehensive service delivery?

Hypotheses

If the Board has a large number of mentally ill cases, then the size of the budget will be positively correlated with the caseload size.

If the county population is large, then a pool of families and consumers are available for input into program services.
If the Board utilizes family and consumer input, then comprehensive service delivery will be reflected in its service array.

If the Board has a large budget, then comprehensive service delivery will be positively correlated with the size of the budget.

If the Board has a large number of active mentally ill cases, then a large number of comprehensive services will be positively correlated with the number of active cases.

If the Board utilizes family and consumer input, then increased services for specialized mentally ill populations will be reflected in the service array.

If the Board has a large budget, then services for the specialized mentally ill population will be positively correlated with the size of the budget.

If the Board utilizes family and consumer input, then staff/consumer education, training and university collaboration will be evident.

If the Board has a large budget, then staff/consumer education, training and university collaboration will be positively correlated with the size of the budget.

If the Board has a strong emphasis on interagency collaboration, then program evaluation will be positively correlated with the agencies collaborative efforts.

If the Board collaborates with other agencies, then the management structure will be positively correlated with
the agencies collaborative efforts.

If the Board collaborates with other agencies, then comprehensive services will be positively correlated with the agencies collaborative efforts.

If the Board demonstrates a strong program evaluation system, then comprehensive service delivery will be positively correlated to the sophistication of the evaluation system.

If the Board demonstrates a strong program evaluation system, then specialized services for the mentally ill will be positively correlated with the sophistication of the evaluation system.

If the Board demonstrates a strong management structure, then specialized services for the mentally ill population will be positively correlated with the sophistication of the management structure.

If the Board demonstrates a strong management structure, then comprehensive service delivery will be positively correlated with the sophistication of the management structure.
METHOD

Subjects

All 55 county-based Community Mental Health Boards in the State of Michigan were mailed a survey instrument with instructions to complete and return to the AMI/SHARE President of Kalamazoo. The questionnaire was addressed to the Executive Director of each CMH board. Participation in the survey was voluntary. Thirty-one CMH boards returned the survey, comprising the sample. Participation in the research project did not require informed consent as the data received from the survey is public information.

Instrument

The survey was developed by members of the Alliance for the Mentally Ill of Michigan (AMIM). The questionnaire consisted of 97 items designed to yield information which would describe a county community mental health program along 18 dimensions from fiscal year October 1, 1990 to September 30, 1991.

The 18 dimensions of the survey included a variety of sections. Section 1 contained descriptive information such as size of the population, source of funding, total budget, expenditures, percent of Medicaid and Medicare collected,
active number of mentally ill child and mentally ill adult cases and other basic information. Information in section 2 concerned the names of advocacy organizations in each county and estimated number of members. Section 3 pertained to the number of board members involved in advocacy and the presence/absence of consumers as CMH board members. Section 4 examined family involvement, collaboration with other agencies, supported housing, and the number of housing options provided. Information regarding evaluations to track consumer movement between programs was contained in Section 5. Section 6 consisted of questions regarding evaluations to track readmissions to state and private hospitals. In addition, this section examined process and outcome evaluations the board implemented for agencies providing direct services to consumers. Section 7 contained questions on evaluation of consumer adjustment post hospitalization in both independent and dependent living environments. Evaluation of consumer input into agency programs and services was the focus of Section 8. Section 9 examined the Board’s implementation of formal planning to outline the future direction of programs. Section 10 explored the collaborative relationships held with colleges and universities for integrating students into service areas and providing supported education programs for consumers. Collaboration with other human service agencies to integrate services was the focus of Section 11. Section
12 and 13 reviewed training and education provided to staff and consumers, respectively. Section 14 examined qualitative outcome evaluation of services. Section 15 focused on the use of consultants in designing or implementing evaluations of local programs. Using formal consumer input to facilitate program development comprised Section 16. Section 17 contained 28 items regarding services available in the county including supported employment, Fairweather Lodges, drop-in-centers, Assertive Community Treatment, outpatient care, behavioral treatment, skills training and other program options. Section 18 examined the tracking system for consumers detained in the correctional system. The percentage of mental health services provided to persons with mental illness in the correctional system was an additional component of Section 18. Please refer to Appendix A to view the instrument in its entirety.

**Scoring Criteria**

Selected questions in the survey were scored using a scale of 0-2. Other items were scored on a 0-1 point range. The remaining items were not scored and used as classification variables. The total score possible for all 18 sections was 74. For the scoring of each specific section, please refer to Appendix B.
Procedure

The survey was mailed in January of 1992 to the Executive Directors of 55 Community Mental Health Boards in the State of Michigan. The Alliance for the Mentally Ill of Michigan completed the mailing. The CMH agencies were given 16 weeks to complete the questionnaire. In an effort to increase the response rate, a board member from AMIM met with executive staff of the Michigan Association of CMH Boards (MACMHB). A final meeting with the board presidents of MACMHB and AMIM was held leading to an agreement letter supporting the AMIM survey of CMH agencies. The agreement letter was sent by facsimile to CMH Directors across the state. The agreement letter extended the initial return date to an additional 4 weeks, giving the agencies 20 weeks from the initial mailing. One week following the agreement letter, the 55 CMH Directors were called. If they had not received a questionnaire, one was sent to them the same day.

Construction of Variables

A variety of critical variables based on content were developed from sections of the instrument.

Variable number one entitled, Family/Consumer Input, addressed CMH Board arrangements where both families and consumers were directly involved in providing or receiving
services. Items grouped within this variable included families and consumers receiving and driving the CMH Board's direction for delivery of services.

Variable number two, Interagency Collaboration, examined the CMH Board's affiliations with community groups, human service agencies and State of Michigan programs. Each CMH Board was assessed regarding their ability to network with other organizations to improve services provided for persons with serious mental illness.

Variable number three labeled, Program Evaluation, explored tracking systems of consumer movement throughout the continuum of care. The continuum of care included services such as hospitalization, independent living and agencies that provide direct services contracted by the Board.

Variable number four, Management Structure, studied the current, future direction and evaluation standards by the CMH Board.

Variable number five entitled, Staff/Consumer Education, Training and University Collaboration, focused on training provided to consumers and staff. University involvement in supported education for consumers and integrating students into programs provided by the Board were additional components of this variable.

Variable number six, Comprehensive Service Delivery, scrutinized 28 services significant for treatment of
persons with a serious mental illness.

Variable number seven, Services for Specialized Mentally Ill Populations, examined six distinct areas of service delivery for individuals who suffer from serious mental illness.

To review each question clustered within these seven variables please refer to Appendix C.
RESULTS

The data are presented first in descriptive format regarding mean, modes and ranges for variables present followed by a Pearson product-moment of correlation analysis of selected variables having relevance to the initial hypotheses (Pearson, 1901). Conservative estimations of correlations were used when examining relationships between primary variables. These estimations are applicable to this study only.

Demographics

Thirty-one out of 55 County Community Mental Health Boards participated in the study, with a response rate of 56%. The minimum range of the county population was 26,365, reported by Mason County, with the maximum range of 510,000, located in Kent County. The mean population was 129,419, while the mode was 40,000. In relation to total budget, the minimum was reported by Barry County at 1,396,825, with the maximum of 49,338,803 reported by Kent County. The active number of mentally ill adult cases reported a minimum of 25 in Antrim/Kalkaska County and a maximum of 6,719 in Genesee County. The mean number of active, mentally ill adult cases was 1,542 with the mode
recorded at 1,127.

Relationships Between Primary Variables

Each of the following 18 questions are analyzed using a product-moment coefficient of correlation analysis.

Question number one examined the relationship between active MI cases and total budget. The relationship between these two variables demonstrated a correlation of .849. See Table 1.

Table 1
Relationship Between Active MI Cases and Total Budget

<table>
<thead>
<tr>
<th>Count</th>
<th>Covariance</th>
<th>Correlation</th>
<th>R-squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>12043792.054</td>
<td>.849</td>
<td>.72</td>
</tr>
</tbody>
</table>

Question number two explored the relationship between county population and family and consumer input. These variables were correlated at .24. See Table 2.

Question number three scrutinized the relationship between family and consumer input and comprehensive service delivery. The correlation of this relationship was .688. See Table 3.
Table 2

Relationship Between County Population and Family and Consumer Input

<table>
<thead>
<tr>
<th>Count</th>
<th>Covariance</th>
<th>Correlation</th>
<th>R-squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>67.72</td>
<td>.24</td>
<td>.058</td>
</tr>
</tbody>
</table>

Table 3

Relationship Between Family and Consumer Input and Comprehensive Service Delivery

<table>
<thead>
<tr>
<th>Count</th>
<th>Covariance</th>
<th>Correlation</th>
<th>R-squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>5.803</td>
<td>.688</td>
<td>.473</td>
</tr>
</tbody>
</table>

Question number four investigated the relationship between total budget and comprehensive service delivery. These variables were correlated at .426. See Table 4.

Question number five scrutinized the relationship between active mentally ill adult cases and comprehensive service delivery. The correlation of these variables was .295. See Table 5.
Table 4
Relationship Between Total Budget and Comprehensive Service Delivery

<table>
<thead>
<tr>
<th>Count</th>
<th>Covariance</th>
<th>Correlation</th>
<th>R-squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>14240.202</td>
<td>.426</td>
<td>.181</td>
</tr>
</tbody>
</table>

Table 5
Relationship Between Active Mentally Ill Adult Cases and Comprehensive Service Delivery

<table>
<thead>
<tr>
<th>Count</th>
<th>Covariance</th>
<th>Correlation</th>
<th>R-squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>1726.281</td>
<td>.295</td>
<td>.087</td>
</tr>
</tbody>
</table>

Question number six studied the relationship between family and consumer input and services for specialized mentally ill populations. These variables were correlated at .554. See Table 6.

Question number seven examined the relationship between total budget and services for the specialized mentally ill population. The correlation of these variables was .252. See Table 7.
Table 6
Relationship Between Family and Consumer Input and Services for Specialized Mentally Ill Populations

<table>
<thead>
<tr>
<th>Count</th>
<th>Covariance</th>
<th>Correlation</th>
<th>R-squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>1.502</td>
<td>.554</td>
<td>.307</td>
</tr>
</tbody>
</table>

Table 7
Relationship Between Total Budget and Services for the Specialized Mentally Ill Population

<table>
<thead>
<tr>
<th>Count</th>
<th>Covariance</th>
<th>Correlation</th>
<th>R-squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>2714.524</td>
<td>.252</td>
<td>.064</td>
</tr>
</tbody>
</table>

Question number eight examined the relationship between family and consumer input and staff/consumer education, training and university collaboration. These variables resulted in a correlation of .622. See Table 8.

Question number nine examined the relationship between total budget and staff/consumer education, training and university collaboration. These variables were correlated at .273. See Table 9.
Table 8

Relationship Between Family and Consumer Input and Staff/Consumer Education, Training and University Collaboration

<table>
<thead>
<tr>
<th>Count</th>
<th>Covariance</th>
<th>Correlation</th>
<th>R-squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>2.073</td>
<td>.622</td>
<td>.387</td>
</tr>
</tbody>
</table>

Table 9

Relationship Between Total Budget and Staff/Consumer Education, Training and University Collaboration

<table>
<thead>
<tr>
<th>Count</th>
<th>Covariance</th>
<th>Correlation</th>
<th>R-squared</th>
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<tbody>
<tr>
<td>31</td>
<td>3603.904</td>
<td>.273</td>
<td>.075</td>
</tr>
</tbody>
</table>

Question number ten investigated the relationship between interagency collaboration and program evaluation. The correlation between these variables was .696. See Table 10.

Question number eleven studied the relationship between interagency collaboration and management structure. These variable demonstrated a correlation of .623. See Table 11.
Question number twelve scrutinized the relationship between interagency collaboration and comprehensive service delivery. The correlation among these variables was .647. See Table 12.

Question number thirteen examined the relationship between program evaluation and comprehensive service delivery. These variables were correlated at .637. See Table 13.
Table 12
Relationship Between Interagency Collaboration and Comprehensive Service Delivery

<table>
<thead>
<tr>
<th>Count</th>
<th>Covariance</th>
<th>Correlation</th>
<th>R-squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>3.697</td>
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<td>.419</td>
</tr>
</tbody>
</table>

Table 13
Relationship Between Program Evaluation and Comprehensive Service Delivery

<table>
<thead>
<tr>
<th>Count</th>
<th>Covariance</th>
<th>Correlation</th>
<th>R-squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>8.028</td>
<td>.637</td>
<td>.406</td>
</tr>
</tbody>
</table>

Question number fourteen investigated the relationship between program evaluation and specialized services for the mentally ill population. The correlation of these variables was .627. See Table 14.

Question number fifteen explored the relationship between management structure and specialized services for the mentally ill population. These variables were correlated at .463. See Table 15.
Table 14
Relationship Between Program Evaluation and Specialized Services for the Mentally Ill Population

<table>
<thead>
<tr>
<th>Count</th>
<th>Covariance</th>
<th>Correlation</th>
<th>R-squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>2.541</td>
<td>.627</td>
<td>.393</td>
</tr>
</tbody>
</table>

Table 15
Relationship Between Management Structure and Specialized Services for the Mentally Ill Population

<table>
<thead>
<tr>
<th>Count</th>
<th>Covariance</th>
<th>Correlation</th>
<th>R-squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>1.267</td>
<td>.463</td>
<td>.214</td>
</tr>
</tbody>
</table>

Question number sixteen evaluated the relationship between management structure and comprehensive service delivery. The correlation of these variable was .466. See Table 16.

Table 17 is a correlation matrix of variables examined in the study.
Table 16
Relationship Between Management Structure and Comprehensive Service Delivery

<table>
<thead>
<tr>
<th>Count</th>
<th>Covariance</th>
<th>Correlation</th>
<th>R-squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>3.967</td>
<td>.466</td>
<td>.217</td>
</tr>
</tbody>
</table>
Table 17

Correlation Matrix for Variables: $X_1 \ldots X_9$

<table>
<thead>
<tr>
<th></th>
<th>County</th>
<th>Active</th>
<th>Total Bud</th>
<th>Fam/Co</th>
<th>Interag</th>
<th>Progra</th>
<th>Manage</th>
<th>Staff/Compreh</th>
</tr>
</thead>
<tbody>
<tr>
<td>County</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Active</td>
<td>.874</td>
<td>1</td>
<td>.849</td>
<td>1</td>
<td>.485</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total Bud</td>
<td>.925</td>
<td>.849</td>
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<td>1</td>
<td>.485</td>
<td>.696</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Fam/Co</td>
<td>.24</td>
<td>.117</td>
<td>.304</td>
<td>.485</td>
<td>1</td>
<td>.696</td>
<td>.577</td>
<td>.496</td>
</tr>
<tr>
<td>Interag</td>
<td>.393</td>
<td>.211</td>
<td>.377</td>
<td>.485</td>
<td>.696</td>
<td>1</td>
<td>.577</td>
<td>.496</td>
</tr>
<tr>
<td>Progra</td>
<td>.297</td>
<td>.196</td>
<td>.267</td>
<td>.66</td>
<td>.696</td>
<td>1</td>
<td>.577</td>
<td>.496</td>
</tr>
<tr>
<td>Manage</td>
<td>.403</td>
<td>.335</td>
<td>.407</td>
<td>.434</td>
<td>.623</td>
<td>.577</td>
<td>1</td>
<td>.535</td>
</tr>
<tr>
<td>Staff/Compreh</td>
<td>.294</td>
<td>.124</td>
<td>.273</td>
<td>.622</td>
<td>.559</td>
<td>.541</td>
<td>.496</td>
<td>.535</td>
</tr>
<tr>
<td>Compreh</td>
<td>.428</td>
<td>.295</td>
<td>.426</td>
<td>.688</td>
<td>.647</td>
<td>.637</td>
<td>.466</td>
<td>.535</td>
</tr>
</tbody>
</table>
DISCUSSION

The original hypotheses of this study showed a mixed response when analyzed with the product-moment coefficient of correlation analysis.

The relationship of active cases and total budget demonstrated a high correlation of .849 which supported the previous hypothesis. This upholds the recommendation made by Torrey et al. (1990), stressing that the public mental health programs must serve people with serious mental illness or state and federal subsidies should be terminated. Families of persons with serious mental illness in Michigan can feel assured that over half of the CMH Boards are using major portions of their budget in treating active cases.

Family and consumer input in relation to county population showed a nonexistent correlation of .24 which did not support the original hypothesis that having a larger pool of individuals would increase the availability of families and consumers presence in providing input into the system. CMH Boards with a smaller county population have involved families at a significant level compared to larger boards who may have greater numbers of families and consumers available as resources. Conditions other than county population appear to affect the variable of family
and consumer input.

The relationship between family and consumer input and comprehensive service delivery demonstrated a modest correlation of .688. These findings supported the original hypothesis that family and consumer input is correlated with the number and array of services provided by the CMH Board. In contrast, the relationship between the total budget and comprehensive service delivery was .426, not supporting the hypothesis and demonstrating a nonexistent association.

The relationship between active MI cases and comprehensive service delivery was correlated at .295 continuing with the same pattern showing a nonexistent correspondence without support of the hypothesis.

These relationships strongly point out that revenue, and the number of individuals requiring services, are not determining factors of comprehensive service delivery; instead, the input of families and consumers showed a stronger correlation of the CMH Board's efforts to provide a comprehensive array of services. This supports the view held by some authors that family and consumer input is beneficial in service delivery (Hatfield, 1981; Lebow, 1982; Morrison, 1978; Uhlenhuth et al., 1970). Congruent with the original hypothesis, most individuals would assume that budget and need are driving forces in comprehensive service delivery.
The relationship of family and consumer input and increased services for specialized mentally ill populations demonstrated a low correlation of .554, not supporting the hypothesis.

In relation to services for the specialized mentally ill populations and total budget, an even lower correlation of .252 demonstrated a very similar pattern with the above-mentioned relationships of budget and comprehensive services compared with family and consumer input and comprehensive services. Again, the total budget did not drive specialized or comprehensive services as much as family and consumer input in relation to these items. The hypothesis of the CMH Board's total budget driving specialized and/or comprehensive services is not supported.

The relationship between family and consumer input and staff/consumer education, training and university collaboration exhibits a modest correlation of .622 in support of the hypothesis. Family and consumer input has an affect on the education, training, and university collaboration the CMH Board provides to staff and consumers.

Continuing to follow the same patterns discussed above, the relationship regarding the total budget of the Board and staff/consumer education, training and university collaboration was correlated at .273. The total budget of the Board had little significance to the provision of staff/consumer education, training and university
collaboration; whereas, family and consumer input does have an effect on the Board’s provision of these services and programs.

The relationship between interagency collaboration and program evaluation was modestly correlated at .696, supporting the hypothesis.

The relationship between interagency collaboration and management structure demonstrated a modest correlation of .623 in support of the hypothesis.

Following a similar pattern, interagency collaboration and comprehensive service delivery was modestly correlated at .647, again supporting the hypothesis.

These three combined correlations regarding interagency collaboration address the quote made earlier in the literature review by E. Fuller Torrey M.D., calling for an increase in collaborative efforts of different levels of government and agencies whose cooperation with each other will lead to better services for persons with serious mental illness. These modest correlations support the view that collaboration has a positive relationship with program evaluation, management structure and comprehensive service delivery.

The relationship between program evaluation and comprehensive service delivery was modestly correlated at .637 supporting the hypothesis.
The relationship between program evaluation and services to the specialized MI population exhibited a similar correlation of .627, also in support of the hypothesis.

The program evaluation efforts by CMH Boards in Michigan have had an impact on comprehensive services available and services specifically for specialized MI populations. This supports the opinion of previously referenced authors who have called for a greater emphasis on program evaluation to increase accountability and provide coordinated services for persons with serious mental illness (Ebben et al., 1991; Faulkner et al., 1982; Shern et al., 1989). The relationship between management structure and services to specialized MI population had a low correlation of .463.

Of similar status is the relationship between management structure and comprehensive services delivered which had a low correlation of .466.

These relationships demonstrate that the current sophistication of management structure did not correlate with comprehensive services or services for specialized groups. When the management structure does not correlate with service delivery, families such as Weisburd (1990), will directly experience a lack of needed programs or an inability to access services due to disorganization within the CMH system.
Part of the management structure assessed in this study included each CMH Board's mission statement. Of the mission statements reviewed, a variety had either not been updated, did not demonstrate a commitment to providing services to persons with mental illness and/or included statements on prevention of mental illness. In reference to the 1990 passage of a Michigan bill mandating that prevention of mental illness be given top priority for treating serious mental illness, E. Fuller Torrey, M.D. (1990), stated no single individual knows how to prevent serious mental illness, "hopefully Michigan's flakiness will be confined to cereal boxes in Battle Creek" (p. 41). If Boards are unsure of their mission and purpose in providing services for persons with mental illness, it is reasonable to assume that comprehensive or services for specialized populations will be lacking or disorganized.

Limitations

Additional research to assess the Michigan mental health system from a family and consumer perspective is needed. Involvement of skilled researchers in the early development stages of future studies would be beneficial. This questionnaire was developed by AMIM who represented families of persons with serious mental illness. The questions of the instrument were generated from their concerns and are thus assumed to have face validity.
Examination of internal consistency was not addressed in this study.

The response rate of 56% in this study needs to be increased in future research. A shorter questionnaire and site visits to the Executive Director of each CMH Board by members of local AMI affiliates may be helpful interventions to expand the sample size. It would be beneficial to access the same information requested in the survey from nonrespondents. Due to the information being public knowledge, the main disadvantage of seeking a 90%-100% return rate is the time consuming efforts necessary to access the information from all Boards in the state.

Because of the small sample size, conservative estimations of correlations were used when examining relationships between primary variables. Correlations were considered high if .8 or above, modest .6-.7, low .4-.5, and nonexistent at .0-.3. These estimations are only applicable to this study due to the limitations listed above.
CONCLUSION

In summary, this study provided the AMIM with the opportunity to begin examining services provided by CMH Boards across the state. The research both supported and negated a variety of the original hypotheses.

One of the enlightening findings was the modest correlation between family/consumer input and comprehensive service delivery. In contrast, total budget and active cases were not associated with comprehensive service delivery. This validates the important role families and consumers contribute, when given the opportunity to have input into the CMH system. Additional research on how families and consumers effect comprehensive service delivery would be informative.

The study supported the view that interagency collaboration is correlated with program evaluation, management structure and comprehensive service delivery. This signifies that CMH Boards who prioritize collaboration with other agencies, may in turn demonstrate strengths in the areas of management, evaluation and the variety of services available for persons with serious mental illness.

The weakness seen in management structure must be addressed with the Boards receiving low scores on this
section of the survey. Executive Directors and the Board of each county needs to reexamine the mission and purpose of their organization in relation to persons with serious mental illness and the idea that prevention is an appropriate priority in the allocation of services and funds.

Research examining the needs of families and consumers is lacking in the public mental health system in Michigan. This study is the first documented effort of research collaboration in Michigan between families, professionals, and faculty in a university setting regarding services provided to persons with a serious mental illness. Collaborative efforts with consumers and families are important to the field of mental health and the profession of psychology. Further studies to bridge the relationships of families, professionals, consumers, and university faculty will only enhance the treatment and services provided to persons with a serious mental illness and at the same time benefit those individuals who are fortunate to work with families and this specific population group.
Appendix A

Survey Instrument
Survey of Community Mental Health Boards
in Michigan
For fiscal year 1990-91

Please respond to all items on the questionnaire below, for the period October 1, 1990 through September 30, 1991. Please attach copies of brief reports or instruments as requested, before returning the questionnaire responses. Your assistance is greatly appreciated. In all cases your answers should pertain to services for persons with mental illness.

If you have questions regarding any of the items included please contact:
John Bennett
1011 Crown Street
Kalamazoo, MI 49007

Thank you.

The Alliance for the Mentally Ill of Michigan

Section 1:

1. Name of County:

2. Population of County:

3. Active cases of MI Adults:

4. Active cases of MI Children:

5. Total Budgeted Revenue:

(a) Was this budget an increase over the previous year?
(b) Please indicate how much increased revenue over or decreased revenue under the previous year this budget represents in dollars.

7. (Estimate the percentage of your total budget and actual dollars is received from the following sources)

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Dollar Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal and State:</td>
<td>_____</td>
</tr>
<tr>
<td>County:</td>
<td>_____</td>
</tr>
<tr>
<td>Local Match:</td>
<td>_____</td>
</tr>
<tr>
<td>Fees and Commissions:</td>
<td>_____</td>
</tr>
<tr>
<td>Other:</td>
<td>_____</td>
</tr>
</tbody>
</table>

8. Mental Health Expenditures:

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Dollar Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration:</td>
<td>_____</td>
</tr>
<tr>
<td>MI Children:</td>
<td>_____</td>
</tr>
<tr>
<td>MI Adult:</td>
<td>_____</td>
</tr>
<tr>
<td>Other:</td>
<td>_____</td>
</tr>
</tbody>
</table>

9. Total Budgeted Expenditures: _____

10. For what percent of eligible medicaid clients does the CMH collect medicaid reimbursement? _____

11. For what percent of eligible medicare clients does the CMH collect medicare reimbursement? _____

12. Do you receive any additional reimbursements from other sources? If so, list the source categories and the amounts?
Please add additional sheet if required as "Section I, item 12 continued."

Please enclose a copy of the local County Community Mental Health Board's Mission Statement as "Attachment 1."

Section 2:
Please supply the names of the organized MH advocacy organizations in your County.
(Names of organizations and estimated membership)

<table>
<thead>
<tr>
<th>Names</th>
<th>Estimate number of Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
</tr>
</tbody>
</table>
7. ____________________________
8. ____________________________

Attach additional sheets as necessary as "Attachment 2."

Section 3:
A. Please list the names of members on your local CMH Board who are involved with Mental Health advocacy organizations. Include Task Forces or Committee.

<table>
<thead>
<tr>
<th>Names of Persons on Board</th>
<th>Name of Advocacy Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
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<td>7.</td>
<td></td>
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<tr>
<td>8.</td>
<td></td>
</tr>
</tbody>
</table>

B. Please list the names of members on your CMH Board who are or have been consumers of mental health services. For these purposes consumer is an individual who is now receiving or has received mental health services in the
past. (If due to confidentiality you are unable to supply the names, please supply the number of such persons serving on the board or obtain a waiver of confidentiality if possible).

**Board Members' Name** or **Number who are consumers**

Please attach additional pages as necessary as "Attachment 3."

**Section 4:**

A. Please indicate whether your county has a

<table>
<thead>
<tr>
<th>Single entry</th>
<th>or</th>
<th>Open system</th>
</tr>
</thead>
</table>

(please circle the correct option)

B. **Family Involvement:**

1) Does the county provide family education? **Yes**  **No**

2) Are families and / or consumers notified of treatment team meetings? **Yes**  **No**

3) How many families are on task forces committees or boards pertaining to mental health?

4) Is special support provided to families during the commitment process? **Yes**  **No**

5) Please list other types of family involvement in mental health service delivery, training
administration or governance, on a separate sheet of paper as "Attachment 4, Item E 5."

C. Collaboration:
1) Does the county collaborate or network with the following agencies?
   Michigan Rehabilitation Services   Yes    No
   Disability Determination Services  Yes    No
   Department of Social Services     Yes    No
   Other agencies (please list as "Attachment 4 Item C 1.")

2) Please describe any important results of these collaborations for any of the items for which you indicated "Yes." Attach on separate sheets as "Attachment 4 Item C 2."

D. Housing:
1) Does the county provide supported housing? Yes    No
   If yes, how many units are available? _________
   If no, is there a current plan to provide such supported housing? Yes    No
   If there is such a plan, please give the anticipated date for implementation: ____________

2) List all types of housing alternatives available for persons who are mentally ill in the county (i.e. residential, adult foster care, behavioral treatment, semi-independent living, etc.)
   For each type listed please provide the number of units with bed capacity on a separate sheet as "Attachment 4 Item D 2."

3) Is there a waiting list for any of the above housing options? Yes    No

4) What types of support are given to families / significant others who provide housing for persons with mental illness? Please describe on a separate sheet as "Attachment 4 Item D 4."
Section 5:
Has the local CMH Board instituted an evaluation to track consumer movement between programs in the Mental Health system (please circle appropriate answer)?

Yes  No

(If yes, please enclose a brief (not longer than 2 pages) description of the report from such evaluation(s) and a copy of the instruments used as “Attachment 5.”)

Section 6:
A. Has the local CMH Board has implemented any evaluation system to track readmissions to state hospitals.

Yes  No

(Please enclose a brief (not longer than 2 pages) description of the report from such evaluation system(s) “Attachment 6a.”)

B. Has the local CMH Board implemented any evaluation system to track readmissions to private hospitals?

Yes  No

(Please enclose a brief (not longer than 2 pages) description of the report from such evaluation(s) and a copy of the instrument used as “Attachment 6b.”)

C. Has the CMH Board implemented any process or outcome evaluations of agencies that directly deliver services to patients, in the last year?

Yes  No

(If yes, please enclose a brief (not longer than 2 pages) description of the report(s) from such evaluations and a copy of the instrument(s) used as “Attachment 6c.”)

Section 7:
A. Has the local CMH Board conducted any evaluation of consumer adjustment in dependent living environments, post hospitalization programs?
Yes

No

(If yes please enclose a brief (not longer than 2 pages) description of the results of such evaluations and a copy of the instruments used as "Attachment 7a.")

B. Has the local CMH Board conducted any evaluation of consumer adjustment in independent living environments, post hospitalization?

Yes

No

(If yes please enclose a brief (not longer than 2 pages) description of the results of such evaluations and the instruments used as "Attachment 7b.")

Section 8:

Has the local CMH Board conducted any evaluation to assess the extent of consumer input into the local CMH programs or agency services?

Yes

No

(If yes please enclose a brief (not longer than 2 pages) description of the results of such evaluations and the instruments used as "Attachment 8.")

Section 9:

Does your local CMH Board implement a formal periodic planning process that outlines future directions for programs within the county's control?

Yes

No

(If yes, please enclose a brief (not longer than 2 pages) description which details the findings from the most recent implementation of the planning process as "Attachment 9.")

Section 10:

A. Does the County CMH program have collaborative relationships with colleges or universities to support ongoing integration of students into local service delivery, service administration or the mental health field more generally?

Yes

No
(If yes, please list the colleges or universities involved during the fiscal year ending September 30, 1991, as "Attachment 10.")

B. Does the county CMH program have a collaborative relationship with colleges or universities to provide supported education for consumers?

<table>
<thead>
<tr>
<th>College or University</th>
<th>Number of Consumers Served</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

Section 11:

Does your county provide service integration or other direct effort to assist consumers who require access to public health, social services or other non-mental health programs?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

(Please provide a brief (not longer than 2 pages) description of local efforts to assist consumers' access to other non-mental health services as "Attachment 11.")

Section 12:

Did the local CMH Board fund programs that provided training, inservice and education for CMH staff?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

(If yes please enclose a brief (not longer than 2 pages) description of the training, education or inservice including dates and name of the trainer as "Attachment 12.")

Section 13:
Did the local CMH Board fund programs that provided training for consumers of mental health services?

Yes  --  No

(If yes please enclose a brief (not longer than 2 pages) description of the training, education or inservice including dates and name of the trainer(s) as "Attachment 13.")

Section 14:
Did the CMH Board implement any qualitative or outcome evaluation of Mental Health services based on measurable and/or existing standards?

Yes  --  No

(If yes please enclose a brief (not longer than 2 pages) description of the results from such evaluations and one copy of the instrument(s) used in each case as "Attachment 14.")

Section 15:
Did the local CMH Board make use of any consultants to help design or implement evaluations of local programs?

Yes  --  No

(If yes, please enclose a list of names of consultants, dates evaluation consultants were utilized, and if not included in the above listed items, a brief (not longer than 2 pages) description of how the results from such use of consultants were implemented or utilized in other ways as "Attachment 15.")

Section 16:
Did the local CMH make use of formal consumer input during last year that facilitated or caused changes in services within your county CMH?

Yes  --  No

(If yes, please enclose a description of how services were altered as a result of such input as "Attachment 16.")

Section 17:
Are any of the following services available through the local CMH Board in your County? For items 1 - 3 and 6-9 below, please provide the capacity in number of available consumer slots during fiscal year 91 for each service listed.

<table>
<thead>
<tr>
<th>Service</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Supported employment</td>
<td>Yes \ No</td>
</tr>
<tr>
<td>2. Other psychosocial day treatment programs</td>
<td>Yes \ No</td>
</tr>
<tr>
<td>3. Transitional employment</td>
<td>Yes \ No</td>
</tr>
<tr>
<td>4. Senior Outreach Agencies</td>
<td>Yes \ No</td>
</tr>
<tr>
<td>5. Multi-cultural programs for consumers</td>
<td>Yes \ No</td>
</tr>
<tr>
<td>6. Drop-in centers</td>
<td>Yes \ No</td>
</tr>
<tr>
<td>7. Respite Alternatives for MI persons</td>
<td>Yes \ No</td>
</tr>
<tr>
<td>8. Food services for MI homeless persons</td>
<td>Yes \ No</td>
</tr>
<tr>
<td>9. Social recreational services for MI adults</td>
<td>Yes \ No</td>
</tr>
<tr>
<td>10. Interpretation services for bilingual or hearing impaired consumers</td>
<td>Yes \ No</td>
</tr>
<tr>
<td>11. Are church groups involved in support roles</td>
<td>Yes \ No</td>
</tr>
<tr>
<td>12. Are other community groups involved in support of consumers served by your CMH</td>
<td>Yes \ No</td>
</tr>
<tr>
<td>13. Fairweather Lodge program(s)</td>
<td>Yes \ No</td>
</tr>
<tr>
<td>14. Case Management system</td>
<td>Yes \ No</td>
</tr>
<tr>
<td>15. Assertive Community Treatment Teams</td>
<td>Yes \ No</td>
</tr>
<tr>
<td>16. Psychiatrists employed or contracted</td>
<td>Yes \ No</td>
</tr>
<tr>
<td>17. Outpatient services</td>
<td>Yes \ No</td>
</tr>
<tr>
<td>18. Inpatient hospitalization care units</td>
<td>Yes \ No</td>
</tr>
</tbody>
</table>
How many clients in your county were being detained by County jails?

For what percentage of the total combined clients detained in state correctional programs, county jail programs or were being served by probation programs did your CMH programs also provide mental health services?

Was your county CMH board or any of its programs under any type of consent decree during the fiscal year ending September 30, 1991?

Yes No

(If yes, please attach a description of the consent agreement and a brief description of improvements made in connection with the agreement, as "Attachment 18.")

Section 19

During the period specified, were any of the agencies operating under CMH jurisdiction or was the Board itself on probation or actually denied access to any federal, state or other reimbursement programs?

Yes No

(If yes, please attach a summary of the appropriate documentation describing the probation or denied status, the alleged infractions and any plans of correction or remediation, as "Attachment 19.")

Thank you for your assistance. If you would like a copy of the report summarizing the findings from this survey, please indicate so by circling "yes" below.

Yes No

Please return the questionnaire to: John Bennett
1011 Crown Avenue
Kalamazoo, MI 49007
<p>| | | | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>19.</td>
<td>Liaison service with other human services including Disability Determination.</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>Day treatment or Day activity</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>Services to homeless mentally ill homeless</td>
<td>Yes</td>
<td>No</td>
<td></td>
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</tr>
<tr>
<td>22.</td>
<td>Emergency services</td>
<td>Yes</td>
<td>No</td>
<td></td>
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<tr>
<td>23.</td>
<td>Family support</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>Caregiver training</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Vocational rehabilitation services for persons with mental illness.</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>Required adaptive equipment for persons with mental illness.</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>Behavioral treatment services</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>Professional peer review services</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>Crisis service</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
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<tr>
<td>30.</td>
<td>Skills training</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(For all items which were circled "yes", please enclose a description of the service as "Attachment 17" with an indication for each as to whether there was a waiting list maintained for the service during the fiscal year.) Recall that service capacity is for the period of the fiscal year ending September 30, 1991.

**Section 18**

How many clients in your county were being detained by State Correctional programs?

How many clients in your county were being serviced by State Correctional probation programs?
Appendix B

Survey Scoring Guide
Scoring Guide

Those items scored in the 0-2 point range include:

Section 1: CMH Board’s mission statement.

0 - not attached
1 - if attached
2 - if attached and consistent with AMI objectives.

Section 4A: Important results of collaborations with Michigan Rehabilitative Services, Disability Determination Services and Department of Social Services and other agencies.

0 - no results
1 - results included
2 - results included were described in relation to outcomes.

Section 5: Evaluation to track consumer movement between programs in the mental health system.

0 - no evaluation
1 - indication of yes answer that evaluation is done
2 - copy of instrument is enclosed supporting yes answer.

Section 6: Each question in this section is scored separately for a total of six points.

Implementation of an evaluation system to track readmissions to state hospitals, implementation of an evaluation system to track readmissions to private hospitals, implementation of process or outcome evaluations of agencies that directly deliver services.

0 - no evaluation system exists
1 - evaluation system is reported to exist
2 - evaluation system exists and a copy of instrument/description of report is included.

Section 7: Each question in this section is scored separately for a total of four points.

Evaluation of consumer adjustment in dependent living environment, post hospitalization, evaluation of consumer adjustment in independent living environment, post hospitalization.
0 - no evaluation exits
1 - evaluation is reported to exist
2 - evaluation exists and copy of instrument/report is included.

Section 8: Evaluation to assess consumer input into programs.

0 - no evaluation exists
1 - evaluation is reported to exist
2 - evaluation exists and description of results are included.

Section 9: Implementation of a formal periodic planning process outlining future direction.

0 - no planning process exists
1 - planning process is reported to exist
2 - description of planning process is included detailing findings.

Section 10: Collaborative relationships with colleges and universities integrating students into the agency.

0 - no relationships exist
1 - relationship reported to exist
2 - relationship described and number of affiliations is included.

Section 11: Integrating services and providing a direct effort to assist consumers in accessing non-mental health agencies.

0 - service integration and direct efforts to assist do not exist
1 - service integration and direct effort to assist is reported to exist
2 - description of services integration and direct assist are included.

Section 12: Funding for staff training/education programs.

0 - no programs were provided
1 - programs were reported as provided
2 - description of training, including dates and names of trainers was included.

Section 13: Funding for consumer training/education programs.
0 - no programs were provided
1 - programs were reported as provided
2 - description of training, including dates and names of trainers was included.

Section 14: Qualitative or outcome evaluation of services based on measurable and existing standards.

0 - no evaluation exists
1 - evaluation of measurable standards reported to exist
2 - description of evaluation and copy of instrument is included and is based on measurable standards.

Section 15: Use of consultants to help design or implement evaluations of programs.

0 - consultants not used
1 - consultant reported as assisting in design or evaluation of local programs
2 - list of names of consultants, dates utilized and description of how results were implemented is included.

Section 16: Use of formal consumer input that caused changes within the agency.

0 - no consumer input was utilized
1 - consumer input reported as utilized
2 - input reported and description of how services were altered is included.

Items in the survey scored on a scale of 0-1 include:

Section 3: Board members who are consumers.

0 - there are no consumers as board members
1 - board consists of one or more members as a consumer(s) of mental health services.

Section 4B: Family Involvement

Family education:
0 - does not exist
1 - family education is provided.

Family and/or consumers notified of team meetings:
0 - not notified
1 - notified.
Special support providing during the commitment process:

0 - no support provided
1 - support provided.

Section 4C: Collaboration.

Michigan Rehabilitative Services:

0 - no collaboration
1 - collaboration.

Disability Determination Services:

0 - no collaboration
1 - collaboration.

Department of Social Services:

0 - no collaboration
1 - collaboration.

Section 4D: Housing.

Availability of Supported Housing:

0 - no supported housing available
1 - supported housing provided.

Support given to families/significant others who provide housing:

0 - no support provided
1 - support provided.

Section 17: 28 items of services available through the Community Mental Health Board are scored; items 87 and 105 were thrown out of the sample due to misinterpretation of the answers by the Boards. Scored items are listed below:

1. Supported employment
2. Psychosocial treatment programs
3. Transitional employment
4. Senior outreach agencies
5. Multicultural programs
6. Drop-in-centers
7. Respite alternative
8. Food services
9. Social recreational services
10. Interpretation Services
11. Church group involvement
12. Other community groups
13. Fairweather Lodge
14. Case Management
15. Assertive Community Treatment
16. Psychiatrists employed or contracted
17. Outpatient services
18. Inpatient hospitalization
19. Liaison services
20. Day Treatment
21. Services to homeless mentally ill
22. Emergency services
23. Family support
24. Caregiver training
25. Vocational rehabilitation
26. Behavioral Treatment
27. Professional peer review
28. Crisis service
29. Skills training

0 - service does not exist
1 - service exists.

**Section 18:** Percentage of mental health consumers serviced by the Board while detained in jail.

0 - less than 75% of consumers were served
1 - 75% or more of consumers were served.

Items not scored but used as classification variables include:

**Section 1:** County, population, active cases mentally impaired adults, active cases of mentally impaired children, total budgeted revenue, percentage of total budget from sources, expenditures, percent of Medicaid/Medicare collected and additional reimbursement.

**Section 2:** Names of organized mental health advocacy organizations.

**Section 3:** Members of Community Mental Health board involved in advocacy organizations.

**Section 4:** Single v open entry, families on task forces, other family involvement, types of housing alternatives, waiting list for housing.
Section 18: Number of consumers detailed by state correctional programs, number of consumers serviced by probation programs, number of clients detained by county jail, a presence of consent decree.

Section 19: Board denied access to reimbursement programs and copy of survey report.
Appendix C

Description of Variables
Variable 1: Family/Consumer Input

<table>
<thead>
<tr>
<th>Possible Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of board members who are consumers 1</td>
<td>1</td>
</tr>
<tr>
<td>2. Provision of family education 1</td>
<td>1</td>
</tr>
<tr>
<td>3. Notification of treatment team meetings 1</td>
<td>1</td>
</tr>
<tr>
<td>4. Special support provided during the commitment process 1</td>
<td>1</td>
</tr>
<tr>
<td>5. Supported education programs 2</td>
<td>2</td>
</tr>
<tr>
<td>6. Assistance in accessing non mental health programs 2</td>
<td>2</td>
</tr>
<tr>
<td>7. Use of formal consumer input to affect services 2</td>
<td>2</td>
</tr>
<tr>
<td>8. Psychosocial Treatment Program 1</td>
<td>1</td>
</tr>
<tr>
<td>9. Drop-In-Center 1</td>
<td>1</td>
</tr>
<tr>
<td>10. Fairweather Lodge 1</td>
<td>1</td>
</tr>
<tr>
<td>11. Family Support 1</td>
<td>1</td>
</tr>
</tbody>
</table>

TOTAL POSSIBLE 14

Variable #2: Interagency Collaboration

<table>
<thead>
<tr>
<th>Possible Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Collaboration with Michigan Rehabilitation Services 1</td>
<td>1</td>
</tr>
<tr>
<td>2. Collaboration with Disability Determination Services 1</td>
<td>1</td>
</tr>
<tr>
<td>3. Collaboration with Department of Social Services 1</td>
<td>1</td>
</tr>
<tr>
<td>4. Documented results of Collaboration 2</td>
<td>2</td>
</tr>
<tr>
<td>5. Involvement of church groups 1</td>
<td>1</td>
</tr>
<tr>
<td>6. Other community group involvement 1</td>
<td>1</td>
</tr>
<tr>
<td>7. Liaison with other human services 1</td>
<td>1</td>
</tr>
</tbody>
</table>

TOTAL POSSIBLE 8

Variable #3: Program Evaluation

<table>
<thead>
<tr>
<th>Possible Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Evaluation to track consumer movement 2</td>
<td>2</td>
</tr>
<tr>
<td>2. Evaluation to track State hospital readmissions 2</td>
<td>2</td>
</tr>
<tr>
<td>3. Evaluation to track private hospital readmissions 2</td>
<td>2</td>
</tr>
<tr>
<td>4. Evaluation of contract agencies providing direct service 2</td>
<td>2</td>
</tr>
</tbody>
</table>
5. Evaluation of dependent adjustment post hospitalization 2
6. Evaluation of independent adjustment post hospitalization 2
7. Evaluation of services based on standards 2
8. Professional peer review 1

TOTAL POSSIBLE 15

Variable #4: Management Structure

<table>
<thead>
<tr>
<th>Possible Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mission statement 2</td>
</tr>
<tr>
<td>2. Documented results of agency collaboration 2</td>
</tr>
<tr>
<td>3. Formal periodic planning for future 2</td>
</tr>
<tr>
<td>4. Evaluation of services based on standards 2</td>
</tr>
<tr>
<td>5. Use of consultants for planning and implementation 2</td>
</tr>
</tbody>
</table>

TOTAL POSSIBLE 10

Variable #5: Staff/consumer education, Possible training and university collaboration

<table>
<thead>
<tr>
<th>Possible Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Integration of students in the mental health field 2</td>
</tr>
<tr>
<td>2. Fund training programs for staff 2</td>
</tr>
<tr>
<td>3. Fund training program for consumers 2</td>
</tr>
<tr>
<td>4. Supported education for consumers 2</td>
</tr>
</tbody>
</table>

TOTAL POSSIBLE 8

Variable #6: Comprehensive Service Delivery

<table>
<thead>
<tr>
<th>Possible Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Supported employment 1</td>
</tr>
<tr>
<td>2. Psychosocial treatment programs 1</td>
</tr>
<tr>
<td>3. Transitional employment 1</td>
</tr>
<tr>
<td>4. Senior outreach agencies 1</td>
</tr>
<tr>
<td>5. Multicultural programs 1</td>
</tr>
<tr>
<td>6. Drop-in-centers 1</td>
</tr>
<tr>
<td>7. Respite alternatives 1</td>
</tr>
<tr>
<td>8. Social recreational services 1</td>
</tr>
<tr>
<td>9. Interpretation services 1</td>
</tr>
<tr>
<td>10. Church Involvement 1</td>
</tr>
<tr>
<td>11. Other community group involvement 1</td>
</tr>
<tr>
<td>12. Fairweather Lodge 1</td>
</tr>
<tr>
<td>13. Case Management 1</td>
</tr>
<tr>
<td>14. Assertive Community Treatment 1</td>
</tr>
<tr>
<td>15. Psychiatrists employed or contracted 1</td>
</tr>
</tbody>
</table>
16. Outpatient services 1
17. Inpatient hospitalization 1
18. Liaison services 1
19. Day Treatment 1
20. Services to homeless mentally ill 1
21. Emergency services 1
22. Family support 1
23. Caregiver training 1
24. Vocational rehabilitation 1
25. Behavioral Treatment 1
26. Professional peer review 1
27. Crisis service 1
28. Skills training 1

TOTAL POSSIBLE 28

Variable #7: Services for Specialized MI Possible Populations Score

1. Senior outreach 1
2. Multicultural programs 1
3. Interpretation services for bilingual and hearing impaired 1
4. Services to homeless mentally ill 1
5. Behavioral treatment services 1
6. Percentage of mental health services provided for individuals detained in county jail 1

TOTAL POSSIBLE 6
Appendix D

Exempt Letter From the Human Subjects Institutional Review Board
Date: September 11, 1992
To: Pamela Warner
From: Mary Anne Bunda, Chair
Re: HSIRB Project Number: 92-09-06

This letter will serve as confirmation that your research protocol, "Examination of Community Mental Health Services for Persons with Serious Mental Illness: A Descriptive Study of 31 Counties in Michigan" has been approved under the exempt category of review by the HSIRB. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the approval application.

You must seek reapproval for any changes in this design. You must also seek reapproval if the project extends beyond the termination date.

The Board wishes you success in the pursuit of your research goals.

xc: Spates, Psychology

Approval Termination: September 11, 1993
BIBLIOGRAPHY


Community Mental Health Centers Amendments of 1975, Section 1115 of Public Law 94-63 (1975).


Mental Health Systems Act, Section 1177 of Public Law 96-398 (1980).


Pearson, K. (1901). On lines and planes of closest fit to the systems of points in space. Philosophical Magazine (Series 6), 2, 559-572.


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