A SURVEY OF COMMUNITY MENTAL HEALTH SERVICES PROGRAMS IN THE STATE OF MICHIGAN

NOVEMBER 2012 – JANUARY 2013

Conducted by the Mental Health Association in Michigan
~A United Way Agency affiliated with Mental Health America~
Supported by a Grant from the Ethel & James Flinn Foundation

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ABOUT THE MENTAL HEALTH ASSOCIATION IN MICHIGAN (MHAM)

MHAM, incorporated in November 1936, is the state's oldest advocacy organization for persons experiencing or at risk of mental illness.

The Mental Health Association believes it can accomplish the greatest good for the greatest number by analyzing policy issues and advocating with state government for regulatory actions (laws, rules, policies, etc.) that are in the best interest of our constituents.

MHAM, headquartered in Southfield, is affiliated with Mental Health America (Alexandria, VA) and partly funded by local United Ways.

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ABOUT THE ETHEL AND JAMES FLINN FOUNDATION

The Ethel and James Flinn Foundation is a Detroit-based private entity established by Ethel "Peggy" Flinn and her brother, James "Jim." Jim Flinn, who was diagnosed with schizophrenia at an early age, led a remarkable life till his passing in 2007 at age 91. His sister, Peggy, passed away in 1994. The Foundation is committed to improving the scope, quality and delivery of mental health services in Michigan. Since its inception, over $20 million in grants have been awarded. The Foundation's geographic focus is primarily on the counties of Wayne, Oakland, Macomb and Washtenaw.

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Survey Results tabulated and report written by Dr. Mark Reinstein and Dr. Greg Dziadosz of the Mental Health Association in Michigan.

ACRONYM KEY

CMHSP: Community Mental Health Services Program

DCH: (Michigan) Department of Community Health

FY: Fiscal Year

MHAM: Mental Health Association in Michigan

PIHP: Prepaid Inpatient Health Plan

SED: Serious Emotional Disturbance

SMI: Serious Mental Illness

Assessment Instruments

Children

CAFAS: Child and Adolescent Functional Assessment Scale

CALOCUS: Child and Adolescent Level of Care Utilization System

DECA: Devereux Early Childhood Assessment

PECFAS: Preschool and Early Childhood Functional Assessment Scale

Adults

DLA: Daily Living Activities

GAF: Global Assessment of Functioning

LOCUS: Level of Care Utilization System

OQ45: Outcome Questionnaire (45 items)

SIS: Supports Intensity Scale

SOQ20: A shorter version (20 items) of the OQ45

EXECUTIVE SUMMARY

This investigation surveyed Michigan's Community Mental Health Services Programs (CMHSPs) on seven topics of importance during a three-month period from late 2012 through early 2013. Responses were received from 32 of the state's 46 CMHSPs, representing 75% of Michigan counties.

The topics covered were:

1. Prevention services

2. Percentage of clients possessing dual Medicaid-Medicare eligibility, and levels of reimbursement received from serving such individuals

3. Effects of a 2009 Attorney General Opinion on jail mental health services and costs

4. Criteria employed to respectively determine severity-of-condition and level-of-functioning among service applicants/recipients

5. Respective utilization of state-operated psychiatric hospitals and psychiatric beds in private and community hospitals

6. Screening criteria for and consumer acceptance of recommendations to voluntarily undertake psychiatric hospitalization

7. Restructuring of the state's Prepaid Inpatient Health Plan (PIHP) configurations – from 18 to 10 – among the CMHSPs

Key findings were:

1. In the absence of a specific state office (closed in 2002) to provide prevention service leadership and assistance, respondents in the aggregate were doing a commendable job of attempting to maintain prevention initiatives targeted to youth at risk of emotional disorder.

2. In the aggregate, respondents were serving a sizable number of dually enrolled Medicaid-Medicare beneficiaries, and such service represented a considerable portion of CMHSP reimbursement income. However, the correlation between number served and reimbursement generated was weak – i.e., the number served by a CMHSP was not a strong statistical predictor of the CMHSP's resulting reimbursement income.

3. The majority of respondents did not think quality and/or quantity of jail mental health service had been affected by the Attorney General's ruling on service payment responsibilities. However, almost 30% of respondents felt quality/quantity

had been lessened. The predominant view was that related costs for CMHSPs had not been impacted. A quarter of respondents said their costs had decreased, while a small number stated their costs had gone up.

4. Respondents were not uniform in how they determine "the most severe forms" of mental illness and emotional disorder (which qualify for priority service consideration under Michigan law but are not defined). Considerable variability existed in criteria for these determinations. There was more uniformity in terms of the instruments used to assess consumer level-of-functioning.

5. Respondents reported 413 consumers in state-operated psychiatric hospitals at the time of the survey. The median length of stay reported for state hospitals was six months; the average (weighted mean) was five months. Another 535 consumers were reported to be in other types of psychiatric hospitals (private/community) at the time of the survey. Both the median and average length of stay for these other hospitals was less than seven days.

6. In the absence of legal guidance on criteria for recommending voluntary hospitalization, a majority of respondents used Michigan's three legally required criteria for involuntary hospitalization decisions. Almost half of respondents (44%) used only one or two of these three criteria. The majority of respondents rarely experienced a consumer declining a recommendation for voluntary hospitalization. But for 38% of respondents, such recommendations were declined occasionally.

7. Respondents were generally split on the reconfiguration of PIHP regions and affiliations within Michigan's CMHSP network. One-third saw no compelling reason for the reconfiguration, 27% believed 9-10 regions (10 was settled upon by the state) represented an ideal number for reconfiguration, and another 27% had no opinion.

Recommendations emanating from this investigation are listed on the next two pages.

RECOMMENDATIONS

1. A prevention services unit should be re-established within DCH so that greater assistance can be rendered to the many CMHSPs that have shown commendable interest and involvement in primary prevention services targeted to youth at risk of emotional disorder.

2. Whether a new dual-eligible (Medicaid-Medicare) project with capitated funding (being negotiated by Michigan and the federal government) proves helpful, harmful or neither to CMHSP resources for service provision will have to be monitored and assessed on a case-by-case basis.

3. The Departments of Community Health (DCH) and Corrections should convene a summit of stakeholders, including but not limited to CMHSPs and sheriffs, to review where jail mental health services stand four years after the Attorney General's Opinion on payment responsibilities, and to recommend what regulatory changes Michigan may need to foster service improvements and take advantage of new funding opportunities (if Medicaid is expanded in the state).

4. DCH should follow-up on this investigation and ascertain additional commonalities and differences among CMHSPs in determining severity-of-condition. This analysis should be followed by state regulatory action to see that the same criteria (operationalized in the same way) are employed by all CMHSPs in identifying "the most severe forms" of SMI and SED. The importance to a service applicant/recipient of achieving or missing out on priority status under Michigan law is too great to be left to local variances.

5. All CMHSPs should employ standardized functional assessment tools, with reasonable reliability and validity ratings, for youth and adults. The vast majority of CMHSPs covered by this survey met such a criterion. Additionally, all standardized instruments for assessment of functioning should be signed off on by DCH as being acceptable and appropriate to the Department.

6. DCH should prepare and publish – for the state-operated adult psychiatric hospitals other than the Forensic Center – a report breaking down per forensic status utilization variables such as those from this study.

7. The state needs to develop psychiatric hospital beds or alternative residential options – and assure adequate funding and clinically appropriate usage – for persons who require protected intensive care for a period that is in-between acute (i.e., typically one week) and long-term (i.e., often 5-6 months or longer). We respectfully suggest that Governor Snyder's Mental Health & Wellness Commission (established in early 2013, with a report due December of 2013) incorporate planning for this in its work.

8. Section 409 of the Mental Health Code should be revised to specify uniform statewide criteria for CMHSP preadmission screening criteria. Until this happens, all CMHSPs should apply each of the Code section 401-hospitalization criteria for preadmission screening determinations.

9. DCH should follow-up this survey by ascertaining and reporting: (a) the annual number of statewide cases seen by CMHSP preadmission screening, and how many screenings result in hospitalization recommendations; (b) whether CMHSPs across the state employ common and effective practices to protect the health and safety of those declining inpatient recommendations. If investigation of the latter does not yield satisfactory information, state law should be revised so there are specific next steps for CMHSPs to follow in such situations.

INTRODUCTION

From November 2012 – January 2013, the Mental Health Association in Michigan (MHAM) surveyed via postal-mail the state's 46 Community Mental Health Services Programs (CMHSPs) on seven important mental health topics. The survey was supported by a grant from the Detroit-based Ethel and James Flinn Foundation.

Responses were received from 32 CMHSPs (70%), a strong response rate for a mail survey. Respondents are listed in Appendix A. We are grateful to all those who took the time to provide us with valuable information.

The topics selected, and the rationales for them, were:

1. Involvement in Prevention Programming – MHAM has been a long-standing supporter of prevention initiatives targeted to youth at risk of emotional disorder. Prevention programming was also an interest of Governor Granholm's 2004 Mental Health Commission (which the Flinn Foundation helped fund). From 1977-2002, a state prevention services unit existed, but ceased due to budget cuts. This survey sought to determine the extent of CMHSP continuation of prevention efforts given that a supportive state unit has been off the table for the past decade.

2. Dual Eligibility (Medicaid/Medicare) – Michigan has been seeking federal approval for a three-year demonstration project that would attempt to integrate all health care of persons enrolled in both Medicaid and Medicare. As CMHSPs will have an important role in any such project, this survey sought to learn how many dual-eligible clients CMHSPs have, and the level of reimbursement income these clients represent to CMHSPs.

3. County Jail Mental Health Service – Incarceration of persons with mental illness has become a major societal problem and was a concern for the 2004 Mental Health Commission. A 2009 Attorney General's Opinion (that legal responsibility for jail mental health service payment rested with county governments, from which most CMHSPs are legally separate "authorities") was perceived by some as a potential hindrance to such service. This survey attempted to determine CMHSP perspectives on availability and cost of jail services subsequent to the 2009 Opinion.

4. Criteria and Tools for Determining Client Severity – Michigan law requires that priority populations for service from a CMHSP include persons with the most severe forms of mental illness and emotional disorder. However, what might constitute "the most severe forms" is not defined. This survey endeavored to learn about local CMHSP criteria for determining severity, as well as what assessment tools are being applied to measure service applicant/recipient level-of-functioning.

5. Access to Hospital Beds – The degree to which persons with severe mental disorders can and should be hospitalized (and where) has been a subject of ongoing policy debate. Michigan has one of the lowest per capita rates of state-operated

psychiatric hospital beds in the nation. Some would consider that a positive; others find it a negative. This survey sought to determine public and private hospital bed availability and utilization patterns for CMHSPs.

6. Preadmission Screening – Section 409 of Michigan's Mental Health Code requires assessment by a CMHSP preadmission screening unit as a precursor to many potential psychiatric hospitalizations. Code section 409 does not, however, specify criteria to be used in determining whether hospitalization is warranted. This survey asked about the criteria employed for such determinations and how often screened individuals reject a recommendation that inpatient care is needed.

7. CMHSP/PIHP Regionalization – As this survey was first initiated, the executive branch was announcing that Michigan would go from 18 CMHSPs designated as Prepaid Inpatient Health Plans (PIHPs) for receipt of capitated Medicaid funding (with some of these then sub-contracting with the other 28 CMHSPs for Medicaid service) to a system of 10 regions of CMHSPs that would be designated as the new PIHPs (still potentially involving a total of 46 CMHSPs). This survey asked respondents for their views on the new approach.

A copy of the survey instrument may be seen in Appendix B.

This report proceeds to describe the aggregate results for each of the above topic areas (no CMHSP is identified by its individual answers), and to discuss the results – including recommendations and important next questions to be asked.

SURVEY RESULTS

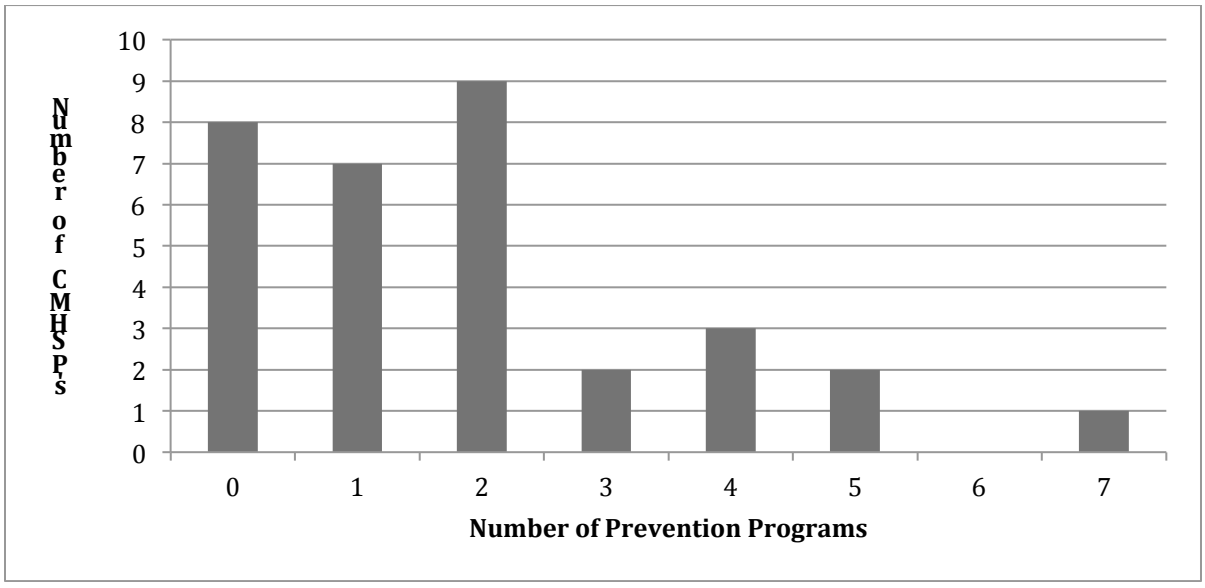
Response Rate

The survey was mailed to each of the state's 46 CMHSPs. Thirty-two were returned, a 70% response rate. Altogether, the respondents represented 63 of the 83 (75.9%) Michigan counties. There was no apparent bias in either the geographic location or population size among the respondents.

Prevention Programs

Twenty-four (75.0%) of the CMHSPs reported having at least one active primary prevention program. Sixteen (half the total of respondents) had one or two programs. Eight (25%) reported from three to seven programs. Eight (25%) reported having no current prevention programming.

The distribution of prevention programs was:



Among those16 that reported one or two prevention programs, infant mental health (provided by 50% of these CMHSPs) was the most common, representing 8 of the 25 total programs (32% of their total prevention activity). As seen in the following table, youth-focused programs were next most prevalent.

Among CMHSPs offering three or more programs, infant mental health was also provided by 50%. However, the majority of prevention activity in these CMHSPs consisted of youth-focused programs including but not limited to suicide prevention. Parenting education followed in frequency. All eight of the CMHSPs in this category offered one or more of these types of programs.

Prevention Activity	Frequency of provision by a CMHSP with 1 - 2 programs	with 3 or more programs	Total
Infant mental health	8	4	12
School based	4	3	7
Youth activity	3	6	9
Youth suicide prevention	3	5	8
Anti-bullying	0	2	2
Juvenile justice outreach	2	3	5
Parenting education	3	6	9
Children of adults with MI	1	2	3
Wraparound	1	1	2
Outpatient outreach	0	2	2
Mental Heath First Aid	0	1	1
Number of CMHSPs	**16**	**8**	**24**

Impact of Dual-Eligible Clients

DCH may soon be piloting implementation of combined Medicaid and Medicare funding and benefits for people who are eligible for both. The funding would be capitated. Mental health and developmental disabilities interests have expressed concern that this change, if managed via non-CMHSP entities, could have a negative effect on both client access to services and on CMHSP funding. The results of the survey suggest that any impact would be highly variable among the CMHSPs and not readily predictable from any particular factor such as size or geographic location.

Thirty-one of the 32 CMHSPs reported the percentage of their clients who were dually eligible, and 26 estimated the portion of their revenue coming from these clients. The proportion of dual-eligible clients ranged from 5% to 65%, with a mean of 27.1% and a median, or mid-point, of 25%. A comparison of those above and below the median showed no apparent differences in location, size, or multi-county organizational status

The proportion of income associated with those who were dually eligible was also highly variable, ranging from under 1% to 65%, with a mean of 36.9% and a median of 39.5%. On this variable, multi-county CMHSPs, which tend to be more rural and located further north, appeared to be more dependent on revenue from these clients

with 40.3% of their revenue coming from them versus 33.6% in single-county CMHSPs.

The results suggest that, on average the potential financial impact on a CMHSP is up to 36% higher than the proportion of clients who now have both coverages. However, there is only a weak correlation (r=0.247, meaning that one variable accounts for only 6% of the variance in the other) between the proportion of dually eligible clients and the proportion of revenue attributed to them. The ratio of revenue to those dually eligible ranges from 2.9% to 290%. The average is 144.8% and the median 137.0%.

DCH has most recently proposed piloting combined funding and benefits for those who are dual-eligible in four regions of the state. Eight of the respondents are located in those potential pilot regions. All eight provided an estimate of the proportion of their clients who were dually eligible and six also provided revenue estimates. The following table compares their data with that reported for all of the respondents. While the ranges are narrower, the means, medians, and correlations don't vary much from the totals. Explained variance was only slightly higher. Nothing would be statistically significant. It looks like the pilot CMHSPs, at least the ones that reported, were typical of the state.

	Pilot CMHSPs	**All Responding CMHSPs**
Average % Dual-eligible	26.9%	27.1%
Median % Dual-eligible	27.5%	25.0%
Range	16.5 - 43	5 - 65
Average % Attributed Revenue	36.6%	36.9%
Median % Attributed Revenue	37.7%	39.5%
Range	24 - 45	1 - 65
Average Ratio Income to Eligible	149.7	144.8
Median Ratio Income to Eligible	133.3	137
Range	93 - 236	2.9 - 290
Correlation Income to Eligible	0.334	0.247
% of Variance Explained	11.1%	6.1%

Any impact of changes in funding for dual-eligible clients will be highly CMHSP-specific and can't be predicted by the location or size of the CMHSP or even by the ratio of their dual-eligible clients to their total client population.

Effect of Attorney General's Opinion

In May 2009 the Michigan Attorney General issued Opinion 7231 making the county the payer of last resort for mental health services in their jails. The obligation of the

CMHSPs is to first seek payment from available insurance or other sources. The survey asked CMHSPs to report the impact of the opinion on the quality and quantity of mental health services in the county jails in their catchment area and the impact, if any, on CMHSP cost to provide services in the jail. (Respondents were instructed to answer the cost question only if they had been providing jail service at the time of the Attorney General Opinion.)

Responses are summarized as follow.

Impact on quality and quantity of service

	Number	Percent
Lessened	9	28.1%
Expanded	1	3.1%
No impact	21	65.6%
No response	1	3.1%

Impact on CMHSP cost

	Number	Percent	
Increased	4	12.5%	
Decreased	8	25.0%	
No impact	20	62.5%	*

*Includes one respondent not likely providing jail service at the time of the Attorney General Opinion

For a significant majority of CMHSPs, the opinion had no impact on services or their cost to the CMHSP. There is evidence that experience varies considerably among CMHSPs. Five added a note that they either did not provide services or that the jail contracted for them directly with other providers. We believe one of these was not providing jail service in May 2009 (and that CMHSP did not answer the quality/quantity question), while the other four were.

One respondent felt that jail service was an unfunded mandate. Three (75%) of the four who reported increased cost also reported no impact of the opinion on quality or quantity of services. It is of interest that six (75%) of the eight who reported a decrease in cost also reported that services were decreased (67% of that total), suggesting that those CMHSPs provided fewer services to the jails after the opinion than before. We also note one report of the Attorney General Opinion resulting in a temporary cessation of CMHSP jail service that was resumed after legislative budget language endorsing local choice to spend non-Medicaid money for such purpose.

Criteria to Determine Severity of Condition

The Mental Health Code (Sections 116 and 208) requires the public mental health system to give priority to "individuals with the most severe forms of serious mental illness, serious emotional disturbance, or developmental disability." However, the

Code does not provide a definition of "most severe," potentially leaving the door open to differences in eligibility determination among the CMHSPs. The survey asked CMHSPs to describe their criteria for determining the severity of a potential client's condition. The survey also asked whether the CMHSP used a standardized testing instrument for assessing the functional status of children and adults.

Responses to severity criteria were rather varied; no two were an exact match. Responses were also mostly general (i.e., entering "diagnosis" without detailing which ones). The main exception to generality was when scores on a diagnostic or functional assessment test were referenced; there was often mention of the instrument(s) involved.

There were 31 respondents to this question. All listed at least two criteria, with most listing more. Mentioned most frequently were:

Criterion	Number Using	Percent Using
Disruption of Function	20	64.5%
Standardized Test	15	48.4%*
Diagnosis	13-20**	42-64.5%
Mental Health/Service History	11	35.5%
Symptom Duration	7	22.6%
Symptom Severity	5	16.1%

*Most often stated were LOCUS and CAFAS, with 10 citations each

**Seven respondents appeared to be saying any mental illness was a criterion. It is unknown if they were veering into the realm of general service eligibility consideration, or were indicating they attach no particular diagnoses to priority status without the accompaniment of other (non-diagnostic) factors.

Other criteria receiving mentions were Medicaid guidelines; the state's Mental Health Code; and potential harm to self or others.

The majority of respondents had client level-of-functioning in their "severity" assessment mix. (This survey does not tell us how that gets applied from one community to another.) Elements often joining in were: standardized test results; diagnosis (though which types are generally unknown); and overall mental health or service utilization history. However, no respondents appear to be exactly alike, even in terms of the generalized criteria headings that constituted the bulk of the answers provided.

Regarding the types of standardized instruments applied by CMHSPs in making consumer assessments, there was a high degree of uniformity for youth testing, with a little more variability on the adult side.

Standardized Assessment Instrument	Number Using	Percent Using
Children		
CAFAS	32	100.0%
PECFAS	6	18.8%
DECA	2	6.3%
CaLOCUS	1	3.1%
Adults		
LOCUS	22	68.8%
GAF	6	18.8%
DLA	5	15.6%
SIS	5	15.6%
SOQ20	1	3.1%
OQ45	1	3.1%
locally developed tool	5	15.6%
none	1	3.1%

All of the CMHSPs reported using the CAFAS for children as required by DCH. Seven supplemented the CAFAS with another instrument; those noted in the table. Twenty-two used the LOCUS with adults. Eight of those reported also using a second instrument (4 GAF, 3 SIS, 1 OQ45) and two both the DLA and SIS in addition to the LOCUS. Three used the DLA as their primary assessment tool. Five, three of which were large CMHSPs, had developed their own tool, the other two using that developed by their PIHP. Only one CMHSP reported using no standardized assessment tool in measuring functional status. We caution that, even when there is instrument commonality across respondents, this survey did not explore commonality of testing applications and interpretations.

Psychiatric Inpatient Beds and Length of Stay

The survey asked CMHSPs to report the number of state-operated and non-state inpatient psychiatric beds available, the number of persons currently in those facilities, and the average length of stay. Responses noted that all CMHSPs have access, at least in theory, to all of the state-operated beds. These are budgeted by the Legislature for FY -2013 at 893, including 210 at the Forensic Center. Similarly, CMHSPs have, at least in theory, access to a very large number (one reported 913) of non-state-operated beds in hospitals throughout Michigan and even in neighboring states. Fewer than half of respondents gave a number for availability of either type of bed. These varied widely, perhaps reflecting different understanding of the question. Other analyses provide some information about the availability of beds.

State-operated facilities

Twenty-six (81.3%) of the CMHSPs reported having at least one person in a state-operated psychiatric hospital. The remaining six reported none at the time of the survey. There were a total of 413 people reported by respondents in state-operated facilities at the time of the survey. Extrapolating from the response rate, this projects to occupancy of 592 statewide. Among those that did have at least one person in a state-operated facility, the number varied widely, from 1 to 203 (the average was 15.8 with a median of 3.5), reflecting the large variation in population size of the CMHSPs. It was clear that state-operated facilities were used primarily for long-term care. The average length of stay for those reporting at least one person in a state-operated facility was 213 days (range of 10 to 730) with a median of 183 days. The weighted average, taking into account the number of consumers in a state-operated facility from each county, was somewhat lower, 152 days. Several CMHSPs with very few admissions reported high lengths of stay, which skewed the non-weighted average. This, as noted by three of these CMHSPs, reflected the potentially life-long hospitalization of a few people. These very long-term stays were diluted by the larger number of people admitted for 4 to 6 months to these facilities by high-population CMHSPs.

It is important to note that this survey did not ask for a breakdown of state psychiatric hospital usage according to forensic status. Based on our conversations with DCH officials, it appears that approximately 40% of those in adult state hospitals other than the Forensic Center (Caro, Kalamazoo and Walter Reuther) are so-called "forensic cases," including determinations such as incompetent to stand trial and not guilty by reason of insanity. (The remaining state-operated hospital is for youth and would rarely have forensic placements.) In other words, of the approximately 600 adult state beds budgeted outside of the Forensic Center for FY-13, over 200 are likely "reserved" as a practical matter for persons who have run afoul of the law. CMHSPs are not absolved of responsibility for financially supporting these admissions, even in instances where the CMHSP was not involved in determining an individual's placement.

Non-state-operated facilities

All but one of the respondents reported having at least one person in a non-state-operated inpatient facility. The one exception subcontracts the authority for those admissions to non-profit agencies and was unable to get a count. As with state-operated hospitals, the number of people in these facilities varied widely, from 1 to 100 with an average of 15.3 and a median of 5.0. It was clear that non-state-operated facilities were used for short-term inpatient stays. Both the average and weighted average length of stay was 6.8 days (range 4.5 to 14.2) with a median of 6.7 days. The 31 responding CMHSPs reported that 535 people were in such facilities at the time of the survey. If non-state facility use for the CMHSP that was the exception noted above were proportional to its state-operated facility use, this

would add another 260 people to the total. Adding them, and extrapolating from that total, suggests that CMHSPs may have over 1,100 people in non-state operated facilities at any given time. Given the much higher turnover rate – related to the short length of stay – the use of non-state psychiatric facilities likely dwarfs that of state-operated ones.

While CMHSPs reported potential access to a large number of non-state-operated beds, several commented that actual access was sometimes difficult and that distant, and even out-of-state, facilities sometimes had to be used.

Preadmission Screening

Criteria for screening for voluntary admissions

Section 409 of the Mental Health Code calls for a preadmission screening by the CMHSP which will be responsible for payment for a voluntary admission to determine whether the person is clinically appropriate for that admission. However, the Code does not specify the criteria to be used for making that determination. The survey asked whether CMHSPs used one or more of the following potential criteria (which are in Code section 401 regarding persons "requiring treatment"):

- Immediate danger to self or others
- Inability to attend to basic needs
- Impaired judgment or lack of understanding suggesting that there is a future danger to self or others.

All CMHSPs used immediate danger to self or others. Twenty-seven (84.4%) used at least two and 18 (56.3%) used all three. The results are as follow.

Criterion	**Number**	**Percent**
Immediate danger	5	15.6%
Immediate danger and basic needs	4	12.5%
Immediate danger and future danger of harm	5	15.6%
Immediate danger, basic needs and future harm	18	56.3%

There was some commonality and some variability among respondents in the use of criteria to determine clinical appropriateness for a voluntary inpatient admission. All used immediate danger to self or others (but, as with determination of severity-of-condition, commonality of a criterion does not necessarily mean uniformity of application). Only a little over half employed all three criteria from Mental Health Code section 401.

Frequency with which individuals decline admission

Because the Code section 409 admission is voluntary, a person who is found to be clinically appropriate for inpatient care does not necessarily agree to admission. CMHSPs were asked how often a person with a positive screen declined voluntary hospitalization. Twenty-nine of the 32 CMHSP's responded. They reported that this happened:

Frequency	**Number of CMHSP's**	**Percent**
Rarely	18	62.1%
Some, but less than half the time	10	34.5%
About half the time	1	3.4%

Not everyone who is found to be appropriate for inpatient admission is hospitalized. While this may happen rarely in a majority of CMHSPs, the results leave unanswered questions about the next steps taken by CMHSPs and what services these individuals are offered, and accept, in lieu of inpatient care.

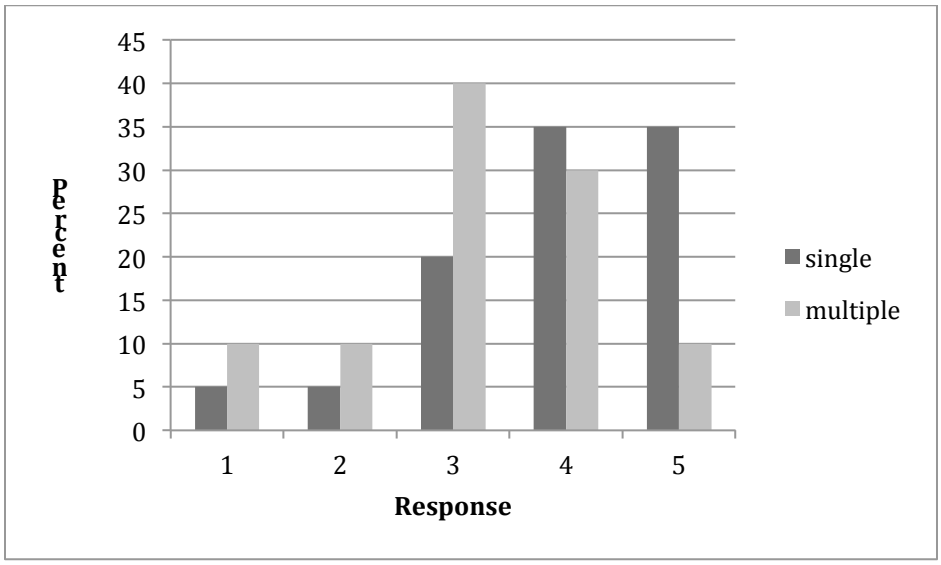
Prepaid Inpatient Health Plan (PIHP) Regionalization

Michigan is moving from 18 PIHPs to 10 regional PIHPs by mid-2013. These will handle all capitated Medicaid funding for specialty behavioral health care services beginning October 2013. (If Michigan's dual-eligible proposal is approved, they would also manage its behavioral services in the state's dual-eligible demonstration regions.) Of the ten regions, only three will be single CMHSP entities. The remainder will require that multiple CMHSPs form a single, legal PIHP administrative entity, though there is no requirement that any individual CMHSP dissolve. The survey asked for CMHSP opinions about the necessity for and the proposed number of PIHP regions.

Ten (33.3%) of the 30 respondents to the question stated that there was no compelling reason for any regions. Eight (27%) offered "no opinion." Of the remaining twelve (40% of total respondents), eight believed (27% of all respondents) that 9-10 was an ideal number, with the other four (13% of total) splitting their opinion evenly between the state's new number being too few and too many, respectively. On this issue, multi-county CMHSPs, those that have had experience with a multi-county organization, were notably more willing to express an opinion, with a plurality indicating that 9-10 was an ideal number of regions. The percentage of responses is shown as follows.

Response key:

- **1**: 9 to 10 regions is too few
- **2**: 9 to 10 regions is too many
- **3**: 9 to 10 regions is an ideal number
- **4**: There isn't a compelling need for any CMHSP "regions"
- **5**: No opinion



DISCUSSION OF RESULTS

Primary Prevention Programming

It has been 11 years since DCH's Prevention Services Unit was closed for budgetary reasons. In light of this circumstance, we find it commendable that 75% of survey respondents were providing at least one prevention program, and over half of all survey respondents (53%) were providing at least two. While the extent to which a brain disorder can be technically "prevented" is unknown, most CMHSPs are recognizing – and acting upon – the proven importance of targeting certain initiatives to children at risk of developing emotional disorders.

This does not mean we find the closure of the DCH Prevention Services Unit a sound policy decision. Without that unit, the state is lacking in research on potentially new prevention initiatives, as well as technical assistance to local communities in replicating newly validated approaches. The Prevention Services Unit was a low-cost ($2 million annually) investment that produced many positive results.

RECOMMENDATION 1: A prevention services unit should be re-established within DCH so that greater assistance can be rendered to the many CMHSPs that have shown commendable interest and involvement in primary prevention services targeted to youth at risk of emotional disorder.

Note: This recommendation was also made by the state's 2004 Mental Health Commission.

Dual-Eligibility

The finding on percentage of clientele with dual Medicaid-Medicare eligibility (27%) is consistent with the general perception in the mental health community that the figure would be about 25%.

The finding on reimbursement income attributable to dual-eligible clientele (39.5% statewide and 38% in the regions ultimately selected for the demonstration) is a little lower than the general perception in the mental health community that the figure would be around 50%.

The survey results clearly show any integration of health care for those with dual-eligibility will involve a fair number of CMHSP clients and a significant source of aggregate CMHSP income. Some stakeholders may find this important backing for the state's decision to propose a program structure that retains an important role for CMHSP service management. But the results also show that the number of dual-eligible clients served by a CMHSP is not a strong predictor of that CMHSP's current reimbursement income from such service. (Nor did any other apparent predictors emerge.) In fact, the correlation is rather weak.

RECOMMENDATION 2: Whether a new dual-eligible project with capitated funding proves helpful, harmful or neither to CMHSP resources for service provision will have to be monitored and assessed on a case-by-case basis.

Note: Interested readers are referred to the public policy section of MHAM's website (www.mha-mi.com) for respective sets of dual-eligible project principles developed by MHAM and the "Advocates Concerned with Dual Integration" coalition.

Attorney General's Opinion/Jail Services

While the majority of respondents felt that there had been no subsequent decline in the quality/quantity of jail mental health services, it is of concern that nine of 31 respondents (29%) did perceive a decline. That is a high-enough percentage to warrant further investigation of this issue.

Regarding subsequent costs to CMHSPs, one might have expected a decrease, and this was only reported by 25% of respondents. The majority, however, reported no cost impact in either direction. This may be attributable to the strong interest several CMHSPs have in jail service, coupled with legislative budget language over the last several years assuring that CMHSPs have the option to spend non-Medicaid General Fund money on such service. (If Michigan ultimately expands Medicaid under the federal Affordable Care Act, more jail inmates will meet Medicaid eligibility criteria, and off-site medical services for inmates who meet eligibility criteria are Medicaid-reimbursable).

What are the perspectives of sheriffs and jail administrators on these questions? An unpublished 2010 survey of sheriffs/jail administrators by Dr. Sheryl Kubiak of Michigan State University and Terry Jungel of the Michigan Sheriffs Association received responses from 67 county jails. While almost two-thirds of those respondents indicated positive working relationships with their local CMHSPs, another 22% reported problems in these relationships. Additionally, respondents in the aggregate expected that their costs for jail mental health service would be rising due to the Attorney General's Opinion, and it was stated that "confusion about the ruling…is widespread."

Putting the two surveys together, there is evidence to suggest that in some parts of the state (more than just a few), jail mental health services – and how they are managed, coordinated and funded – may be in need of review and improvement.

RECOMMENDATION 3: The Departments of Community Health and Corrections should convene a summit of stakeholders, including but not limited to CMHSPs and sheriffs, to review where jail mental health services stand four years after the Attorney General's Opinion, and to recommend what regulatory changes Michigan may need to foster service improvements and take advantage of new funding opportunities (if Medicaid is expanded in the state).

Severity of Condition and Functional Status

Should all CMHSPs have the same criteria (operationalized the same way) for determining whether someone has one of "the most severe forms" of serious mental illness" (SMI) or "serious emotional disturbance" (SED)? The terms SMI and SED are defined in the Mental Health Code; the "most severe forms," which qualify someone for priority service consideration, do not have a regulatory definition in Michigan.

Similarly, should all CMHSPs assess applicant/recipient level-of-functioning in the same way(s)?

These are critical and difficult questions. Is it important – and if so, to what degree – that people in "Community X" qualify for priority status and receive functional assessments in the same ways as do individuals in "Community Y?"

Severity

Regarding overall severity, the survey results clearly show there is a lack of uniformity, even if we assume similar local definition of terms such as "diagnosis" and "mental illness history." As stated in the Results section, no two CMHSPs were a match on what constitutes the most severe forms of SMI and SED. (This finding would not surprise most observers of mental health in Michigan.) Ascertaining the exact degree of existing disparity would require further investigation.

The state's 2004 Mental Health Commission recommended uniform statewide criteria for consumer "enhanced access" (priority status) based on the criteria of certain specified diagnoses, functional impairment below a certain level, or illness history crossing a certain threshold. (MHAM has supported the Commission's recommendation). Looking at these criteria, only six respondents' answers indicated use of all three of them – and these six could have local differences in how they're applied.

If one looks only at diagnosis and level-of-functioning for uniform severity criteria (as the state's Advisory Council on Mental Illness did in a 2006 recommendation as follow-up to the Commission's work), the number of respondents covering both of these in their answers grew to 16 – out of 31. Again, these may not be operationalized uniformly across the CMHSPs employing them. (In five of the sixteen cases, what was entered regarding diagnosis appeared to be the existence of any mental illness at all. In another three of the sixteen, credit was given for the mention of LOCUS testing, which has a functional status component among several behavioral health categories.)

RECOMMENDATION 4: The Department of Community Health should ascertain additional commonalities and differences among CMHSPs in determining severity-of-condition. This analysis should be followed by state regulatory action to see that the same criteria (operationalized in the same way) are employed by all CMHSPs in

identifying "the most severe forms" of SMI and SED. The importance to a service applicant/recipient of achieving or missing out on priority status under Michigan law is too great to be left to local variances.

Functional Status

Turning to measures for level-of functioning, the CMHSPs have a uniform standardized tool for youth in CAFAS. Per DCH's requirements, every respondent entered CAFAS. Seven respondents supplemented CAFAS with an additional instrument.

For adults, the situation is more variable, but 22 of 32 respondents used LOCUS. Fifteen respondents used other instruments, sometimes in concert with LOCUS. In five of these fifteen instances, a locally developed tool was used; the results provide no descriptive information about the local tools. Finally, one respondent reported having no standardized instrument to assess functioning of adults.

As long as an instrument possesses reasonable reliability and validity, we do not see a compelling need for all CMHSPs to use the exact same tool(s) for assessing functional status of adults. And we recognize that the executive branch has struggled unsuccessfully for years – in concert with the CMHSPs and other stakeholders – to develop a uniform adult assessment tool that could/would be used long-term by the field. With the exception of the five locally developed tools, about which there is a lack of information to inform a judgment, all other instruments entered for adults – and those entered for youth – appear to have at least adequate reliability and validity levels in the research literature. (SIS is a tool for intellectual/developmental disability, which can co-occur with mental illness. All respondents referencing SIS were using at least one other adult tool.) Of course, those figures are partly dependent on the specifics of how an instrument is administered and whether an instrument requires – and receives – any special staff training.

RECOMMENDATION 5: All CMHSPs should employ standardized functional assessment tools, with reasonable reliability and validity ratings, for youth and adults. The vast majority of CMHSPs covered by this survey met such a criterion. Additionally, all standardized instruments for assessment of functioning should be signed off on by DCH as being acceptable and appropriate to the Department.

Psychiatric Hospitals

Michigan has one of the lowest per capita rates in the nation of state-operated psychiatric hospital bed availability – less than 9 beds per 100,000 population if the Forensic Center is included; less than 7 beds per 100,000 if it is not. (According to the Virginia-based Treatment Advocacy Center, the national average is 14.1 beds per 100,000.) Some would take comfort in these figures; others would not. This survey attempted to ascertain CMHSP usage patterns for both the state-operated

facilities and the private/community psychiatric inpatient resources available to the system.

At the time of the survey, the vast majority of respondents (81%) had at least one person in a state psychiatric hospital, with an aggregate total of 413. Extrapolated across all Michigan CMHSPs, that number would translate into 592. This would represent 66% of all available beds if the Forensic Center were included, and 87% of all non-Forensic Center beds. We did not ask for a breakdown according to forensic status, and some respondents may have omitted forensic cases. Further information on such cases represents an important area for follow-up of this investigation.

By any measure – simple mean, weighted mean or median – the state hospital stays reported by respondents are moderately or highly lengthy. Across the respondents with admissions at the time of the survey, the median length-of-stay was a half-year, and the weighted mean was five months.

Regarding other types of psychiatric hospitalization (i.e., private psychiatric hospitals, psychiatric units in community hospitals), all but one respondent had at least one person in such placement at the time of the survey, and the remaining respondent may have through an admissions contractor. The aggregate number in non-state operated facilities was 535. Extrapolating across all Michigan CMHSPs, that number would translate to over 1,100. It would appear that CMHSPs utilize private and community facilities to a greater degree than state-operated ones, which would not be a surprise. (We were unable to ascertain the total number of private and community beds available to the system, as our question about this apparently wasn't well-worded enough to draw a sufficient number of responses.)

Once again, length-of-stay could be characterized – this time, as extremely acute – by any measure. The mean (whether weighted or simple) was 6.8 days; the median 6.7; and the upper end of the range was less than 15 days. This creates a higher yield of caseload turnover opportunities, so that CMHSP volume of annual admissions for community and private facilities likely swamps that for the state hospitals. Again, this is not a surprise, and it is not automatically unsound. Many factors impinge on hospital placement decisions, including but not limited to the circumstances of each case and economic factors. For example, Medicaid and at times private insurance can pay for community and private hospital beds, with these payers promoting short stays through their utilization management rules and financial incentives. On the other hand, Medicaid is federally forbidden to support state hospital usage by a non-geriatric adult, and private insurance is of little help when it comes to state hospitals.

This survey cannot settle the issue of whether Michigan has enough available state-operated psychiatric hospital beds – and, if so, whether they are sufficiently utilized. But it can perhaps be helpful in pointing out a possible gap between the two types of placements examined. One (community/private) will likely involve a one-week stay. The other (state-operated) will likely involve a stay of at least several months. But

what about consumers who can't be stabilized through non-hospital service or a hospital stay of only a week, yet aren't likely to require hospitalization approaching or exceeding 5-6 months? We suspect that a fair number of consumers with severe and persistent mental illness – more than just a few isolated cases – would fall into this potential gap, and that there are enough of these cases to warrant remedial action. We recognize that state hospital beds can and at times do provide such "intermediate length" care. But the evidence, coupled with our observations and experiences over many years, suggests this is not done enough to meet the clinical demand that likely exists.

RECOMMENDATION 6: The Department of Community Health should prepare and publish – for the state-operated adult psychiatric hospitals other than the Forensic Center – a report breaking down per forensic status utilization variables such as those from this study.

RECOMMENDATION 7: The state needs to develop psychiatric hospital beds or alternative residential options – and assure adequate funding and clinically appropriate usage – for persons who require protected intensive care for a period that is in-between acute (i.e., typically one week) and long-term (i.e., often 5-6 months or longer). We respectfully suggest that Governor Snyder's Mental Health & Wellness Commission (established in early 2013, with a report due December of 2013) incorporate planning for this in its work.

Note: The state's 2004 Mental Health Commission recommended that there be small regional public hospitals, and that Michigan field-test small secure residential facilities. Neither has happened.

Preadmission Screening (Criteria)

In the absence of Mental Health Code section 409 screening criteria, over half of respondents applied all three of the involuntary hospitalization criteria from Code section 401. (A hospitalization determination under section 409 is, in effect, a recommendation for a voluntary hospitalization.) We believe these respondents have made a sound decision. Whether or not they operationalize and apply the three criteria uniformly would require further investigation.

Almost half of respondents (44%) did not use all three Code section 401 criteria. Some of these respondents used one of the 401 criteria; some used two. These respondents are not in violation of any regulation, but we're left with a situation where roughly half the state may use certain criteria for preadmission screening, while criteria in the other half of the state are somewhat different.

RECOMMENDATION 8: Section 409 of the Mental Health Code should be revised to specify uniform statewide criteria for CMHSP preadmission screening criteria. Until

this happens, all CMHSPs should apply each of the Code section 401-hospitalization criteria for preadmission screening determinations.

Preadmission Screening (Denials)

The majority of respondents rarely encounter a screened individual declining a recommended voluntary hospitalization. But 38% of respondents encounter this situation more than rarely – a figure high enough to warrant further exploration. State law provides no specific regulatory guidance here. (Code section 409 says that if the preadmission screening unit doesn't find hospitalization necessary, the unit is to provide information about other possible services as well as make referrals, but there is nothing on follow-up for a screened individual's refusal of an inpatient recommendation.)

Although this survey didn't inquire about percentage of screenings resulting in hospitalization recommendations, there is a general perception that CMHSPs don't/can't give such recommendations easily (just as it's perceived that courts don't/can't give involuntary orders easily). Additionally, CMHSPs are often financially liable for hospitalizations, which can add pressure to the decision-making process. Thus, preadmission screening cases yielding an inpatient recommendation are likely to involve very severe symptomatology. What do CMHSPs do next when a recommendation is declined? What should they do next?

MHAM has supported draft legislation that would require courts to treat a declined preadmission screening inpatient recommendation as a petition for a hearing on a possible civil order for care. We recognize that some would want to first know how CMHSPs presently deal with denials of CMHSP inpatient recommendations.

RECOMMENDATION 9: The Department of Community Health should follow-up this survey by ascertaining and reporting: (1) the annual number of statewide cases screened, and how many screenings result in hospitalization recommendations; (2) whether CMHSPs across the state employ common and effective practices to protect the health and safety of those declining inpatient recommendations. If investigation of the latter does not yield satisfactory information, state law should be revised so there are specific next steps for CMHSPs to follow in such situations.

PIHP Regionalization

Results here should be treated with caution, as the initiation of this survey coincided with executive branch announcement of the coming reconfiguration of PIHP regions. The Department of Community Health had released possible alternatives for new regionalization in the summer of 2012; the Michigan Association of CMH Boards had responded with a detailed recommendation on the composition of ten regions; and the executive branch accepted that recommendation. The settling of the regionalization structure could have influenced some respondents' views.

A plurality of respondents (33%) stated there was no compelling reason for any regions. Responses were split fairly closely, however, between that option; the option of 9-10 regions as an ideal number; and no opinion. The "no compelling reason" and "no opinion" response rates (combined 60%) could reflect ambivalence about regionalization – past and present – being primarily a state-driven concept.

Of note was the finding that CMHSPs that have had previous experience in CMHSP affiliations were more likely than those that have been single-county entities to support 9-10 regions as an ideal number.

There has been and will continue to be policy discussion about how many CMHSPs Michigan requires, and whether both CMHSPs and PIHPs are needed. For the purpose of this report, given that a new PIHP configuration has been selected and will begin soon, the results of our survey do not yield any recommendations for application to the new configuration.

APPENDIX A: Responding CMHSPs

Bay-Arenac
Clinton-Eaton-Ingham (CEI)
Centra Wellness
Central Michigan
Copper Country
Detroit-Wayne
Genesee
Gratiot
Hiawatha
Huron
Ionia
Kalamazoo
Lapeer
Lifeways
Livingston
Macomb
Montcalm
Network180
Newaygo
Northeast
Northpointe
Northern Lakes
Ottawa
Pathways
Saginaw
Saint Clair
Saint Joseph
Sanilac
Shiawassee
Tuscola
Van Buren
Woodlands

Appendix B: Survey Instrument

Mental Health Assn. in Mich. CMHSP Survey: November 2012 – January 2013
Commissioned by the Flinn Foundation (Detroit)

Name of Your CMHSP (please print): _____

_____

Name of Person Filling out Survey (please print): _____

I. Prevention Programming

A. The state lost a potentially valuable resource around 2002 when DCH's Prevention Services Unit was closed due to budget reductions. How many prevention programs, targeted to youth at risk of emotional disorder, is your CMHSP presently providing?

_____

B. Please list the titles of those projects (please print):

_____

_____

_____

_____

II. Dual-Eligibility (Medicaid-Medicare)

MHAM supports the concept of respective management tracks for mental health and non-mental health. Please list below your current approximate percentages of dual-eligible clients served and dual-eligible reimbursements received.

A. Our approximate current % of dual-eligible service recipients is: _____

B. The approximate current % of our overall income from dual-eligible service is:

_____

III. County Jail Mental Health Service

In May 2009, the Michigan Attorney General (Opinion #7231) stated that counties were the payer of last resort for jail mental health service, and that CMHSPS' obligation is to first seek to obtain payment from "available insurance or other sources." To help us assess ramifications of that ruling, please answer the following questions if your CMHSP provided county jail mental health service prior to the Attorney General's Opinion.

A. The effect of the Attorney General Opinion on county jail mental health service in our catchment area has been (please check one):

1) ___ To lessen the quantity and/or quality of available services

2) ___ To expand the quality and/or quantity of available services

3) ___ There has been no appreciable impact one way or the other on county jail mental health service

B. The net effect of the Attorney General Opinion on our cost to provide jail service has been (please check one):

1) ___ Our cost has increased

2) ___ Our cost has decreased

3) ___ There has been no effect on our cost

IV. Criteria and Tools for Severity

Among the criteria for public mental health system prioritization are "individuals with the most severe forms of serious mental illness, serious emotional disturbance, or developmental disability" (sections 116 and 208 of the Mental Health Code). We are unaware of any state law, rule or policy specifying what the most severe forms of serious mental illness or serious emotional disturbance are. Thus, we are interested in cataloguing the most common criteria across the state for this determination (whether or not SMI or SED evinces severity), as well as any standardized tools used to assess severity of condition and/or functioning.

A. Our primary criteria for whether or not someone is experiencing one of the most severe forms of serious mental illness or serious emotional disturbance are (please print):

_____

_____

_____

_____

_____

B. For youth, our main standardized severity assessment tool is: CAFAS___ Other___

(If other, please specify: _____)

C. For adults, our main standardized assessment tool for severity is:

_____

V. Access to Hospital Beds

The Treatment Advocacy Center (Arlington, VA) recently reported that in 2010, Michigan had 5.4 state-operated psychiatric inpatient beds per 100,000 population. We believe the actual figure for 2010 was about 7 per 100,000 without the Forensic Center, or about 9 per 100,000 with the Forensic Center. Regardless of what the exact figure was, looking only at state-operated beds omits other inpatient psychiatric beds to which the public mental health system has access. Please help us learn the number and types of beds you have access to, and the degree to which they're presently utilized.

A. The # of state-operated psychiatric inpatient beds available to our CMHSP is:

_____

B. The # of state-operated hospital admissions we're presently overseeing is: _____

C. The average length-of-stay in state hospitals for our clients is approximately:

_____

D. The # of other (non-state) psych. hospital beds available to our CMHSP is: _____

E. The # of other (non-state) hospital admissions we're presently overseeing is:

_____

F. The average length of our clients' stay in other (non-state) psych. hospitals is:

____

VI. Preadmission Screening

Section 409 of the Mental Health Code states, "A preadmission screening unit shall assess an individual being considered for admission into a hospital operated by the department or under contract with the community mental health services program. If the individual is clinically suitable for hospitalization, the preadmission screening unit shall authorize voluntary admission to the hospital." Code section 409 does not specify criteria for a determination of whether someone is clinically suitable for hospitalization.

A. Please check the one answer below that best represents your CMHSP's primary criterion or criteria for authorizing voluntary hospitalization under section 409.

1) ____ Immediate danger of harm to self or others

2) ____ Inability to attend to basic needs like food, clothing, shelter

3) ____ Impaired judgment and lack of understanding suggest there is a future danger of harm to self or others

4) ____ 1. or 2. above

5) ____ 1. or 3. above

6) ____ 2. or 3. above

7) ___ any one of 1., 2., or 3. above

8) ___ other (please specify: _____)

B. The frequency with which your preadmission screening clients decline a voluntary hospitalization that you have recommended is (please check one):

1) ____ Rarely

2) ___ It happens some, but less than half the time

3) ___ About half the time

4) ___ More than half the time

5) ____ The vast majority of the time

VII. CMHSP Regionalization

This August, DCH released for discussion purposes three different drafts of state maps creating nine CMHSP regions. In those regions with multiple CMHSPs, presumably one would be designated the region's lead CMHSP (as is the case today with PIHPs in multi-CMHSP collaborations). Reacting to those alternatives, the CMH Boards Association in October presented DCH with a state map entailing ten CMHSP regions for Michigan, and DCH accepted that map. Please check below the response that best represents your current (and confidential) thinking on the number of CMHSP regions the state should have.

A. ____ 9-10 regions is too few

B. ___ 9-10 regions is too many

C. ____ 9-10 regions is an ideal number

D. ____ There isn't a compelling need for any CMHSP "regions"

E. ____ No opinion