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COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

APPLICATION GUIDANCE AND INSTRUCTIONS

FY 2004



**CENTER FOR MENTAL HEALTH SERVICES
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES
ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Statutory Authority: Under the authority of Sections 1911-1920 and 1941-1954 of the Public Health Service Act (PHS Act) and subject to the availability of funds, the Secretary of the Department of Health and Human Services, through the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), awards Block Grants to States to establish or expand an organized community-based system of care for providing mental health services for adults with serious mental illness (SMI) and children with serious emotional disturbances (SED). In order for the Secretary to award Block Grants for this purpose, States, all Territories and the District of Columbia (herein after referred to as States) are required to submit an application, prepared in accordance with the law, for each fiscal year for which the State is seeking funds. Specifically, the funds awarded are to be used to carry out the State plan contained in the application, to evaluate programs and services set in place under the plan and to conduct planning, administration and educational activities related to the provision of services under the plan. Specific authority for collecting data from the States is found in three different Sections of the law. First in Section 1912(c)(1) and (2)(42 U.S.C. 300x-2), the Secretary is required to establish definitions for SMI and SED. Second, Section 1943(a)(3) (42 U.S. C. 300x-53) states that a funding agreement for a grant under Section 1911 or 1921 is that the State involved will provide to the Secretary any data required by the Secretary pursuant to Section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section. Lastly, Section 1917(a)(7) states that the application (including the plan under Section 1912(a)), is otherwise in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subpart. A grant may be made only if the plan meets the five (5) criteria in the law (Section 1912 (b)) and is approved by CMHS. After review of the State plan implementation report for the previous fiscal year, CMHS must also determine that the State has completely implemented the plan approved for the previous fiscal year.

NOTICE TO RESPONDENTS

The annual reporting burden for collection of this information is estimated to average 300 hours for a one-year application and 270 hours for a two-year application. This includes the time required for reviewing instructions and preparing the application, writing the implementation report and gathering, maintaining, and reporting the needed data. Comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden should be addressed to: SAMHSA Reports Clearance Officer, Paperwork Reduction Project (0930-0168), Room 16-105, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, or a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

APPLICATION CONTENTS OVERVIEW

Under this guidance and instructions, States may submit a one year (FY 2004) application containing the State plan for the Community Mental Health Services Block Grant (CMHSBG). States may also initiate a request for modification of a previously approved multi-year plan. All applications are required to have a Face Sheet (see page 7), Table of Contents (sample format is provided - see pages 8-9), an Executive Summary in 1-2 pages (a brief description of the context of the State plan and major areas of focus) and the following five sections. If the State fiscal year is different from the Federal fiscal year, the State may use the State fiscal year for the purposes of preparing the State plan, implementation report and reporting the uniform data.

Section I - Application Information

This section contains all funding agreements, certifications, and assurances that must be signed in order to receive an award. Copies of the attached funding agreements, certifications and assurances (Attachments A, B, & C) contain all necessary language and signature lines. To expedite review and avoid the need to resubmit, applicants are requested to complete and sign as is.

This section also requires information on the Maintenance of Effort (MOE), set-aside for children's services, mental health planning council and requests for waiver where permitted according to Section 1913(a)(2)(A)(B)(C) (42 US 300x-3), Section 1917(b) (42 U.S.C. 330x-6), and Section 1915(b)(3) (42USC 300x-4) of the PHS Act.

Section II- State Plan Context

In this section, States will describe significant issues or initiatives within the State, which are important in understanding the State, plan in the context of the broader system. This may include a brief summary of areas identified by the State in the previous plan as needing particular attention and significant achievements to date under the previous year's plan. This section will also identify critical gaps in services and unmet needs projected for the fiscal year 2004.

Section III - State Plan

This section will address the five criteria under section 1912(b) of the PHS Act that are required to be addressed in the State Plan. States are required to write the State plan addressing criteria 1, 2, 4, and 5 for adults with SMI and criteria 1-5 for children with SED separately, following the sample format included in this guidance. The given format requests that for each criterion for adults with SMI and children with SED, States provide an appropriate narrative, identify a goal, one or more objectives and corresponding performance indicators.

If a multi-year plan has been submitted that covers FY 2004, all of Section I (application) will be required. It is not necessary to submit a new plan (Section II and Section III). In addition to materials that need to be submitted annually, States are requested to include proposed modifications, if any, to the FY 2004 plan.

In modifying the State plan, it is expected that States will ensure that their plans are updated to reflect current status of their mental health systems. It is important that the MHBG program be aware of changes made in the mental health system since the submission of the previous year's multi-year plan. Thus, prior to completion of the FY 2004 application and plan, States should assess the impact of any changes (positive and negative) that occurred in FY 2003 or anticipated in FY 2004 that will affect the State's ability to carry out the FY 2004 portion of the multi-year plan.

If additional changes (those beyond any previously identified modifications) need to be made, it is expected that States will report the changes as part of the application package thus modifying the original plan. In modifying the plan, you are asked to identify specific changes referring to page numbers of the original plan. Please do not simply make changes in the original plan and resubmit. These modifications should be discussed in detail within the context of the affected criteria, goals, objectives, and performance indicators. If new programs or initiatives are developed, it is expected that new goals, objectives and performance indicators will be added to the plan. States are also reminded that Criterion 5 requires information on how the grant will be expended for FY 2004. If the original plan does not address funding plans for FY 2004, it should be included in the application update.

Each year, the State must submit the maintenance of effort and the block grant certification and assurances. Additionally, States submitting multi-year plans must also provide documentation (preferably a letter from the chairperson) that the mental health planning council reviewed the FY 2003 block grant plan, which includes recommendations for modifications to the plan.

As required by Section 1915(a)(2) of the PHS Act (42 U.S.C. 300x-4), this section will contain any recommendations received by the State for modifications to the plan in the form of a letter or report from the Chair of the Mental Health Planning Council.

Section IV - State Plan Implementation Report

This section will contain the State Plan Implementation Report for FY 2003 as required by Section 1942(a) of the PHS Act (42 U.S.C. 300x-52). For ease of review and for making a determination regarding the extent to which a State has implemented its prior fiscal year's plan, States are requested to prepare and submit their implementation reports for the last completed FY in a format provided for this purpose in this guidance. This will contain a report on the purposes for which the Community Mental Health Services Block Grant monies for the prior FY were expended, the recipients of funds provided under the grant and a description of activities using the funds as required by Section 1942(a)(1) and (2) (42 U.S.C. 300x-52). The report shall focus on the extent to which the State has implemented its plan for the prior FY with particular attention given to the goals, objectives and performance indicators. As required by section 1915 (a)(2), this section will contain any comments regarding modifications to the report from the mental health planning council.

Section V - Uniform Data on Public Mental Health System

The completion of Section V is now a term and condition for funding of States and Territories that were awarded Data Infrastructure Grants. Thus, all States and Territories that accepted the grant agreed to submit Section V as part of the FY 2002-2004 Implementation Reports (Section IV). The Report for FY 2003 is due December 1, 2003. States and Territories that did not apply for the Data Infrastructure Grant are encouraged to submit data under Section V. **Further instruction regarding the completion of Section V will be forthcoming in the regularly scheduled Data Infrastructure Grant phone calls and other communications.**

Submission Requirements and Due Dates

Please submit an original application plus two copies to Ms. LouEllen M. Rice, Grants Management Officer, Division of Grants Management, OPS, SAMHSA, 5600 Fishers Lane, Room 13-103, Rockville, Maryland 20857. Sections I, II, and III of the FY 2004 application was due on September 2, 2003, and Section IV (Implementation Report for FY 2003) **is due by December 1, 2003** as required by Section 1917(a)(1) (42USC 300x-6) of the PHS Act. If a two-year or three year plan was previously submitted, an updated Section I and any modifications to Sections II and III should have been submitted to CMHS by September 2, 2003. Revisions and projections on performance indicator tables should be submitted annually. **Section V (uniform data) is to be submitted with the FY 2003 Implementation Report (Section IV) by December 1, 2003.** Detailed guidance and instructions as they apply to the various sections of this application are provided under the respective sections below. Upon request, CMHS will supply 3.5" WordPerfect version 9 disk containing the application guidance and instructions. The application will also be available at the Web site <http://www.mentalhealth.org/>. All parts of the application may be filed electronically and e-mailed to Marie Danforth, Branch Chief of State Planning and Systems Development, at mdanfort@samhsa.gov. If the application is sent electronically, a signed original hard copy of Section I must also be submitted to Ms. Rice by the due date. Should you need additional information related to grants management issues, contact Ms. Rice at 301-443-4456. Should you have programmatic questions, you may contact your Federal Project Officer at 301-443-4257.

The application will be reproduced using automatic sheet feeders to provide sufficient copies for the peer consultative regional review. The original and two copies should be unbound with no staples, paper clips or fasteners. Do not include anything that cannot be photocopied using automatic feeder sheets. Do not attach or include anything folded, pasted, or in a size other than 8^{1/2}" x11" on white paper. Heavy or lightweight paper will jam the photocopy machine and could be destroyed by the machine. Your submission should be printed on one side. Please do not condense type closer than 15 characters per inch. Because application materials can get out of order when being reproduced, as well as during the review process, each sheet of the application should be numbered consecutively from beginning to the end (for example, page 1 for the face

sheet, etc.). If appendices or additional materials are included, they should be numbered, continuing the same sequence. It is desired that the application be limited to 120 pages. If the application is greater than 120 pages and /or is bound, please provide 10 copies.

FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

FY 2002-2004 **FY 2003-2004** **FY 2004**

STATE NAME: _____

I. AGENCY TO RECEIVE GRANT

AGENCY: _____

ORGANIZATIONAL UNIT: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: _____ FAX: _____ DUNS #: _____

**II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR
ADMINISTRATION OF THE GRANT**

NAME: _____ TITLE: _____

AGENCY: _____

ORGANIZATIONAL UNIT: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: _____ FAX: _____

III. STATE FISCAL YEAR

FROM: _____ TO: _____

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: _____ TITLE: _____

AGENCY: _____

ORGANIZATIONAL UNIT: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: _____ FAX: _____ EMAIL: _____

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ATTACHMENTS

- Attachment A - Community Mental Health Services Block Grant Funding Agreements
- Attachment B - Certifications
- Attachment C - Assurances - Non Construction Programs

**SECTION I
APPLICATION INFORMATION**

All necessary funding agreements, certifications and assurances are attached in a format suitable for direct use and signature. Do not retype any of the attachments included in this Section. Retyping may require an extra review and possible need for re-submission of an agreement or certification which could delay the award of funds.

1. Funding Agreements (Attachment A)

The Chief Executive Officer (Governor) or a formally authorized designee must sign the statutory funding agreements, hereby attesting that the State will comply with them. If the funding agreements are signed by a designee, a letter from the Governor authorizing the person to sign must be included with the application.

2. Certifications (Attachment B) - (OMB Approval 0348-0040)

a. Debarment and Suspension

A fully executed Debarment and Suspension Certification must be included.

b. Drug-Free Workplace Requirements

A fully executed certification regarding Drug-Free Workplace Requirements must be included with the application unless the State has an acceptable FY 1997 Statewide or Agency-wide certification on file with the Department of Health and Human Services. Federal regulations regarding these requirements are found in 45 CFR Part 76.

c. Lobbying and Disclosure

A fully executed Lobbying Certification must be included (for all awards exceeding \$100,000). This certification must be signed by the Chief Executive Officer of the State (Governor) or his/her formally authorized designee. Additional information regarding this requirement can be found in 45 CFR Part 93.

d. Program Fraud Civil Remedies Act (PFCRA)

e. Environmental Tobacco Smoke

3. Assurances (Attachment C) - (OMB Approval 0348-0040)

4. Maintenance of Effort (MOE)

Section 1915(b)(1) of the PHS Act (42 U.S.C. 300x-4) requires that States submit information sufficient to enable the Secretary to make a determination of compliance with the statutory MOE requirements. Specifically, MOE information is required to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant. Section 1915(b)(2) provides that the Secretary may exclude from the aggregate State expenditures under subsection (a), funds appropriated to the principle agency for authorized activities which are of a non-recurring nature and for a specific purpose. Please provide the following information:

MOE information reported by:

State FY _____

Federal FY _____

State Expenditures for Mental Health Services

Actual	Actual	Actual/Estimated
FY 2001 \$ _____	FY 2002 \$ _____	FY 2003 _____

5. Set-Aside for Children’s Mental Health Services

Section 1913(a) of the PHS Act (42 USC 300x-3) requires that the State provide systems of integrated services for children with serious emotional disturbances (SED). Each year the State shall expend not less than the calculated amount for Fiscal Year 1994.

Please provide the following information:

DATA REPORTED BY:

STATE FY _____

Federal FY _____

State Expenditures for Mental Health Services

Calculated	Actual	Actual	Actual/Estimated
FY 1994	FY 2001	FY 2002	FY 2003
\$ _____	\$ _____	\$ _____	\$ _____

6. State Mental Health Planning Council Membership Requirements

Section 1914(c) of the PHS Act (42 U.S.C. 30x-4) requires that State Mental Health Planning Councils conform with certain membership requirements. This includes representatives of certain principal State agencies, other public and private entities concerned with the need, planning, operation, funding and use of mental health services and related services, family members of such adults and children with serious emotional disturbances, and representatives of organizations of individuals with mental illness and their families and community groups advocating on their behalf. (See Table I, page 13). Specifically, the law stipulates that not less than 50% of the members of the planning council shall be individuals who are not State employees, or providers of mental health services. (See Table I, page 14). The law also requires that the ratio of parents of children with SED to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council.

7. Planning Council Charge

Section 1914(b) of the PHS Act (42 U.S.C. 300x-4) requires that State Mental Health Planning Councils perform certain duties. A charter or a narrative summarizing the duties of the State Mental Health Planning Council should be included in the application. This should also specify the policies and procedures for the selection of council members, their terms, and the conduct of meetings.

8. State Mental Health Planning Council Comments and Recommendations (Section 1915(a))

Along with the State plan, States are required to submit documentation from the State Mental Health Planning Council containing any recommendations for modifications to the State plan received by the State, regardless of whether the State has accepted the recommendations. Similarly, along with the annual implementation report, States are required to submit documentation from the Council containing any comments received by the State on the State's annual implementation report. The documentation should indicate that the Council has reviewed the State plan and the annual report as appropriate.

9. State Mental Health Planning Council Membership List

Complete Table I for FY 2004 using the format given on the following page for the purpose of demonstrating compliance with the statutory requirements. In the column titled "Type of Membership," indicate whether a member is a primary consumer, family member of a child with SED, family member of an adult with SMI, provider, state employee, or other representative not otherwise stated in the statute. The principle State agencies are: mental health, education, Medicaid, vocational rehabilitation, housing, social services and criminal justice.

11. Planning Council Composition by Type of Member (Table 2)

Type of Membership	Number & Percent Membership
TOTAL MEMBERSHIP	# _____
Primary Consumers	
Family Members of Children with SED	
Family Members of Adults with SMI	
Vacancies (Primary consumers & family members)	
Others	
Total Primary Consumers, Family Members & Others	_____ # _____ %
State Employees	
Providers	
Vacancies	
Total State Employees, & Providers	_____ # _____ %

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) Consumers and family members shall constitute no less than 50% of the total members of the Planning Council, and 3) Other representatives may include individuals with interest in children with SED or adults with SMI.

12. Waivers

a. Maintenance of Effort (MOE)

Under Section 1915(b)(3) of the PHS Act (42 USC 300x-4), a State may request a waiver for all or part of the MOE requirements if the Secretary of the Department of Health and Human Services, acting through the SAMHSA Administrator, determines that extraordinary economic conditions justify the waiver. The State must submit information sufficient for the Secretary to make the determination, including the nature of the extraordinary economic circumstances, documented

evidence, appropriate data to support the claim and documentation of the year for which the State seeks the waiver. Any waiver granted will be applicable only to the fiscal year involved. “Extraordinary economic condition” means a financial crisis in which the total tax revenue of the State declines by at least one and one-half percent, and either unemployment increases by at least one percentage point or employment declines by at least one-half percent.

In the case of any territory of the United States, except Puerto Rico, the Secretary may waive such provisions of Subpart I and Subpart III as the Secretary determines to be appropriate, other than the provisions of Section 1916.

b. **Set-Asides for Children’s Mental Health Services**

Waiver of set-aside for children’s mental health services requirement may be requested under Section 1913(a)(2)(A)(B)(C) of the PHS Act (42 U.S.C. 300x-3).

SECTION II
STATE PLAN CONTEXT

General Guidance

In this section, States are requested to identify any issues or initiatives within the State that are important in understanding the State plan in the context of the broader system.

Specific Areas for Inclusion:

- A.** A brief description of the State public mental health service system as it is envisioned for the future;
- B.** A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year;
- C.** New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waiver, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements;
- D.** Legislative initiatives and changes, if any;
- E.** A brief description of regional/sub State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State;
- F.** Description of how the State mental health agency provides leadership in coordinating mental health services within the broader system;
- G.** The role of the State Mental Health Planning Council in improving mental health services within the State;
- H.** Description of critical gaps in services and unmet needs projected for the duration of the plan being submitted; and
- I.** Identification of the source of data which was used to project critical service gaps and unmet needs.

SECTION III

STATE PLAN

Fiscal Planning Assumptions

If final allocation for Community Mental Health Services Block Grant for the FYs covered by the State plan is not available at the time of the preparation of this application, we recommend that the intended use of the funds be based on the amount of allocation made to the State for the prior FY. For example, the FY 2004 State plan should be prepared based on the allocation for FY 2003. States should plan to amend the plan once their final appropriations for FY 2004 and subsequent years covered by the plan are known, should the final allocation/s change from the FY 2003 level.

Funds awarded under this Block Grant are available for obligation and expenditure for the full two-year period. For the FY 2004 block grant award, the period is October 1, 2003 through September 30, 2005.

State Plan Format and Content

Under Section 1912(b) of PHS Act (42 USC 300x-2), the State Plan must address the five (5) legislated criteria. Criteria 1, 2, 4 and 5 must be addressed for adults with SMI, and Criteria 1-5 must be addressed for children with SED. **States should submit a single plan in which services for both adults with SMI and children with SED are addressed separately.** Transitional services between the child system and adult system should be addressed in the children's plan. A listing of the **“Five Criteria to be Addressed in the State Plan”** (Table 2) is included in this Section. For each criterion for adults with SMI and children with SED, the State plan shall have a narrative appropriate to the criterion, one goal, one or more objectives and a minimum of one performance indicator for each objective identified. The selection of specific goals, objectives, and performance indicators will be determined by each State. The goal, objectives, and performance indicators should be prepared for all criteria following the one page

sample, **“Format for Performance Indicator Description”**, for criteria 1 and 2 included in Section III. For each objective with corresponding performance indicators included in the State plan, a similar one-page description employing the same format should be included. A **“Menu of Illustrative Performance Indicators”** that may be appropriate for the plan under the five criteria is also included in Section III. States may choose performance indicators from the given menu or use State specific performance indicators.

Whenever possible, chosen performance indicators must be outcome focused. Additionally, the plan shall include a **“State Plan Performance Indicator Data Table”(Table 3)**, prepared according to **“Guidance for Preparing State Plan Performance Indicator Data Table”**. If a State has an approved multi-year plan, the performance indicator descriptions and the performance indicator data tables should be prepared separately for each FY covered by the plan. This is required for the purpose of allowing CMHS to determine whether a State has completely implemented its plan for each FY.

This application also includes tables for the submission of uniform data in Section V. If possible, states should develop performance measures using data consistent with the tables in terms of sources, definitions and time frames. Several initiatives by the Center for Mental Health Services such as the efforts supported by the State Reform Grants and the Data Indicator Grants have promoted the use of mental health performance measures and their standardization. States should consider performance indicators and measures developed in these initiatives for use in this plan.

States will not be requested to submit data under the six voluntary Government Performance and Results Act (GPRA) measures for the FY 2004 application and plan.

Narrative Appropriate for Each Criterion

“Suggested Items for Narrative Under Each Criterion and Illustrative Performance Indicators.” States may choose from the suggested items, modify the items or provide unique items. Narratives appropriate to the criterion might convey the extent to which the services required to be addressed by the criterion have already been implemented, and the present gap between the need for those services and the availability of resources. For each objective stated in the State plan under a particular criterion, a minimum of one performance indicator should be identified in the narrative and an appropriate outcome that is relevant to each criterion. States should show the value for the selected performance indicator(s) for FY 2002, FY 2003 and the projected value for FY 2004 (to the extent that information is available and can be projected). States should also prepare separate **“State Plan Performance Indicator Descriptions”** and **“State Plan Performance Indicator Data Tables”**.

The narrative should focus on and explain how the indicator fits with the State’s identified objective. It should also include implementation strategies to be employed under each criterion to organize, finance and deliver services within the community mental health system. Specifically, human resources that will be available to carry out the plan should be identified.

Goal: For the purpose of this application, a goal is a long-term outcome generally expressed as an aspiration. Goals may not be easily measured, nor fully realized but they constitute desirable ends toward which efforts and resources are directed.

Objective: An objective is a specific, measurable target expected to be achieved within a defined period of time, and which, if attained, is expected to contribute to the realization of the goal. The objectives under each criterion must be designed to meet the critical gaps in service needs identified in the narrative section of that particular criterion. When the implementation report is prepared, based on the information provided, States will be expected to state clearly whether or not each objective as stated in the approved plan is “achieved” or “not achieved”.

Five Criteria to be Addressed in the State Plan (Table 2)**Criterion 1: Comprehensive Community-Based Mental Health Service Systems**

- ? Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.
- ? Describes available services and resources in a comprehensive system of care, including services for individuals diagnosed with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:
 - Health, mental health, and rehabilitation services;
 - Employment services;
 - Housing services;
 - Educational services;
 - Substance abuse services;
 - Medical and dental services;
 - Support services;
 - Services provided by local school systems under the Individuals with Disabilities Education Act;
 - Case management services;
 - Services for persons with co-occurring (substance abuse/mental health) disorders; and
 - Other activities leading to reduction of hospitalization.

Criterion 2: Mental Health System Data Epidemiology

- ? Contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children; and
- ? Presents quantitative targets to be achieved in the implementation of the system of care described under Criterion one (1).

Criterion 3: Children’s Services

- ? Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:
 - Social services;
 - Educational services, including services provided under the Individuals with Disabilities Education Act;
 - Juvenile justice services;
 - Substance abuse services; and
 - Health and mental health services.
- ? Establishes defined geographic area for the provision of the services of such system.

Criterion 4: Targeted Services to Rural and Homeless Populations

- ? Describes State’s outreach to and services for individuals who are homeless;
- ? Describes how community-based services will be provided to individuals residing in rural areas.

Criterion 5: Management Systems

- ? Describes financial resources, staffing and training for mental health service providers that are necessary for the implementation of the plan;
- ? Provides for training of providers of emergency health services regarding mental health; and
- ? Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal year involved.

Note: Criteria 1, 2, 4 and 5 should be addressed for adults with SMI and Criteria 1-5 should be addressed for children with SMI.

Suggested Items for Narrative Under Each Criterion and Illustrative Performance Indicators**Criterion 1: Comprehensive Community Based Mental Health Service Systems**

- ? Provides for the Establishment and implementation of an organized community-based system of care for individuals with mental illness.
- ? Describes available services and resources in a comprehensive system of care. This consists of services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities, including services for individuals diagnosed with both mental illness and substance abuse.

Items for Inclusion in the Narrative:

- Organizational structure of the comprehensive system of care;
- Health and mental health services;
- Rehabilitation services;
- Employment services;

- Housing services;
- Educational services;
- Substance abuse services;
- Medical and dental services;
- Support services;
- Services provided by local school systems under the Individuals with Disabilities Education Act;
- Case management services;
- Activities leading to reduction of hospitalization;
- Services for persons with co-occurring (substance abuse/mental health) disorders; and
- Other historical information to describe the reduction in State and county hospitals/inpatient beds and changes in utilization of psychiatric inpatient care.

Illustrative Performance Indicators:

- ? An extensive list of performance indicators that are relevant to Criterion 1 is included in Menu of Illustrative Performance Indicators (begins on page 29). This list is subdivided into three areas: Access to services, Appropriateness of services, and Outcome of services. Because Criterion 1 requires States to address an array of services, States should consider developing more service objectives and corresponding performance indicators under this criterion for adults with SMI and children with SED.

Criterion 2: Mental Health System Data Epidemiology

- ? Contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children; and
- ? Presents quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Items for Inclusion in the Narrative:

- ? Statements on adults with SMI and children with SED definitions used in the State with explanation if they are different from the Federal definitions: (Federal Register, Vol. 58, No 96, pp. 29422-29425, Thursday, May 20, 1993);
- ? Statement on estimation methodology used by the State with explanation if the estimation methodology for adults with SMI differs from the published Federal estimation methodology (Federal Register Vol. 64, No 121, pp. 33890-33897, Thursday, June 24, 1999);
- ? Statement on estimation methodology used by the States with explanation if the methodology used for children with SED differs from the published Federal estimation methodology (Federal Register, Vol. 63, No. 137, pp. 38661-38664, Friday, June 7, 1998);
- ? Description of individuals needing and demanding publicly funded services, broken down by sub-populations, (e.g., age, gender, race/ethnicity, SMI/SED, SMI with substance abuse, SED with substance abuse and others, as appropriate);
- ? Description of individuals receiving publicly funded services, broken down by sub-populations (e.g., age, gender, race/ethnicity, SMI/SED, SMI with substance abuse and SED with substance abuse, as appropriate);
- ? Description of populations or sub-populations who do not have sufficient access to services appropriate to their needs.

Illustrative Performance Indicators:

- ? Percentage of adults with serious mental illness who receive publicly funded services;
- ? Percentage of children with serious emotional disturbance who receive publicly funded services.

Criterion 3: Children's Services

- ? Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any service under such a system other than comprehensive community mental health services.

Items for Inclusion in the Narrative:

- ? Responsible agency for coordination of all children's services;
- ? Responsible agency for coordination of State Children's Health Insurance Program (SCHIP);
- ? Responsible agency for mental health services for children;
- ? Description of initiatives to assure transition to adult mental health services;
- ? Description of interagency collaboration initiatives and expectation of the collaboration in the areas of social services; educational services, including services provided under the Individuals with Disabilities Educational Act (IDEA), juvenile services; substance abuse services; and health and mental health services; and
- ? Description of geographic areas for the provision of the services under such system.

Illustrative Performance Indicators:

- ? Percentage of children with SED who are placed out-of-home (e.g. foster care, residential home, juvenile detention);
- ? Percentage of children with SED who are attending school regularly;
- ? Percentage of children with SED who are receiving special education services;
- ? Percentage of children with SED who are also clients of the juvenile justice system;
- ? Percentage of children with SED who are also receiving substance abuse services.
- ? Percentage of children with SED who receive therapeutic foster care.

Criterion 4: Targeted Services to Rural and Homeless Populations

- ? Describes State's outreach to and services for individuals who are homeless;
- ? Describes how community-based services will be provided to individuals residing in rural areas.

Items for Inclusion for the Narrative:

- ? Descriptions of the homeless; SMI and SED population;
- ? Descriptions of available services for homeless SMI population;
- ? Descriptions of PATH, Shelter Plus Care, ACCESS, and HUD grants held by the State or local governments;
- ? Definition of rural and urban locations in the State (States are encouraged to use the Census Bureau definition for "rural" and "urban"); and
- ? Description of barriers to access to services in rural areas (e.g. transportation) and State efforts to overcome them.

Illustrative Performance Indicators:

- ? Percentage of homeless persons with SMI (or SED) and who receive mental health services; and
- ? Percentage of rural persons with SMI (or SED) and who receive mental health services.

Criterion 5: Management Systems

- ? Describes financial resources, staffing and training for mental health services providers that are necessary for the plan;
- ? Provides for training of providers of emergency health services regarding mental health; and
- ? Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal year(s) involved.

Items for Inclusion in the Narrative:

- ? Description of the role of the Community Mental Health Services Block Grant in the State, including new, innovative services funded by the grant;
- ? Plans to reallocate resources or otherwise expand funding to community-based programs to enable individuals with mental illness to function outside of inpatient or residential institutions;
- ? Financial statements and description of other funding sources;
- ? Structures to improve the efficiency and effectiveness of the system (e.g. managed care, performance contracting);
- ? Description of staffing resources, needs, deficits, and plans to address them; and
- ? Human Resources Department efforts (e.g., training, including training for emergency health services regarding mental health; redeployment; recruitment).

Illustrative Performance Indicators

- ? Proportion of State mental health block grant funds allocated to new, innovative programs;
- ? Percentage of SMHA-controlled expenditures for community programs of total SMHA-controlled expenditures; and
- ? Number of persons with SMI (or SED) who are enrolled in Medicaid managed care for health and/or mental health services.

Menu of Illustrative Performance Indicators

The mental health performance indicators listed in the menu below give States a choice. A State's selection of indicators from the list would reflect the specific priorities and plans of each State for each FY covered by the Plan. Selection of performance indicators, particularly for Criterion 1, should seek to represent the domains of access, appropriateness/quality, and outcome.

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

ACCESS INDICATORS

- ? Percentage of persons with SMI and parents of children with SED who rate access to care positively;
- ? Percentage of persons with SMI and children with SED who are diagnosed with both mental illness and substance abuse and rate access to care positively (include percentage of parents who respond on behalf of their children when data is available);
- ? Number of persons with SMI (or SED) who are receiving case management services;
- ? Number of persons with SMI who are receiving employment services;
- ? Number of admissions to state and county hospitals among persons with SMI (or SED); and
- ? Number of patients-in-residence in State and county hospitals among persons with SMI (or SED).

APPROPRIATENESS/QUALITY INDICATORS

- ? Percentage of SMI population (or SED persons or their parents) receiving services who rate the quality and appropriateness of care positively;
- ? Percentage of persons with SMI and children with SED who are diagnosed with both mental illness and substance abuse and rate quality and appropriateness to care positively (include percentage of parents who respond on behalf of their children when data is available);
- ? Percentage of persons with SMI (or SED or their parents) receiving services who positively rate respect and caring by their providers;
- ? Percentage of persons with SMI who are actively involved in decisions regarding their own treatment;

- ? Percentage of parents of children and adolescents who are in the SED population who are actively involved in decisions regarding their child's treatment;
- ? Percentage of persons discharged from psychiatric inpatient care who receive follow-up, face-to-face visit within seven days (or less) of discharge;
- ? Percentage of persons with SMI who are receiving supported housing services;
- ? Percentage of persons with SMI who are receiving supported employment services;
- ? Percentage of persons with SMI who are receiving assertive community team services; and
- ? Percentage of persons with SMI who receive a physical health examination annually.

OUTCOME INDICATORS

- ? Percentage of persons with SMI (or SED or their parents) who report positive outcomes of care (or for whom positive changes are reported);
- ? Percentage of persons with SMI (or SED or their parents) diagnosed with both mental illness and substance abuse who rate outcomes of care as positive;
- ? Percentage of persons with SMI for whom there are positive changes in employment;
- ? Percentage of children with SED for whom there is improvement in school functioning;
- ? Percentage of persons with SMI for whom there are positive changes in living situation;
- ? Percentage of persons with SMI for whom there are improvements in personhood, hope, and recovery;
- ? Percentage of individuals with SMI or SED for whom there are positive changes in level of functioning;
- ? Percentage of individuals with SMI or SED for whom there is reduction in symptoms of mental illness;

- ? Percentage of individuals with SMI or SED for whom there is either no impairment or reduced impairment from substance abuse;
- ? Percentage of persons with SMI who experience adverse outcomes of mental health services;
- ? Percentage of persons readmitted to psychiatric inpatient care within 30 days of discharge; and
- ? Percentage of persons with SMI who spend one or more days in jail or prison.

Criterion 2: Mental Health System Data Epidemiology

POPULATION ACCESS INDICATORS

- ? Percentage of adults with serious mental illness who receive publicly funded services; and
- ? Percentage of children with serious emotional disturbances who receive publicly funded services.

SPECIAL POPULATION INDICATORS

For all illustrative indicators shown under Criteria 1 and 2 above or others that States may develop, the estimation of performance on these same indicators for significant sub-populations, including breakouts by age, race, ethnicity, sex and diagnosis (SMI, SED, SMI with substance abuse, and SED with substance abuse) shall be provided.

Criterion 3: Children's Services

- ? Percentage of children with SED who are placed out-of-home (e.g., foster care, residential home, juvenile detention);
- ? Percentage of children with SED who are attending school regularly;
- ? Percentage of children with SED who are receiving special education services;

- ? Percentage of children with SED who are also clients of the juvenile justice system; and
- ? Percentage of children with SED who are also receiving substance abuse services.

Criterion 4: Targeted Services to Rural and Homeless Populations

- ? Percentage of homeless persons with SMI (or SED) and who receive mental health services;
- ? Percentage of rural persons with SMI (or SED) and who receive mental health services; and
- ? For all relevant, illustrative indicators shown under Criteria 1 and 2 above or others that States may develop, estimation of performance on the same indicators for persons with SMI/SED and homeless, SMI/SED with Substance Abuse and homeless and for persons with SMI/SED with Substance Abuse and are living in rural areas of the State.

For Mental Health, Medicaid Managed Care Plans:

- ? Number of persons with SMI (or SED) and who are enrolled in Medicaid managed care for health and mental health services (integrated plan) or mental health/behavioral health services only (carve out plan);
- ? Per member per month plan premium rate (statewide average);
- ? Percent of total plan expenditures attributable to (1) Medicaid loss, (2) administrative loss, and (3) net profit/loss; and
- ? Extent of involvement of consumers and families in (a) policy development, (b) planning and (c) quality assurance/monitoring within the managed care plan.

Criterion 5: Management Systems

- ? Proportion of state mental health block grant funds allocated to innovative programs;
- ? Percentage of SMHA-controlled expenditures for community programs of total SMHA-controlled expenditures;
- ? Mental health expenditures per capita;
- ? Mental health expenditures per person served; and
- ? Extent of involvement of consumers and families in (a) policy development, (b) planning and (c) quality assurance/monitoring at the statewide level, the local mental health authority, and the provider level.

Format for Performance Indicator Description**Criterion 1 - Example A**

Goal: To reduce significantly the inpatient census of State and county operated mental health specialty facilities by placing all eligible, mentally ill individuals appropriately in the community.

Objective: To reduce inpatient census of State and county operated mental health specialty facilities by another fifty individuals from the current level.

Population: Adults diagnosed with a serious mental illness.

Criterion: Comprehensive, community-based mental health system.

Brief Name: State & county inpatient census.

Indicator: Number of patients-in-residence in State and county hospitals among persons who are SMI or SED.

Measure: This number may be either (1) the number of patients who are in residence in State and county mental health specialty hospitals at the end of the State's fiscal year OR (2) the average daily inpatient census for the State's fiscal year.

NOTE: If the State contracts out for care that formerly would have been provided in its inpatient system, patients-in-residence or daily average census for these contracts should be incorporated and explained on this indicator page. Separate performance indicators should be maintained for adults and for children. For adults, States should indicate whether forensic inpatient information is included in the total.

Sources(s) of

Information: State hospital reporting system; contract reporting system.

Special Issues:In many States, reduced utilization of State hospital care may be the result of expanded utilization of general hospital psychiatric inpatient beds, particularly by persons who are eligible for Medicaid and Medicare. States may wish to track utilization of psychiatric inpatient care under this and other auspices. For individuals working with children, this indicator would not include persons

served in residential treatment facilities. States may wish to track this utilization separately or include it under the indicator percentage of children with SED who are placed out-of-home (e.g., foster care, residential home, juvenile detention).

Significance: A major outcome of the development of a community-based system of care is expected to be reduced utilization of state and county-operated psychiatric inpatient beds.

Criterion 1 - Example B

Goal: To provide case management services for all persons who receive substantial amounts of public funds or services.

Objective: To expand access to case management services among persons who receive substantial amounts of public funds or services by 5%.

Population: Adults diagnosed with a serious mental illness.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Percentage receiving case management.

Indicator: Percentage of seriously mentally ill adults who receive case management services among those who receive substantial amounts of public funds or services.

Measure: Numerator: The number of adult recipients who are diagnosed with a serious mental illness receiving case management services during the fiscal year.

Denominator: The number of adults who receive a substantial amount of mental-health related public funds or services during the fiscal year.

Sources of

Information: Contract reporting system, Medicaid management information system, SMHA client information system, and estimates of treated prevalence.

Special Issues: States must also define key terms. The count of persons receiving case management may include only those enrolled in formal case management programs or may extend to those who receive case management services in any program which offers those services in conjunction with other mental health services. States must also operationally define the concept of “adults” who

receive substantial amount of mental-health related public funds or services during the fiscal year”. This definition will depend upon what information is most readily available to the State.

Significance: Assuring access to case management services for persons diagnosed with a serious mental illness is a primary goal of the mental health block grant law.

Criterion 1 - Example C

Goal: To provide assertive community treatment to all eligible individuals who could benefit from it.

Objective: To increase the number of persons receiving assertive community treatment (ACT) by another 40.

Population: Adults diagnosed with a serious mental illness.

Criterion: Comprehensive, community-based health system.

Brief Name: Persons receiving ACT.

Indicator: The number of persons receiving assertive community treatment during the fiscal year.

Measure: Count of persons receiving services through a formal ACT program. Teague, Drake, and Acheson (1993) identified the following fidelity criteria for ACT:

- ? Service provided in community: team works to monitor status, develop community living skills in vivo rather than in office;
- ? Assertive engagement: initial intensive outreach, visits to community settings, use of legal mechanisms for engagement such as representative payees;
- ? Intensity of service: high level of staff contact, as needed;
- ? Continuous responsibility: team has 24-hour responsibility for discrete group of clients; handles crises, is involved in hospital admissions and discharges;
- ? Continuity of staffing: team maintains same staff over time;

- ? Team approach: provider group functions as team rather than as individual practitioners; clinicians know and work with all clients;
- ? Multi-disciplinary team: team includes at least a psychiatrist, a nurse, a substance abuse treatment specialist, and a staff member of another discipline with experience in treating severe mental disorders; and
- ? Work closely with support system: team provides support and skills for clients' support network, including family members, landlords, and employers.

Sources of

Information: Contract reporting, Medicaid management information system

Significance: Research evidence supports the development of ACT programs to meet the needs of persons diagnosed with serious mental illness.

Criterion 2 - Example:

Goal: Expand access to mental health services for all persons who have a serious mental illness.

Objective: To expand access to mental health services for 4% more of the population of persons who have serious mental illness.

Criterion: Prevalence and treated prevalence of mental illnesses

Population: Adults diagnosed with a serious mental illness.

Brief Name: Treated prevalence of serious mental illness.

Indicator: The percentage of adults with a serious mental illness who receive mental health services during the fiscal year.

Measure: Numerator: Estimated number of adults who have a serious mental illness and who have received mental health services during the fiscal year.

Denominator: Estimated number of adults who annually have a serious mental illness in the State.

Sources of

Information: Numerator: State client information system, Medicaid management information system.

Special Issues: States may use the CMHS definition for “serious mental illness” and “serious emotional disturbance”, and estimates of “prevalence” as an appropriate basis for planning in the public mental health system. If States adopt an alternative definition and a different estimate of prevalence, both the definition and prevalence estimation method should be carefully described and well justified.

Significance: Setting quantitative goals to be achieved for the number of adults who are seriously mentally ill to be served in the public mental health system is a key requirement for the mental health block grant law.

Guidance for Preparing State Plan Performance Indicator Data Table

A sample, blank State Plan Performance Indicator Data Table (Table 3, page 45) is included in this guidance. The purpose of this section is to explain the structure of the table and to provide instructions to complete it.

Please provide separate pages for each of the two population groups (SMI and SED). The blank table shows three performance indicators per criterion—although the actual number of performance indicators chosen by the State may vary depending on the number of objectives identified under each criterion.

The State’s first performance indicator data table page would show **“SMI Adult”** in the population block and **“Comprehensive Community-Based Mental Health Services Systems”** in the criterion block (Criterion 1). The following page would show **“SMI Adult”** in the population block and **“Mental Health System Data Epidemiology”** in the criterion block (Criterion 2). This would continue through the remaining block grant criteria, and then the sequence of pages would begin again with **“SED Children”** in the population block and **“Comprehensive Community-Based Mental Health Service Systems”** in the criterion block (Criterion 1). The sequence will continue for the next page showing **“SED Children”** in the population block and **“Mental Health System Data Epidemiology”** in the criterion block (Criterion 2). This will follow until all criteria are covered.

The remainder of the State Plan Performance Indicator Data Table shows space for individual indicators.

The top of the blank State Plan Performance Indicator Data Table is shown in bold below.

Fiscal Year: _____

Population: SMI Adult or SED Children (Circle One)

Criterion: _____

(Please start a new page for each of the criteria)

	FY 2002	FY 2003	FY 2004	%
	Actual	Projected	Objective	Attain
(1)	(2)	(3)	(4)	(5)
Performance Indicator:				
1. _____ (Brief Name)	_____	_____	_____	_____
Value	_____	_____	_____	_____
If Rate:				
Numerator				
and	_____	_____	_____	_____
Denominator	_____	_____	_____	_____

For column (1) “brief name” for each performance indicator selected is to be entered in the appropriate block. For example, the brief name “State and County Inpatient Census” might be selected to represent a performance indicator titled “Number of Patients-in-Residence” in State and local community mental health hospitals at the end of the fiscal year.

The fuller, more descriptive title, as well as other information about the design of the performance indicator is to be included on the separate page, following the one page “Format for

Performance Indicator Description,” for Criterion 1 and included in this guidance. This description should cover the following elements:

- ? The goal of the State plan under each criterion;
- ? Specific, measurable objective(s) identified to reach the goal;
- ? The relevant population group (SMI or SED);
- ? The relevant mental health block grant criterion;
- ? Brief name for the indicator;
- ? Full, descriptive indicator;
- ? Description of the measure(s) employed to construct the indicator (e.g. contract reporting system, Medicaid claims data, recipient survey);
- ? Explanatory note, if any;
- ? Sources of information employed to obtain data for the indicator (e.g. contract reporting system, Medicaid claims, recipient survey);
- ? Special issues, if any; and
- ? Significance of the identified objective for the Community Mental Health Services program.

The actual or projected value for each performance indicator is to be entered in Columns (2) through (4). For example, if a State chooses to use State and county hospital inpatient census as an indicator, the values might be as follows:

- ? 1,000 patients-in-residence at the end of the last fiscal year (FY 2002) to be entered in column (2);
- ? 950 projected patients-in-residence at the end of the current fiscal year (FY 2003) to be entered in column (3);
- ? 900 patients-in-residence as the plan objective for the end of the next fiscal year (FY 2004) to be entered in column (4); and
- ? The fifth column is completed at the time of preparing the Implementation Report.

In this example, the performance indicator is a simple value, so no additional information is necessary. However, if the value were a rate, then the numerator and denominator employed to construct the rate should also be presented. For example, if the performance indicator is “**the rate or percentage**” of adults who are diagnosed with a serious mental illness who are served in the public mental health system during the fiscal year, then this rate would be the value presented. The **numerator** would be the estimated number of adults who are diagnosed with a serious mental illness who are served in the public mental health system during the fiscal year, and the **denominator** would be the estimated number of adults who have a serious mental illness.

Multi-Year Data

States must show a specific performance indicator to measure each of the objectives identified for the FY 2004 Plan. If States do not have actual or projected values available for FY 2002 and FY 2003, then “N/A” for “Not Available” should be shown in these columns. If a multi-year plan was approved, States should submit “State Plan Performance Indicator Data Tables”, separately identifying the States goals, objectives, performance indicators for each FY covered by the plan. Any modifications to change the FY actual or projected indicators may be reported to CMHS at any time. When preparing additional State Plan Performance Indicator Tables, the years under which the actual and projected values to be entered should be adjusted accordingly. This requirement is necessary for CMHS to determine whether or not a State has completely implemented its plan for each FY based on the goals, objectives and performance indicators identified in the plan for that year. Depending upon the State’s goals and objectives, it is expected that historical data will be available for some performance indicators, but not for others.

Administrative Goals, Objectives and Indicators

Not all goals set by a State need to be immediately associated with service delivery. Some may be related to the changes in the structure for the administration of the public mental health system. For example, State mental health authorities may wish to develop a mechanism to pool or blend funding for children's mental health services that are under the jurisdiction of multiple State and/or local government agencies (e.g. to promote the reallocation of resources from State inpatient care to community-based services). For objectives identified under such goals, the performance indicator might be an interagency memorandum of agreement or new statutory authority conferred by the Legislature and the Governor or changes in regulations or contracting procedures.

While the majority of indicators selected by States for inclusion in plans should be of the type described in the "**Menu of Illustrative Performance Indicators**", States are also encouraged to set administrative goals and objectives and to select performance indicators appropriate to them. They should be included within the most appropriate of the mental health block grant criteria. No special format is offered here. States can adapt the format for describing quantitative performance indicators for this purpose.

State Plan Performance Indicator Data Table (Table 3)

Fiscal Year: _____

Population: SMI Adult or SED Children (Circle One)

Criterion: _____

(Please start a new page for each of the criteria)

(1)	FY 2002 Actual (2)	FY 2003 Projected (3)	FY 2004 Objective (4)	% Attained (5)
Performance Indicator: 1. _____ (Brief Name) Value: If Rate Numerator: and Denominator	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Performance Indicator: 2. _____ (Brief Name) Value: If Rate Numerator: and Denominator	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Performance Indicator: 3. _____ (Brief Name) Value: If Rate Numerator: and Denominator	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____

SECTION IV**IMPLEMENTATION REPORT****General Guidance**

Section 1912(d)(1) of PHS Act (42 USC 300x-2) requires CMHS to determine the extent to which the State has implemented the plan required in Section 1912 (a) for each FY. This section also indicates that if a State has not completely implemented the plan, a 10% reduction in the new fiscal year's CMHS award will result. In order for CMHS to make this determination, States need to report on the status of activities under each of the objectives for adults with SMI and children with SED in the prior year's approved plan. Thus each State is required to submit an annual report on its prior FY plan. States are required to submit the FY 2004 implementation report by December 1, 2004. Along with the annual implementation report, States are asked to submit a letter from the State Mental Health Planning Council containing its comments on the report.

To facilitate the review and to ensure that the information presented in the implementation report is understood as clearly and completely as possible, States are requested to restate and report on the criteria, objectives and corresponding performance indicators for adults with SMI and children with SED separately and in the same sequence as they were identified and written in the original plan and document the degree to which they were achieved. If the objectives and performance indicators were changed during the year with the approval of CMHS, documentation to this effect should be included in the report. If the State has an approved multi-year plan, the report should address the goals, objectives and performance indicators specifically identified for the FY covered by the report.

The report should include the following:

Report Summary

- ? A summary of areas which the State identified in the prior FY approved plan as needing improvement;
- ? A summary of the most significant events that impacted the mental health system of the State in the previous FY; and
- ? A report on the purposes for which the block grant monies for State FY 2004 were expended, the recipients of funds provided under the grant, and a description of activities using the funds as required by Section 1942(a)(1) and (2)(300x-52).

Accomplishments

For all objectives and the corresponding performance indicators under criteria 1, 2, 4 and 5 for adults with SMI and criteria 1-5 for children with SED, the State should provide a brief narrative, which contains the following information:

- ? Documentation of the activities under each objective, under the respective criterion. This shall include data to support the State's report on the accomplishments of each objective and performance indicator identified in the plan for the prior FY. For FY 2004 reporting purposes, States shall provide data on mental health performance indicators that were used to measure the accomplishments and the results in FY 2004, compared with the data at the end of FY 2003. If the State has an approved multi-year plan, the report should address the objectives and performance indicators separately identified in the FY covered by the report.
- ? Description of State activities and the strategies used to accomplish the objectives;
- ? Any changes in the implementation strategy as compared with that set out in the plan;

- ? Any innovative or exemplary model of mental health delivery system the State developed, and its unique features;
- ? At the end of each narrative for the respective objective, the report should clearly state whether or not that particular objective identified in the plan of the prior State FY for adults with SMI and children with SED was “achieved” or “not achieved”; and
- ? If the objectives were “not achieved” as stated in the plan for the year covered by the report, explain the reasons.

Guidance for Preparing State Plan Implementation Report Performance Indicator Data Table

Along with the narratives of the accomplishments, States are requested to complete the fifth column in Table 4. The purpose of this table is to compare the value on State selected performance indicators over the years at a glance. This is the same table format that is recommended to include in the plan (Table 3). Columns 1-4 were completed with the plan. Now column 5 needs to be completed. Please complete a separate page for each criterion for adults with SMI and children with SED. If the State has an approved multi-year plan, the State should prepare and report on similar tables to reflect actual and projected data for corresponding years covered by the report.

State Plan Implementation Report Performance Indicator Data Table (Table 4)

Fiscal Year: _____

Population: SMI Adult or SED Children (Circle One)

Criterion: _____

Please start a new page for each criterion.

(1)	FY 2002 Actual (2)	FY 2003 Projected (3)	FY 2004 Objective (4)	% Attained (5)
Performance Indicator: 1. _____ (Brief Name) Value: If Rate Numerator: and Denominator	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____
Performance Indicator: 2. _____ (Brief Name) Value: If Rate Numerator: and Denominator	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____
Performance Indicator: 3. _____ (Brief Name) Value: If Rate Numerator: and Denominator	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____

SECTION V
UNIFORM DATA

Instructions regarding the completion of Section V will be forthcoming in the regularly scheduled Data Infrastructure Grant phone calls and other communications.

Data Reporting Instructions

This section requests States to report uniform data in a series of tables (Appendix I) on public mental health services in the State with special focus on community mental health services. The completion of Section V is now a term and condition for funding for States and Territories that were awarded Data Infrastructure Grants. Thus, all States and Territories that accepted the grant agreed to submit Section V as part of the FY 2003 Implementation Report (Section IV). The Report for FY 2003 is due December 1, 2003. (The report for FY 2004 will be due by December 1, 2004). States and Territories that did not apply for the Data Infrastructure Grant are encouraged to submit data under Section V. If a State cannot provide data in tables, it must be indicated in the State Level Data Reporting Capacity Checklist (Appendix II). To ensure uniformity, the data reported shall be based on the data definitions located in Appendix III. States are requested to report data based on the last completed fiscal year. Further instruction regarding the completion of Section V may be forthcoming in the regularly scheduled Data Infrastructure Grant phone calls. Instructions for submission of the data tables will be provided under separate cover.

Uniform data on the public mental health system is required to improve planning for the Community Mental Health Services PPBG and for oversight of community mental health services. Block grant funds further the capacities of the publicly funded community mental health system in each state. The flexible funding of the block grant allows States to fund gap-filling, new and innovative services. To understand the value and usage of block grant funds, it is critical that both CMHS and the State Mental Health Authorities (SMHAs) have accurate and uniform data on the public mental health system in each State. Towards this end, the data

requested in the tables included in this Section answer five basic questions: 1) What are the mental health service needs of the population in your State? 2) Who in your State gets access to publicly funded mental health services? 3) What types of services are being provided in your State? 4) What are the consumer outcomes for the services provided? and 5) What financial resources are expended for the services?

All client data will be aggregated at the State level. No individual client data are requested or should be submitted. State identifiers are required for each table. CMHS will create, on its own, all derived measures from the primary data provided by the States. CMHS will review the State submitted data and make requests for revision, clarification, or additional information as appropriate from the State MHAs. After the final review and analysis of completed data, CMHS will make available State-by-State data profiles as well as summary tables that examine performance across all States for selected data elements.

Each State receiving CMHS BG funds is requested to report data in the following tables for its publicly funded mental health system. In addition, there are eleven (8) tables in "developmental status" that will not be part of this application for FY 2004.

Fiscal Year 2003 CMHS Uniform Reporting System: Guidelines For Basic Tables:**Scope of Reporting:**

Based on the discussions by State workgroups and input provided by state representatives during the regional conference calls, guidelines have been developed for the scope of reporting. A basic tenet is that the “scope” will represent the mental health “system” that comes under the auspices of the state mental health agency.

This approach resulted in concern regarding comparisons that might be made across states that might have disparate mandates and dissimilar systems. After much discussion, the decision regarding scope was that representation of the state mental health agency system was more critical than comparability across states. The principle proposed was that there needed to be common understanding that these data could not be used to compare states but could be used to track a state’s performance across time and to produce U.S. totals.

Major points of discussion were how persons served under Medicaid and through support of local dollars would be counted. For both these areas, persons would be counted insofar as they were considered part of the state mental health agency system and received services from programs funded or operated by the state mental health agency. Persons would be counted if they could be identified and had received a face-to-face service in the reporting period.

More specifically, the workgroup proposes the following guidelines for including and counting people in the URS:

- 1 Include all persons served directly by the state mental health agency (including persons who received services funded by Medicaid)
- 2 Include all persons in the system for whom the state mental health agency contracts for services (including persons whose services are funded by Medicaid).
- 3 Include any other persons who are counted as being served by the state mental health agency or come under the auspices of the state mental health agency system. This includes Medicaid waivers, if the mental health component of the waiver is considered to be part of the SMHA system.
- 4 Count all identified persons who have received a mental health services, including screening, assessment, and crisis services. Telemedicine services should be counted if they are provided to identified clients.
- 5 For states where a separate state agency is responsible for children’s mental health, where feasible, efforts should be made to unduplicate clients between the child mental health agency and the adult mental health agency. If this unduplication is not feasible, please report this potential duplication to indicate there is an overlap between the A0-17 group and the A18 and over group but that there is unduplication within each group.

Persons who would not be included in the URS tables:

- 1 Persons who just received a telephone contact would not be included, unless it was a telemedicine service to a registered client. Hotline calls to anonymous clients should not be counted.
- 2 Persons who only received a Medicaid-funded mental health service through a provider who was not part of the SMHA system would not be included.
- 3 Persons who only received a service through a private provider or medical provider not funded by the SMHA would not be included.
- 4 Persons with a single diagnosis of substance abuse or mental retardation should not be included. All persons with a diagnosis of mental illness should be counted, including persons with a co-occurring diagnosis of substance abuse or mental retardation.

July 2003

Appendix A

Basic Tables

These updated tables have been prepared by the CMHS-funded State Data Infrastructure Coordinating Center (SDICC) at the NASMHPD Research Institute. For additional information or questions about these tables, please contact Ted Lutterman at 703-739-9333 ext.121 (ted.lutterman@nri-inc.org) or Vijay Ganju at 703-739-9333 ext.132 (vijay.ganju@nri-inc.org).

Table 1. Profile of the State Population by Diagnosis

This table summarizes the estimates of adults residing within the State with serious mental illness (SMI) and children residing within the state with serious emotional disturbances (SED). The table calls for estimates for two time periods, one for the report year and one for three years into the future. CMHS will provide this data to States based on the standardized methodology developed and published in the *Federal Register*¹ and the State level estimates for both adults with SMI and children with SED.

Table 1.		
Report Year:		
State Identifier:		
	Current Report Year	Three Years Forward
Adults with Serious Mental Illness (SMI)		
Children with Serious Emotional Disturbances (SED)		

No change to table.
 CMHS will provide this data to each SMHA.

¹ Adults with SMI - Source FR Volume 64 No. 121 Thursday, June 24, 1999 pages 33890 through 33897. Children with SED - Source FR Volume 63 No. 137 Friday, July 17, 1998 pages 38661 through 38665.

Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

This table provides an aggregate profile of persons in the reporting year. The reporting year should be the latest state fiscal year for which data are available. This profile is based on a client receiving services in programs provided or funded by the state mental health agency. The client profile takes into account all institutional and community services for all such programs. Please provide unduplicated counts if possible.

Please enter the “total” in the appropriate row and column and report the data under the categories listed.

Table 2A.																															
Report Year:																															
State Identifier:																															
Persons Served by Age	Total				American Indian or Alaska Native			Asian			Black or African American			Native Hawaiian or Other Pacific Islander			White			Hispanic * use only if data for Table 2B are not available.			More Than One Race Reported			Other Race			Not Available MM		
	F	M	NA	Tota	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA			
0-3																															
4-12																															
13-17																															
18-20																															
21-64																															
65-74																															
75 +																															
Not Available																															
Total																															

State Comments:

State DIG Workgroup Recommendations:

- 1 Include all persons served directly by the state mental health agency (including persons whose services are funded by Medicaid)
- 2 Include all persons in the system for whom the state mental health agency contracts for services (including persons whose served are funded by Medicaid).
- 3 Include any other persons who are counted as being served by the state mental health agency or come under the auspices of the state mental health system. This includes Medicaid waivers, if the waiver is run by the SMHA.
- 4 Count all identified persons who have received a mental health services, including screening, assessment, and crisis services.
- 5 For state where a separate state agency is responsible for children=s mental health, unduplicate between the two child and adult agency when feasible. Otherwise, recognize and indicate that there is overlap between the 0-1 group and the 18 and over group but that there is unduplication within each group.
- 6 Add Not Available by Gender to this table (note this adds 72 cells to the table)
- 7 Add “Hispanic” category to Table 2A to allow for states to report if they do not currently compile Hispanic Origin as a separate question. This recommendation would be for the FY=02 and FY=03 reporting, as OMB, HIPAA and the US Census finalize race/ethnicity reporting guidelines for the future. States that track Hispanic Origin as a separate category should report on Table 2B instead of Table 2A.

Persons who would not be included in the URS tables:

- 1 If direct face-to-face services were provided to a person who could not be identified, this person would not be included. (A concern was that this would exclude persons receiving services in drop-in centers, clubhouses, etc. / the same time there is no way to get an unduplicated count without identification. To address the concern, the proposal was to track persons receiving such services as part of the URS.)
- 2 Persons who just received a telephone contact would not be included.
- 3 Persons who only received a Medicaid-funded mental health service not provided by a SMHA-funded/operated provider would not be included.
- 4 Persons who only received a service through a private provider or medical provider not funded by the SMHA would not be included.
- 5 All persons with a diagnosis of mental illness should be counted, including persons with a co-occurring diagnosis of substance abuse or mental retardation. Persons with a single diagnosis of substance abuse or menta retardation should not be included.

CMHS has sent out to the States a notice from the Federal Office of Management and Budget (OMB) regarding how all Federal Agencies must collect race and ethnicity information. The OMB rules allow for two tables as set up on Table 2a and 2b. One focuses on race: White, Black, Asian, Native Hawaiian and Other Pacific Islander, American Indian and Alaska Native, Multiple Race and Other Race. A separate second table will collect information on Hispanic or Latino Origin. This is the format recommended in the Basic Tables.

The OMB guidance is different from the way many states currently compile Race and Ethnicity data in three (3) key areas:

- 1) Native Hawaiian or other Pacific Islander (NHPI) is a new category that was previously compiled as part of Asian. This NHPI category now needs to be collected separately by states.
- 2) Multiple Race: Programs now need to allow persons to identify multiple racial categories. Thus, a reporting category of More than one Race needs to be compiled by SMHAs. OMB indicates that Multiple Race should NOT be collected by adding a “Multiple Race” option, but rather that it should be identified by the selection of multiple racial categories: i.e., the list of White, Asian, Black, Native Hawaiian, American Indian should allow multiple categories to be selected.
- 3) Ethnicity: Hispanic or Latino Origin should be compiled separately from the “race” categories collected above. The URS Tables are set up this way with Table 2B and Table 5B collecting data on the number of persons of Hispanic or Latino Origin.

CMHS has discussed the implications of this OMB ruling for URS/DIG grants and Year 2 Reporting: The OMB rules means that the 3 categories discussed above must become part of SAMHSA and all other Federal data collection. However, CMHS/SAMHSA realize that states will need time to modify the reporting categories of race and ethnicity. Therefore, the Year 2 Basic Tables will continue to include an option for states to report “Hispanic” within the “Race” categories on Table 2A (and Table 5A). However, now CMHSs expects that states will start changing their MIS to reflect the new OMB guidance and will be able to report the new categories at the end of Year 3 (if possible).

If a person is identified as a combination of racial groups (e.g., white and black), that person should be counted only once and should be reported in the ~~A~~more than one race@category.

Table 2B. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

Of the total persons served, please indicate the age, gender and the number of persons who are Hispanic/Latino or not Hispanic/Latino. Total persons served would be the total as indicated in Table 2A.

Table 2.B													
Report Year													
State Identifier:													
Persons Served by Age	Not Hispanic or Latino			Hispanic or Latino Origin			Hispanic or Latino Origin Not Available			Total			
	F	M	NA	F	M	NA	F	M	NA	F	M	NA	Tota
0-3													
4-12													
13-17													
18-20													
21-64													
65-74													
75 +													
Not Available													
Total													

DIG Workgroup Recommendations:
Same as Table 2.A. Above

Table 3A. Profile of Persons served in the community mental health setting by homeless status.

This table provides a profile for the clients that received public funded mental health services in community mental health setting by Homeless and Not-Homeless status. A person receiving services in the community should be counted in the "Homeless" category if he/she was reported homeless at their most recent assessment during the reporting period (or at discharge for patients discharged during the year).

Table 3.A. Community																			
Report Year:																			
State Identifier:																			
TABLE 3.A.		Age 0-17			Age 18-20			Age 21-64			Age 65+			Age Not Available			Total		
Community/Ambulatory	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	Total
Homeless																			
Not-Homeless																			
Homeless Status Not Available																			
Total Served in Community Mental Health Settings																			

How often does the State Measure Homeless Status? At Admission At Discharge Monthly Quarterly Annually Other: _____

Only Report Homeless status for persons served in the community mental health system.

Note Change from 2002 Reporting: Homeless is no longer being defined as Homeless at any time during the last 12 months. Instead, states should define homeless as their living situation at the time of the last assessment. The "last" Assessments could occur at Admission, Discharge, or at some point during treatment.

State Comments:

Table 3B: Profile of persons served in state psychiatric hospitals and other inpatient settings.

This table provides a profile of the patients that received public funded mental health services in state hospital and/or other inpatient settings that are part of the SMHA mental health system. Persons admitted to hospitals more than once during the fiscal year should be counted only once in one or all applicable rows (a person admitted twice to a state hospital would count one time, a person admitted to both a state psychiatric hospital and an other psychiatric hospital would count once in each row).

Table 3.B. Profiles of Persons Served in Psychiatric Inpatient Settings																			
Report Year:																			
State Identifier:																			
TABLE 3.B.	Age 0-17			Age 18-20			Age 21-64			Age 65+			Age Not Available			Total			
	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	Total
State Psychiatric Hospitals																			
Other Psychiatric Inpatient																			
Residential Treatment Centers for Children (optional Row)																			
Total																			

State Comments:

State DIG Workgroup Recommendations:

- 1 For states that have county psychiatric hospitals that serve as surrogate state hospitals, should report persons served in such settings as receiving services in state hospitals.
- 2 If forensic hospitals are part of the state mental health agency system include them.
- 3 Persons who receive non-inpatient care in state psychiatric hospitals should be included in Table 3.A
- 4 A persons who is served in both community settings, and inpatient settings should be included in both Table 3.A and 3.B.
- 5 Residential Treatment Centers for Children is a new Optional row for 2003. CMHS has a standardized definition of RTC for Children: An organization, not licensed as a psychiatric hospital, whose primary purpose is the provision of individually planned programs of mental health treatment services in conjunction with residential are for children and you primarily 17 years old and younger. It has a clinical program that is directed by a psychiatrist, psychologist, social worker, or psychiatric nurse who has a master’s degree or a doctorate. The primary reason for the admission of the clients is mental illness that can be classified by DSM-IV codes other than the codes for mental retardation, developmental disorders, and substance-related disorders, such as drug abuse and alcoholism (unless these are co-occurring with a mental illness).

Table 4. Profile of Adult Clients by Employment Status

This table describes the status of adults clients served in the report year by the public mental health system in terms of employment status. The focus is on employment for the working age population, recognizing, however, that there are clients who are disabled, retired or who are homemakers, care-givers, etc and not a part of the workforce. These persons will be reporting in the “Not in Labor Force” category. This category has two subcategories: retired and other. (The totals of these two categories should equal the number in the row for “Not in Labor Force”.) Unemployed refers to persons who are looking for work but have not found employment. Data should be reported for clients in non-institutional settings at time of discharge or last evaluation.

Table 4																
Report Year:																
State Identifier:																
	18-20			21-64			65+			Age Not Available			Total			
Adults Served	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Total
Employed: Competitively Employed Full or Part Time (includes Supported Employment)																
Unemployed																
Not in Labor Force: Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled, etc.)																
Not Available																
Total																
State Comments on Data:																

DIG Workgroup Recommendations:

1. **Employed means competitively employed, part-time or full-time. Supported Employment and transitional employment, where consumers work in competitive employment situations should be reported as “employed”. Informal labor, for cash, i.e. day labor is counted as employed.**
2. Sheltered employment should be reported as Not in Labor Force.
3. Employment status should be reported for persons served in community settings.
4. Latest status of employment reported would be used.

Table 5A. Profile of Clients by Type of Funding Support

This table provides a summary of clients by Medicaid coverage. Since the focus of the reporting is on clients of the public mental health service delivery system, this table focuses on the clientele serviced by public programs that are funded or operated by the State Mental Health Authority. Persons are to be counted in the Medicaid row if they received a service reimbursable through Medicaid.

Table 5.B																															
Report Year																															
State Identifier:																															
	Total				American Indian or Alaska Native			Asian			Black or African American			Native Hawaiian or Other Pacific Islander			White			Hispanic * use only if data for Table 2B are not available.			More Than One Race Reported			Other Race			Race Not Available		
	F	M	NA	Total	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA	F	M	NA
Medicaid Only																															
Non-Medicaid Only																															
Both Medicaid & Non Medicaid (Optional row)																															
Medicaid Status Not Available																															
Total Served																															

Q Data are unduplicated

Q Data are duplicated

Q Medicaid data based on paid services

Q Medicaid status determined by Medicaid Eligibility, not Medicaid paid services.

If you cannot unduplicate by Medicaid status, then report using the first two rows above: i.e., any Medicaid would go in Row 1 (Medicaid), if any SMHA or block grant funds, then place in Row 2 (Non-Medicaid) and check the appropriate box below.

State Comments:

Change for 2003: This Table adds an option for states to report “Unduplicated” clients by Medicaid status using the table above. The revised table has 4 rows: (1) persons served only by Medicaid, (2) those only served by SMHA, block grant, or other non-Medicaid funds, (3) those persons who received services from both Medicaid and non-Medicaid sources, and (4) Total Persons Served. Each of the rows would be a unique (unduplicated) count of clients (except row 4). This would enable CMHS and others to answer policy questions about: 1) what percent of consumers were served by Medicaid only? (2) What percent of consumers received services from both Medicaid and other sources? and (3) What percent of consumers received no Medicaid reimbursed services? However, for States that can only track Medicaid Eligible Clients, or who cannot unduplicate, they would report the same as year 1, and would check the box on the table that they are reporting duplicated Medicaid data.

Table 5B. Profile of Clients by Type of Funding Support

Of the total persons covered by Medicaid, please indicate the gender and number of persons who are Hispanic/Latino or not Hispanic/Latino. Total persons covered by Medicaid would be the total indicated in Table 5A.

Table 5.B													
Report Year													
State Identifier:													
	Not Hispanic or Latino			Hispanic or Latino Origin			Hispanic or Latino Origin Not Available			Total			
	F	M	NA	F	M	NA	F	M	NA	F	M	NA	Tot
Medicaid Only													
Non-Medicaid Only													
Both Medicaid & Non Medicaid (Optional row)													
Medicaid Status Not Available													
Total													

State Comments:

Table 6. Profile of Client Turnover

This table presents client flow through the public mental health system for several general categories of services. For the identified services, States are asked to provide a total, a count of additions during the report year, a count of discharges during the report year, and an average length of stay for clients in state hospitals and community programs. Persons may have been admitted or discharged more than once during the report period. Count all such events.

Table 6.							
Report Year:							
State Identifier:							
Profile of Service Utilization	Total Served at Beginning of Year (unduplicated)	Admissions during the year (duplicated)	Discharges during the year (duplicated)	Average Length of Service (in Days): Discharged Patients		Average Length of Service (in Days): Resident Patients at End of Year	
				Average	Median	Average	Median
State Hospitals							
- Children (0-17 yrs.)							
- Adult (18 yrs. and over)							
Other Hospital Inpatient							
- Children (0-17 yrs.)							
- Adult (18 yrs. and over)							
Residential Treatment Centers for Children (<i>Optional Row</i>)							
Community Programs							
- Children (0-17 yrs.)							
- Adult (18 yrs. and over)							

State Comments:

State DIG Workgroup Recommendations:

1. This table reflects client flow and turnover
1. Column 1 represents an unduplicated count of all persons receiving services in state hospitals and all persons receiving services at the start of the reporting period. This includes all people who are on the active books as patients at the start of the year.
2. Column 2 are all additions or new admissions during the reporting period. If a person has multiple admissions during that reporting period, all admissions will be counted.
3. Again as in Table 2, there may be duplication across age categories, depending on the state’s ability.
4. Column 3 are all discharges during the reporting period. If a person has multiple discharges during that reporting period, all discharges will be counted.
5. As in table 3, there will be duplication across the state hospital section and the community section.
6. Consistent with Table 3: Add rows for Other Hospital Inpatient clients and “Residential Treatment Centers for Children”
7. Length of Stay Column needs to be collected for 2 different groups: a. Patients discharged during the year and b. patients still resident in the hospital at the end of the year.
 - a. Drop Average LOS for community programs.
 - b. Report both Mean and Median Hospital Length of Stay
8. Community Discharges: do no report discharges from community services

Table 7. Profile of Mental Health Service Expenditures and Sources of Funding

This table describes expenditures for public mental health services provided or funded by the State mental health agency by source of funding.

Table 7.				
Report Year: FY'02				
State Identifier:				
Profile of Mental Health Service Expenditures and Sources of Funding by General Category of Services.	State Hospital	Other 24-Hour Care	Ambulatory/ Non 24-Hour Care	Total
Total				
Medicaid				
Community MH Block Grant				
Other CMHS				
Other Federal (non CMHS)				
State				
Other				

**NASMHPD Research Institute will provide CMHS data based on the information reported in this table.*

- Data will come from the NASMHPD Research Institute's (NRI) FY'2002 SMHA-Controlled Revenues and Expenditures Study
- Note: Total Expenditures for Other 24-Hour Care are available from the NRI Study, but details by funding source are only available for the categories State Hospitals, Community mental health programs, and Total

Table 8. Profile of Community Mental Health Block Grant Expenditures for Non-Direct Service Activities

This table is used to describe the use of CMHS BG funds for non-direct service activities that are sponsored, or conducted, by the State Mental Health Authority.

Table 8.	
Report Year:	
State Identifier:	
Profile of Community Mental Health Block Grant Expenditures for Non-Direct Service Activities.	
Service	Estimated Total Block Grant Expenditures \$
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	
Total Non-Direct Services	

State DIG Workgroup Recommendations

States should only report on the expenditures of the CMHBG by the SMHA or programs that they directly contract with.

- States should not report on expenditures by programs more than one-level down from the State in funding: e.g., if a state provides CMHBG funds to county mental health authorities, which in turn contract with private, not-for-profit mental health providers, only the expenditures by the SMHA and the county mental health authorities should be reported on this table.

Table 9. Public Mental Health System Service Inventory Checklist

This table is used to provide an overview of the range of services currently operated or funded by the State mental health agency.

Indicate by a checkmark the extent to which the services listed below are provided in the State.

Table 9						
Report Year:						
State Identifier:						
SERVICES PROVIDED THROUGH PROGRAMS THAT COVER:						
Service Available Statewide	URBAN AREAS		RURAL AREAS		Service Not Available in State	Services Inventory
	Some urban areas	All urban areas	Some rural areas	All rural areas		
						Intensive Case Management
						Intensive Outpatient
						Assertive Community Treatment
						Emergency
						Services for persons with mental illness and Mental retardation/developmental disability
						Integrated Services for Persons with Mental Illness and Substance Abuse
						Employment/Vocational Rehabilitation
						In Home Family Services
						School-based Services
						Consumer Run Services
						Intake, Diagnostic, and Screening Services
						Intake/ Screening
						Diagnostic Evaluation
						Information and Referral Services
						Treatment Services
						Individual Therapy
						Family/Couple Therapy
						Group Therapy
						Collateral Services
						Electro-convulsive Therapy
						Medication Therapy
						New Generation Medications
						Activity Therapy
						Behavioral Therapy
						Mobile Treatment Team
						Peer Support
						Psychiatric Emergency Walk-in
						Telephone Hotline

Table 11. Summary Profile of Client Evaluation of Care

This table provides a summary of key indicators of client evaluation of outpatient mental health care used by SMHAs. The measures include those developed and implemented as part of the MHSIP Adult Community Consumer-oriented report card, and the Youth Services Survey for Families but are not limited to the MHSIP survey.

Table 11: Consumer Evaluation of Care			
Year Survey was Completed:			
State Identifier:			
Adult Consumer Survey Results:	Number of Positive Responses	Responses	Confidence Interval
Percent Reporting Positively About Access.			
Percent Reporting Positively About Quality and Appropriateness.			
Percent Reporting Positively About Outcomes.			
Percent Reporting Positively about Participation in Treatment Planning			
Percent Reporting Positively about General Satisfaction			
Child/Adolescent Consumer Survey Results:	Number Positive Responses	Responses	Confidence Interval
Percent Reporting Positively About Access.			
Percent Reporting Positively About General Satisfaction			
Percent Reporting Positively About Outcomes.			
Percent Reporting Positively Participation in Treatment Planning for their Children.			
Percent Reporting Positively About Cultural Sensitivity of Staff.			

* Report Confidence Intervals at 95% confidence level. See below for directions.

State Comments about Data:

Adults

1. Was the Official 28 Item MHSIP Adult Outpatient Consumer Survey Used? _____ Yes _____ No

a. If no, which version:

- 1. Original 40-Item Version _____
- 2. 21-Item Version _____
- 3. State Variation of MHSIP _____
- 4. Other Consumer Survey _____

b. If other, please attach instrument used.

c. Did you use any translations of the MHSIP into another language?

- 1. ___ Spanish
- 2. ___ Other: _____

2. Populations Covered: Did you Send Surveys to: (Note all surveys should cover all regions of state)

- 1. _____ All Consumers in State
- 2. _____ Sample of MH Consumers

2.a If a sample was used, what sample methodology was used?

- 1. ___ Random Sample
- 2. ___ Stratified Random Sample
- 3. ___ Convenience Sample
- 4. ___ Other: Describe: _____

2.b. Do you survey only persons currently in services, or do you also survey persons no longer in service?

- 1. ___ Persons Currently Receiving Services
- 2. ___ Persons No Longer Receiving Services:
- 2.a If yes, to 2. Please describe how you survey persons no long receiving services:

3. Please describe the populations included in your sample: (e.g., all adults, only adults with SMI, etc.)

1. All adult consumers in state
2. Adults with a Serious Mental Illness
3. Adults who were Medicaid eligible or in Medicaid Managed Care
4. Other: describe: (for example, if you survey anyone served in the last 3 months, describe):

4a. Methodology of collecting data? (Check all that apply)

	Self-Administered	Interview
Phone		
Mail		
Face-to-face		
Web Based		

4.b. Who administered the Survey? (Check all that apply)

1. Mental Health Consumers
2. Family Members
3. Professional Interviewers
4. MH Clinicians
5. Non-direct Treatment Staff
6. Other: describe: _____

5. Confidentiality of Surveys

- 5.a. Are responses Anonymous? (No way to identify person who complete Surveys) Yes No
- 5.b. Are Responses Confidential? (Surveys may be identified, but responses are confidential) Yes No
- 5.c. Were survey responses matched to mental health client databases? Yes No

6. Sample Size and Response Rate

- 6a. How many Surveys were Attempted (sent out or calls initiated)? _____
- 6b. How many survey Contacts were made? (surveys to valid phone numbers or addresses) _____
- 6c. How many surveys were Completed? (survey forms returned or calls completed) _____
- 6d. What was your response rate? (number of Completed surveys divided by number of Contacts) _____%
- 6e. If you received “blank” survey’s back from consumers (e.g., surveys with no responses on them), do you count those as “completed” surveys for the calculation of “completion rates” and “response rates”? Yes No

7. Who conducted the Survey

- SMHA Conducted or Contracted for Survey (Survey done at the state level)
- Local Mental Health Providers/County mental Health Providers Conducted or Contracted for Survey (survey is conducted at the local or regional level)
- Other: describe: _____

Children/Adolescent Family Survey:

1. Was the MHSIP Children’s Survey (YSS-F) used? _____ Yes _____ No
 a. If no, please attach instrument used.

b. Did you use any translations of the MHSIP into another language?
 1. ___ Spanish
 2. ___ Other: _____

2. **Populations Covered: Did you Send Surveys to:** (Note all surveys should cover all regions of state)
 1. _____ All Consumers in State
 2. _____ Sample of MH Consumers

2.a If a sample was used, what sample methodology was used?
 1. ___ Random Sample
 2. ___ Stratified Sample
 3. ___ Convenience Sample
 4. ___ Other: Describe: _____

2.b. Do you survey only persons currently in services, or do you also survey persons no longer in service?
 1. ___ Persons Currently Receiving Services
 2. ___ Persons No Longer Receiving Services:

2.c If yes to 2. Please describe how you survey persons no long receiving services:

3. **Please describe the populations included in your sample:** (e.g., all children, only children with SED, etc.)
 1. ___ All child and adolescent consumers in state
 2. ___ Children and adolescents with a Serious Mental Illness or Serious Emotional Disturbance
 3. ___ Children/Adolescents who were Medicaid eligible
 4. ___ Other: describe: (for example, if you survey anyone served in the last 3 months, describe that here):

4a. Methodology of collecting data? (Check all that apply)

	Self-Administered	Interview
Phone		
Mail		
Face-to-face		
Web Based		

4.b. Who administered the Survey? (Check all that apply)

1. ___ Mental Health Consumers
 2. ___ Family Members
 3. ___ Professional Interviewers
 4. ___ MH Clinicians
 5. ___ Non-direct Treatment Staff
 6. ___ Other: describe: _____

5. Confidentiality of Surveys

- 5.a. Are responses Anonymous? (No way to identify person who complete Surveys) Yes No
- 5.b. Are Responses Confidential? (Surveys may be identified, but responses are confidential) Yes No
- 5.c. Were survey responses matched to mental health client databases? Yes No

6. Sample Size and Response Rate

- 6a. How many Surveys were Attempted (sent out or calls initiated)? _____
- 6.b. How many survey Contacts were made? (surveys to valid phone numbers or addresses) _____
- 6.c. How many surveys were Completed? (survey forms returned or calls completed) _____
- 6.d. What was your response rate? (number of Completed surveys divided by number of Contacts) _____%
- 6.e. If you received “blank” survey’s back from consumers (e.g., surveys with no responses on them), do you count those as “completed” surveys for the calculation of “completion rates” and “response rates”? Yes No

7. Who conducted the Survey

- SMHA Conducted or Contracted for Survey (Survey done at the state level)
- Local Mental Health Providers/County mental Health Providers Conducted or Contracted for Survey (survey is conducted at the local or regional level)
- Other: describe: _____

Note: The **confidence interval** is the plus-or-minus figure usually reported in newspaper or television opinion poll results. For example, if you use a confidence interval of 4 and 47% percent of your sample picks an answer you can be "sure" that if you had asked the question of the entire relevant population between 43% (47-4) and 51% (47+4) would have picked that answer.

The **confidence level** tells you how sure you can be. It is expressed as a percentage and represents how often the true percentage of the population who would pick an answer lies within the confidence interval. The 95% confidence level means you can be 95% certain; the 99% confidence level means you can be 99% certain. Most researchers use the 95% confidence level.

When you put the confidence level and the confidence interval together, you can say that you are 95% sure that the true percentage of the population is between 43% and 51%. (From www.surveysystem.com). (Note these can be calculated online at a site such as <http://www.surveysystem.com/sscalc.htm>).

2003 Changes to Table 11:

1. Scoring of domains: The guidance sent out in year one was unclear about how to handle missing or incomplete survey responses. The 16 State Study and 5-State Study approach was that Domain scores should only be calculated using surveys that had 2/3 or more of the items complete for that domain. The recommendation is to use the 16 State Study approach.
2. Report the number of “positive” responses and the total number of responses for each domain instead of just collecting the percent responding positive. I.e., instead of reporting 75% positive, states would report they had received 75 positive responses and 100 total responses for that domain. The reason for the collection of numbers, is it will allow better analysis of data across states and at national levels.
3. States should report confidence intervals at the domain level. In year 1, states were asked to report confidence intervals for the overall survey. However, it was discussed that actual confidence levels should be calculated for each domain, since each domain may have a different number of valid responses. Confidence intervals should be reported at the 95% level. Directions on how to calculate confidence intervals are included on Table 11, along with a website that will assist states in this calculation.
4. The Report Year, at the top to Table 11 is be clarified to reflect the year the consumer survey was conducted.
5. Question 1 on the use of the MHSIP consumer survey: if a state or program conducted the MHSIP consumer survey using the wording from the “official” 28 item adult MHSIP survey, then the state should check that they used the official version. If a state added additional questions to the survey, but added them after the original 28 items, then they are still doing the official MHSIP survey. However, if a state modified the wording of the official 28-item MHSIP, or added questions in the middle of the 28 items, then the state should check that they did a “state variation of MHSIP).
6. Sample Approach: Question 2a: A random sample is a sample where everyone has an equal chance of being selected and the person doing the selection has no way of choosing who is selected. A state that surveys all consumers or all consumers in a particular program is not conducting a random sample. The options should be: 1) random, 2) stratified random sample 3) convenience 4) all consumers.
7. Question 3. Methodology: Switch places with question 3 and Add an option for states to report they are using Internet Web-based methods of conducting the survey.
8. Question 4 Sample population: change: Move to question 3 and change from an open-ended question to a check box question: All adults in state, SMI adults, Medicaid Eligible Adults, or Other: describe:
9. Modify the information on the number of responses and response rate to collect four pieces of information:
 1. How many Surveys were Attempted (number of surveys mailed out or calls initiated)?
 2. How many survey Contacts were made? (surveys to valid phone numbers or addresses, this is the number attempted minus bad addresses or bad phone numbers, or the number of people that were approached to take a survey). This is the number of consumers who had an opportunity to actually respond to the survey.
 3. How many surveys were completed? (survey forms returned or calls completed)
 4. What was your response rate? (number of Completed surveys divided by number of Contacts)

Year 1 State DIG Workgroup Recommendations :**Adult Consumer Surveys:**

The MHSIP Survey is the preferred instrument to compile results. The official 28 Item version of MHSIP is the recommended version. If some other version of the MHSIP Survey is used, individual items should be combined to calculate indicator scores using the question listed below. CMHS and the MHSIP Policy Group, and the DIG Consumer Survey Workgroup also recommends reporting of data for the two optional factors from the full 28 Item MHSIP Survey: Participation in Treatment Planning and General Satisfaction: The following are recommendations that relate to the Adult Survey.

1. **Statewide Surveys:** States should only report consumer survey results from surveys that are conducted on a statewide basis—preferably surveys conducted with a “scientific” sampling technique.
 - a. States that only have pilot data or only data from a few providers or a region of the state should not report data.
 - b. States should use a centrally conducted survey—i.e., individual community providers should not each conduct their own surveys with the state reporting aggregate results.
 - c. States should describe their sampling methodology when they submit data.

2. **Sample Size:** a sufficient sample size (“n”) should be collected for surveys to be reported. States are requested to report the confidence interval and confidence levels for their surveys. States should use a sufficient sample size to report results at high confidence levels.

3. **Specific Questions to Use:** Based on the assumption that most states (currently over 40 states) are using either the official 28 item MHSIP Consumer Survey, or a variant of the MHSIP Consumer Survey, the Workgroup recommends states report results based on the official 28 survey items used by the 16 State Study for calculating scores for the 5 domains (2 domains are optional)
 - a. **MHSIP Consumer Survey: Perception of Access**
 - i. The location of services was convenient.
 - ii. Staff was willing to see me as often as I felt it was necessary.
 - iii. Staff returned my calls within 24 hours.
 - iv. Services were available at times that were good for me.
 - v. I was able to get all the services I thought I needed *
 - vi. I was able to see a psychiatrist when I wanted to *

 - b. **MHSIP Consumer Survey: Perception of Quality and Appropriateness**
 - i. Staff believed that I could grow, change and recover.
 - ii. I felt free to complain.
 - iii. Staff told what side effects to watch for.
 - iv. Staff respected my wishes about who is and is not to be given information about my treatment.
 - v. Staff was sensitive to my cultural/ethnic background.
 - vi. Staff helped me obtain the information needed so I could take charge of managing my illness.
 - vii. I was give information about my rights
 - viii. Staff encouraged me to take responsibility for how I live my life. *
 - ix. I was encouraged to use consumer-run programs. *

 - c. **MHSIP Consumer Survey: Perceptions of Outcomes:**
 - i. I deal more effectively with daily problems.
 - ii. I am better able to control my life.
 - iii. I am better able to deal with crisis.
 - iv. I am getting along better with my family.
 - v. I do better in social situations.
 - vi. I do better in school and/or work.
 - vii. My symptoms are not bothering me as much.
 - viii. My housing situation has improved. *

 - d. **MHSIP Consumer Survey: Perception of Participation in Treatment Planning (Optional)**
 - i. I felt comfortable asking questions about my treatment and medications.
 - ii. I, not staff, decided my treatment goals.

 - e. **MHSIP Consumer Survey: General Satisfaction (Optional)**
 - i. I liked the services that I received here.
 - ii. If I had other choices, I would still get services at this agency.
 - iii. I would recommend this agency to a friend or family member.

* Items noted with an * are items from the full 28 Item Adult MHSIP Consumer Survey that should be used to calculate domain scores. Items marked with an * were not used in the 16 State Study. States that do not have the full 28 Items from the Official MHSIP Consumer Survey should report results based on those items in each domain that they have.

Scoring:

1. Recode ratings of “not applicable” as missing values.²
2. Exclude respondents with more than 1/3rd of the items **in that domain missing**.
3. Calculate the mean of the items for each respondent.
4. Calculate the percent of scores less than 2.5. (percent agree and strongly agree).

Additional Reporting to add to Table 11:

- The workgroup has suggested adding an **optional** the reporting of consumer survey results by consumer characteristics.
- States should report Consumer Survey Results for each domain by Race/ethnicity in addition to the Total rate currently requested in Table 11.
- States should use the same categories as in other URS Tables.
- Patient categories should not be cross tabs: e.g., report results for age, then for race, not age by race.
- States should only report results for patient categories when there are at least 25 or 30 subjects in the category. I.e., do not report results for very small “n” categories.

Children/Adolescent Consumer Surveys:

The workgroup recommends using the Family version (YSS-F) for reporting on Table 11. If states want to conduct the adolescent survey (YSS), that would be reported as an option. This would require adding a third column to Table 11 to accommodate the second child survey.

Questions for each Domain for the YSS-F Survey are as follows:

Good Access to Service:

- The location of services was convenient for us.
- Services were available at times that were convenient for us.

Satisfaction with Services:

- Overall, I am satisfied with the services my child received
- The people helping my child stuck with us no matter what.
- I felt my child had someone to talk to when he/she was troubled.
- The services my child and/or family received were right for us.
- My family got the help we wanted for my child.
- My family got as much help as we needed for my child.

Participation in Treatment:

- I helped to choose my child's services.
- I helped to choose my child's treatment goals.
- I was frequently involved in my child's treatment.

Cultural Sensitivity:

- Staff treated me with respect.
- Staff respected my family's religious/spiritual beliefs.
- Staff spoke with me in a way that I understood.
- Staff were sensitive to my cultural/ethnic background.

Positive Outcomes of Services:

- My child is better at handling daily life.
- My child gets along better with family members.
- My child gets along better with friends and other people.
- My child is doing better in school and/or work.
- My child is better able to cope when things go wrong.
- I am satisfied with our family life right now.

Scoring:

1. Exclude respondents with more missing values than allowed per factor:
2. Calculate the mean of the items for each respondent.
3. Calculate the percent of scores greater than 3.5. (percent agree and strongly agree).

Numerator: Total number of respondents with an average scale score > 3.5.

Denominator: Total number of respondents.

Table 11: Consumer Evaluation of Care by Consumer Characteristics: (Optional Table by Race/Ethnicity.)

Table 11.																		
Year Survey was Completed:																		
State Identifier:																		
Indicators	Total		American Indian or Alaska Native		Asian		Black or African American		Native Hawaiian or Other Pacific Islander		White		More than One Race Reported		Other/Unknown Race		Hispanic or Latino Origin	
	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses
Adult Consumer Survey Results:																		
Percent Reporting Positively About Access.																		
Percent Reporting Positively About Quality and Appropriateness.																		
Percent Reporting Positively About Outcomes.																		
Percent Reporting Positively about Participation in Treatment Planning																		
Percent Reporting Positively about General Satisfaction																		
Child/Adolescent Consumer Survey Results:	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses
Percent Reporting Positively About Access.																		
Percent Reporting Positively About General Satisfaction																		
Percent Reporting Positively About Outcomes.																		
Percent Reporting Positively Participation in Treatment Planning for their Children.																		
Percent Reporting Positively About Cultural Sensitivity of Staff.																		

Please Note: The U.S. Government has shifted the categories of Race and Ethnicity that it collects. This version of Table 11a reflects the new Census Categories. States may need to shift the categories collected with their MHSIP Surveys to reflect these new categories.

C. Please describe how you calculate and count the number of persons with co-occurring disorders:

4. State Mental Health Agency Responsibilities

a. **Medicaid:** Does the state mental health agency have any of the following responsibilities for mental health services provided through Medicaid? (Check all that apply.)

- 1 Medicaid operating Agency G
- 2 Setting Standards G
- 3 Quality improvement/program compliance G
- 4 Resolving consumer complaints G
- 5 Licensing G
- 6 Sanctions G
- 7 Other: _____

4b. Managed Care (Mental Health Managed Care)

Data from these Programs Are Reported in The URS Data

- 1 Does the state have a Medicaid managed care initiative? Yes G No G Yes G No G
- 2 Does the state mental health agency have any responsibility for mental health services provided through Medicaid managed care? Yes G No G Yes G No G

If yes, please check the responsibilities that the state mental health agency has:

- 1. Direct contractual responsibility and oversight of MCOs or BHOs G
- 2. Setting standards for mental health services G
- 3. Coordination with state health and Medicaid agencies G
- 4. Resolving mental health consumer complaints G
- 5. Input in contract development G
- 6. Performance monitoring and measurement G
- 7. Other: _____ G

5. Data Reporting: Please describe the extent to which your information systems allows the generation of unduplicated client counts between different parts of your mental health system. Please respond in particular for Table 2, which requires unduplicated counts of clients served across your entire mental health system.

Are the data reported in the tables:

- | | <u>Yes</u> | <u>No</u> | |
|--|------------|-----------|--------|
| a. Unduplicated: Consumers are counted once even if they were served in both State hospitals and community programs and if they were served in community mental health agencies responsible for different geographic or programmatic areas. | | | G
G |
| b. Duplicated: across state hospital and community programs | | | G
G |
| c. Duplicated: within community programs | G | G | |
| d. Duplicated: Between Child and Adult Agencies | G | G | |

- e. **Plans for Unduplication:** If you if you are not currently able to provide unduplicated client counts across all parts of your mental health system, please describe your plans to get unduplicated client counts by the end of your Data Infrastructure Grant.

6. **Summary administrative data**

Report Year: _____

State Identifier: _____

Summary Information on Data Submitted by State MHA:

Year Being Reported From: MM/YY to MM/YY: _____ to _____

Person Responsible for Data Submission: _____

Contact Phone Number: _____

Contact Address: _____

E-mail Address: _____