Attachment 4

OMB No: 0930-0168
Approval Expires:MM/DD/YYYY

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT APPLICATION GUIDANCE AND INSTRUCTIONS FY 2008 - 2010

TRANSFORMING MENTAL HEALTH CARE IN AMERICA

CFDA No. 93.958

.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

TABLE OF CONTENTS FOR APPLICATION GUIDANCE PACKAGE

Notice to Respondents

The annual reporting burden for collection of this information is estimated to average *255* hours for a one-year application, *235* hours for updating a two-year plan, and *185* hours for updating a three-year application. This includes the time required for reviewing instructions and preparing the application, requesting waivers and modifications, 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 7-1045, One Choke Cherry Road, 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-xxxx.

INTRODUCTION:

The FY 2008-2010 Community Mental Health Services (CMHS) Block Grant Application Guidance and Instruction Packet that follows is intended to provide specific guidance and instructions regarding the development and submission of the required plan. The Guidance is based on the existing CMHS Block Grant legislation and provides a foundation to promote transformation of the state mental health system. The existing five (5) criteria continue to be the framework for the mental health system of care and should be used to guide state planning efforts. There continues to be an emphasis on the reporting and use of the National Outcome Measures (NOMS).

States should submit the FY 2008 -2010 plan based upon the standard guidance in this instruction packet. Unlike the guidance for FY 2007 that introduced mental health transformation but did not require plans to describe transformation activities, this guidance includes a requirement for state transformation efforts to be described and integrated throughout plans for adult and children as well as the mental health planning council. The Guidance is also consistent with SAMHSA/CMHS's commitment to improving accountability of State's use of Federal funds to provide services to adults with serious mental illness (SMI)and children with serious emotional disturbances (SED).

The Application Guidance and Instructions Packet consist of five parts:

- Part A provides a context and overview of the FY 2008 – 2010 application with a more detailed discussion of the transition to mental health transformation and implementing the goals and recommendations of the President's New Freedom Commission on Mental Health.
- Part B outlines the administrative requirements, fiscal planning assumptions, and other special guidance that is required for submission of the application.
- Part C provides guidance for development of the three sections of the plan, including a description of the State's Service System, Identification and Analysis of the Service System's Strengths, Needs, and Priorities,

Mental Health Transformation Activities, and Performance Goals and Action Plans to Improve the Service System for adults and children separately.

- Part D gives guidance for preparation and submission of the Implementation Report which is used to describe the extent to which the State has implemented its prior year plan.
- Part E provides guidance on submission of the data tables from the Uniform Data Reporting System.

There are also several required attachments and appendices that provide useful resource information needed for the plan.

PART A: CONTEXT AND OVERVIEW OF FY 2008-2010 CMHS BG APPLICATION

I. Statutory Authority

Under the authority of the Public Health Service Act (PHS Act)[1] 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 for providing mental health services for adults with SMI and children with SED. In order for the Secretary to award these Block Grants, States, 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. 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 requiring data from the States is found in three different Sections of the law. First, the Secretary is required to establish definitions for SMI and SED.[2] Second, in order to receive funding, States will provide to the Secretary any data required 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. [3] Third, the application (including the plan under Section 1912(a)), must be otherwise in such form, made in such manner, and contain such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subpart.[4] A grant may be made only if the plan meets the five (5) criteria in the law and is approved by CMHS. [5] After review of the State plan implementation report for the previous

1. Sections 1911-1920 and 1941-1954 of the Public Health Service Act (PHS Act)
2 Section 1912(c)(1) and (2) (42 U.S.C. 300x-2)
3. Section 1943(a)(3) (42 U.S. C. 300x-53)
4. Section 1917(a)(7)
5. Section 1912 (b)

fiscal year, CMHS must also determine that the State has completely implemented the plan approved for the previous fiscal year.

II. History and Goals of Federal Mental Health Funding and Planning Requirements

Federal financial support of mental health programs has gone through many transitions from its beginning in 1963 with passage of the Community Mental Health Centers legislation to provide comprehensive services in local communities, [6] through conversion to block grants in 1981, and passage of legislation in 1986 and 1990 requiring states to develop and enhance comprehensive community-based systems of care.[7] In 1992, Congress passed legislation that moved responsibility for administration of the mental health block grant and state planning requirements from the National Institute of Mental Health to the newly formed Center for Mental Health Services, part of the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services. Finally, in 2000, legislative changes allowed states more flexibility in the use of block grant funds. [8]

Over the past 20 years, the evolution of policy changes which tie the mental health block grant funds to the development and implementation of state plans has had the following key goals:

- Access to a comprehensive system of care, including employment, housing, case management, rehabilitation, dental and health services, along with mental health services and supports;
- Participation of consumers/survivors and their families in planning and evaluation of state systems;
- Access for underserved populations, including homeless people and rural populations;
- Promoting recovery and community integration of people with psychiatric disabilities; and,
- Accountability through uniform reporting on access, quality, and outcomes of services.

---

6. Gerald N. Grob, *From Asylum to Community: Mental Health Policy in Modern America*. Princeton, NJ: Princeton University Press, 1991, 113-114.
7. Joseph N. De Raismes, III, *The Evolution of Federal Mental Health Planning Legislation*. http://www.namhpac.org/pages/bckground/back_evolution.html
8. De Raismes, http://www.namhpac.org/pages/bckground/back_evolution.html

These goals have been reaffirmed in recent years by several key federal developments: the Surgeon General's Report on Mental Health (1999); the New Freedom Initiative for People with Disabilities (2001); and the report of the New Freedom Commission on Mental Health (2003). These documents emphasize the importance of access to employment, housing, rehabilitation, and other services which support integration into the community for persons with mental illnesses, as well as the other goals listed above.

III. Center for Mental Health Services Transformation and Planning Initiatives

Mental Health Transformation

In 2003, the President's New Freedom Commission on Mental Health issued a report on the status of mental health care in America. The report titled, *Achieving the Promise: Transforming Mental Health Care in America* called for a fundamental change in the way mental health services are perceived, accessed, delivered, and financed. *Achieving the Promise* outlined a clear direction in which America's system for mental health care should change. Since its publication, *Achieving the Promise* has stimulated significant developments at the national level and proven to be formative to the planning efforts of the Center for Mental Health Services and the Mental Health Block Grant Program.

***Achieving the Promise* declared that millions of Americans with mental illnesses are denied the promise of recovery and a full life in the communities where they live. Many Americans with mental illnesses encounter daily struggles with stigma and discrimination, seek services from a fragmented and inadequate service system, and find available poor opportunities for involvement and self-determination. The Commission's report outlined six (6) overarching**

goals for transforming mental health care in America. The goals are as follows:

- **Americans understand that Mental Health is Essential to Overall Health**
- **Mental Health Care is Consumer and Family Driven**
- **Disparities in Mental Health Services are Eliminated**
- **Early Mental Health Screening, Assessment, and Referral to Services are Common Practice**
- **Excellent Mental Health Care is Delivered and Research is Accelerated**
- **Technology is Used to Access Mental Health Care and Information**

Following the publication of the President's New Freedom Commission's Report, SAMHSA/CMHS, through the U.S. Department of Health and Human Services, was charged to implement the goals and recommendations.

Federal Action Agenda

In FY 2005, CMHS published the *Federal Mental Health Action Agenda* that articulated specific, actionable objectives leading to the initiation of a long-term strategy designed to transform the Nation's public and private mental health service delivery systems. In developing the *Federal Mental Health Action Agenda*, CMHS collaborated with key Federal agencies to compile an inventory of current programs and activities to address the Commission's vision, and proposed numerous action steps to move the transformation agenda forward. To date, twenty-one (21) agencies, known as Federal Partners, have committed to collaborate with CMHS on behalf of adults with SMI and children with SED to:

- **Send the message across the nation that mental illnesses and emotional disturbances are treatable and that recovery is possible.**
- **Act immediately to reduce the number of suicides in the Nation through full implementation of the National Strategy for Suicide Prevention.**
- **Help States develop the infrastructure necessary to formulate and implement Comprehensive State Mental Health Plans that include the capacity to create individualized plans of care that promote resilience and recovery.**
- **Develop a plan to promote a mental health workforce better qualified to practice culturally competent mental health care based on evidence-based practices.**
- **Improve the interface of primary care and mental health services.**
- **Initiate a national effort focused on the mental health needs of children and promote early intervention for children identified to be at risk for mental disorders. Prevention and early intervention can help forestall or prevent disease and disability.**
- **Expand the "Science-to-Services" agenda and develop new evidence-based practices toolkits.**
- **Increase the employment of people with psychiatric disabilities.**
- **Design and initiate an electronic health record and information system that will help providers and consumers better manage mental health care and that will protect the privacy and confidentiality of consumers' health information.**

OMB Program Assessment Rating Tool

In an effort to improve program accountability and ensure fiscal responsibility for Federally funded programs, the Office of Management and Budget (OMB) created the Program Assessment Rating Tool (PART). The CMHS BG was evaluated using the PART in FFY 2003 for the 2005 budget cycle.

The PART, which is one component of the Federal government's effort to hold agencies accountable for their funded programs, assesses four aspects of each program:

- **Program purpose and design – the extent to which the program design and purpose are clear and defensible;**
- **Strategic planning – whether the agency sets valid annual and long term goals;**
- **Program management – agency management of the program, including financial oversight and program improvement efforts; and**
- **Program results – actual program performance towards goals reviewed in the strategic planning section of the PART.**

The CMHS BG was reviewed FFY 2003 and received a rating of *adequate*. In annual updates to OMB, the MHBG Program has been encouraged to continue improving its program performance data collection as a key component of assuring appropriate use of

program funds, and as a means to enhance planning for community based systems if care for adults with SMI and children with SED,

Web Block Grant Application System (WebBGAS)

Beginning in FY 2008, all States are requested to use the WebBGAS system to submit FY 2008 Block Grant plans and 2007 implementation reports. The WebBGAS is consistent with OMB approved guidance for the Mental Health Block Grant and Implementation Report. WebBGAS is a web-enabled block grant management system that allows for the submission, review and archive of the Community Mental Health Services Block Grant Application and Implementation Report that was developed based on the 2006-2007 MHBG Guidance and Instructions which mandated the form and content for applications and implementation reports. WebBGAS benefits both States and Federal government by significantly reducing the paperwork burden required for submission, revision, and reporting. Other benefits of submitting plans electronically include:

- **Elimination of redundant data entry with automatic pre-population of previous year's data;**
- **Online access of Block Grant applications allows for participation across geographical boundaries. Since WebBGAS is on the internet, it is available globally.**
- **Electronic standardization of data set allows for the production of streamlined reports and quantitative analysis on a national level.**
- **Increased communication pathways between the State and SAMHSA/CMHS.**
- **Allows the Plan and Implementation Reports to be viewed immediately by State users, Planning Council Chairs, State Citizens, and Federal staff**
- **Allows States to control access by distributing logins and passwords when the plan is ready to be viewed.**
- **Provides a mechanism for providing feedback to State Planners from all system users, including anonymous citizens.**
- **Produces properly formatted PDF documents for a Plan and Implementation Report in accordance with the "Achieving the Promise: Transforming Mental Healthcare in America, Community Mental Health Services Block Grant Application Guidance and Instructions".**
- **Once a Plan or Implementation Report document has been generated, it may be viewed, searched or printed with Adobe Acrobat.**
- **Allows for multiple State Planners to work on different sections of the Plan or Implementation Report at the same time.**
- **Integrates documents originally written in Microsoft Word, Microsoft Excel, WordPerfect or PDF by uploading the file through WebBGAS.**
- **Eliminates mail receipt issues for States and Territories.**

The website for WebBGAS is: https://bgas.samhsa.gov

NATIONAL OUTCOME MEASURES

Accountability in the delivery of quality mental health services for adults with serious mental illness and children with serious emotional disturbance continues to be a guiding principle of the Federal planning process for the Mental Health Block Grant. CMHS has established that one level of accountability will be measured by the collection of standardized data from States using uniform national outcome measures (NOMS)[9] and other measures specific to mental health services as determined by the individual States according to their priorities and needs. The NOMS are shown in Table 6 and are derived from tables in the Uniform Reporting System (URS) that is described in Part E of the guidance. The URS tables are located in Appendix II.

These tables also serve as the basis for the Data Infrastructure Grants (DIG) that were first offered to States and Territories in FY 2001 to provide funding to improve their data collection activities that would result in reporting uniform data that could be aggregated on a national basis. In FY 2004, States received the second set of Data Infrastructure Grants that substantially improved their ability to collect and report NOMS. The third set of DIG funding is expected to continue in FY 2008. During the FY 2008 – 2010 application cycle, the MHBG Program will continue working with States and Territories to refine and operationalize the NOMS contained in the URS data tables through monthly workgroup meetings with staff from the States.

All States[10] and Territories that accepted a DIG are required to submit data on the URS tables consistent with the work that has been accomplished in the DIG including using the uniform definitions and methods agreed to by the States and Territories. Likewise, the measures that States and Territories use for reporting and planning purposes in their State plans should be consistent with and reflect the data reported in the related URS table. Lastly, as work progresses under the DIG, States will be expected to report those items. Instructions and expectations regarding the

9 CMHS performance measures correspond to SAMHSA's National Outcome Measures (NOMS). Profiles and performance information for each State and Territory are posted to SAMHSA's Website (www.nationaloutcomemeasures.gov).

10 The term "State" refers each of the 50 States, the District of Columbia, and each of the U.S. territories. The term "U.S. territories" means the Commonwealth of Puerto Rico, American Samoa, Guam, the Commonwealth of Northern Marianas, the Virgin Islands, Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia.

actual reporting and implementation of NOMS that are currently being refined or under development at SAMHSA/CMHS will be transmitted separately to States. As stated in previous guidance, all States are expected to report on nine (9) SAMHSA NOMS by December 2007.

IV. Plan Format: Child/Adult Plans; Single Year and Multi-Year Plans

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. **As noted above, State plans should integrate transformation activities within their descriptions of the five (5) criteria.**

(1) Application Format for Single Year Plans in FY 2008-2010

In preparing State Plans for FY 2008 (due September 1, 2007), States should use this Application Guidance and Instructions. The application must include:

- Face Sheet
- Table of Contents
- Executive Summary
- All items in Part B
- All items in Part C (Sections I-III).

The implementation report (Part D & E), due December 1, 2007, will describe the extent to which the State implemented its mental health plan for FY 2007 and include data from the Uniform Reporting System (URS Tables).

The plan Part C (Sections I-III) must address each element of the four (4) criteria for adults and five (5) criteria for children as enumerated in the block grant legislation. **Mental health transformation activities should be described within the specific criterion to which they relate.** The plan should contain goals and fiscal year targets for the NOMS. If changes occur during the year that affect the plan as submitted and subsequently approved by CMHS, States may submit a modification of the Plan by forwarding a copy of the modification to the Grants

Management Office and entering the modification into WebBGAS after contacting the Federal Project Officer.

States are also reminded that criterion 5 requires information on how the grant will be expended and a funding plan. **In FY 2008, States will be asked to report Block Grant and State funding for transformation activities in Table 4.**

(2) Application Format for Multi-Year Plans Approved in FY 2008

In addition to all the requirements for single year plans, multi-year plans must provide narrative, goals, and fiscal year targets to adequately describe the State's activities for each year of the multi-year application. Multi-year applications must include the following:

- Face Sheet
- Table of Contents
- Executive Summary
- All items in Part B
- All items in Part C (Sections I-IV).
- Implementation Report (Part D & E)

  The Implementation Report, due December 1, 2007, will describe the extent to which the State implemented its mental health plan for FY 2007 and include data from the Uniform Reporting System (URS Tables).

Part C (Sections I-III) must address each element of the four (4) criteria for adults and five (5) criteria for children as enumerated in the block grant legislation. **Mental health transformation activities should be described within the specific criterion to which they relate.** The plan should contain goals and fiscal year targets for the NOMS for each year of the application/plan. If changes occur during the year that affect the plan as submitted and subsequently approved by CMHS, States may submit a modification of the Plan by forwarding a copy of the modification to the Grants Management Office and the Federal Project Officer. Similar to single year plans**,** multi year plans require information on how the grant will be expended and a funding plan **included in criterion 5.** Since some States may not be able to project future funding plans in the original

multi-year plan, a description of how the MHBG will be expended and the yearly funding plan will be required in the State's annual update to the multi-year plan. **In FY 2008, States will be asked to report Block Grant and State funding for transformation activities in Table 4.**

Performance indicator tables must be updated each year to include narrative as needed. **Additionally, States must submit at least one performance indicator in the plan to address mental health transformation**

(3) Application Format for Updates to Multi-year Plans Approved in FY 2009

Multi-year plans require that an annual update be submitted on or before September 1 of each year. The required updates to multi-year plans include the following:

- Face Sheet
- Table of Contents
- Executive Summary
- All items in Part B
- All items in Part C (Section III)
- Implementation Report (Part D & E)

  The Implementation Report, due December 1, 2008, will describe the extent to which the State implemented its mental health plan for FY 2007 and include data from the Uniform Reporting System (URS Tables).

For States submitting updates to multi-year plans, Part C (Sections I & II) need not be re-submitted unless the State's public mental health system is substantially changed and or the State Mental Health Authority changes within the State's organizational structure. Only modifications and changes to Part C (Sections II and III) are required to be included in the annual update to the State's plan, and should describe changes in critical gaps and unmet needs, identify significant achievements reflecting progress towards development of a comprehensive community-based mental health system, and should document changes in the original goals and targets.

Performance indicator tables must be updated each year to include narrative as needed. **Additionally, States must submit at least one performance indicator in the plan to address mental health transformation.**

States that submit two-year plans in FY 2008 or 2009 are expected to ensure that their plans are updated to reflect the current status of their mental State' mental health system. States are also reminded that Criterion 5 requires information on how the grant will be expended and a funding plan. Since some States may not be able to project future funding plans in the first year of the multi-year plan, a description of how the MHBG will be expended and the yearly funding plan will be required in the State's annual update to the multi-year plan. **In FY 2008, States are asked to report Mental Health Block Grant and State funding for transformation activities in Table 4.**

It is important that the MHBG Program be notified of changes made in the State's mental health system after the Plan has been submitted through written modification submitted to SAMHSA's Division of Grants Management Office. Before submitting applications each year, States should assess the impact of any positive or negative changes that occurred in the previous year that will affect the State's ability to carry out the proposed plan. If changes are necessary, States may modify the plan as part of the application package (thus modifying the original plan). In modifying previously approved plans, States should identify specific changes referring to related sections page numbers in the original plan, rather than simply making changes to the original plan and resubmitting it. These modifications should be discussed in detail within the context of the affected criteria, goals, and targets and submitted to SAMHSA's Division of Grants Management Office. After notifying the Grants Management Office and the Federal Project Officer, changes to the plan may be entered into WebBGAS.

PART B. ADMINISTRATIVE REQUIREMENTS, FISCAL PLANNING ASSUMPTIONS, AND SPECIAL GUIDANCE

I. FEDERAL FUNDING AGREEMENTS, CERTIFICATIONS AND ASSURANCES AND REQUIREMENTS

Federal funding agreements, certifications, assurances and other requirements are necessary each year in order for States to receive mental health block grant funds.

(1) FUNDING AGREEMENTS (Attachment A)

Do not retype the Funding Agreement; this may require re-submission of the agreement which could delay the award of funds. The Chief Executive Officer (Governor) or a formal 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 – PHS 5161-1 (Attachment B) - (OMB Approval 0920-0428)

Do not retype any of the certifications; this may require re-submission of a certification, which could delay the award of funds.

(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 about this requirement can be found in 45 CFR Part 93.

Included in the FY 2007 Application Guidance and Instructions is a copy of Standard Form-LLL "Disclosure of Lobbying Activities" and instructions to report lobbying activities.

(d) Program Fraud Civil Remedies Act (PFCRA)

(e) Environmental Tobacco Smoke

(3) ASSURANCES SF 424B (Attachment C) - (OMB Approval 0348-0040)

Do not retype any of the assurances; this may require re-submission of the assurance(s), which could delay the award of funds.

(4) DATA UNIVERSAL NUMBERING SYSTEM (DUNS) NUMBER

A DUNS number is a unique 9-digit number required for all applicants for Federal grants and cooperative agreements, with the exception of individuals other than sole proprietors. The number is used to identify related organizations that receive funding under grants and cooperative agreements, and to provide consistent name and address. The DUNS Number should be entered on the Face Sheet of the State's Plan/Application.

II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances (SED).[11] Each year the State shall expend not less than the calculated amount for FY 1994.

State Expenditures for Mental Health Services

Reported by: **State FY _____** **Federal FY_____**

Calculated FY 1994	Actual FY 2006	Estimated/Actual FY 2007
$	**$**	**$**

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the State may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. MAINTENANCE OF EFFORT (MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements.[12] MOE information is necessary 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. States that received approval to exclude funds from the maintenance of effort calculation should include the appropriate MOE approval documents.

States are required to submit expenditures in the following format:

11. Section 1913(a) of the PHS Act
12. Section 1915(b)(1) of the PHS Act

State Expenditures for Mental Health Services

MOE reported by: _____State FY _____Federal FY_

Actual FY 2005	Actual FY 2006	Estimated/Actual FY 2007
$	**$**	**$**

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principal agency for authorized activities of a non-recurring nature and for a specific purpose. [13] States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.
4. The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

13. Section 1915(b)(2) of the PHS Act

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

IV. Fiscal Planning Assumptions

For FY 2008, States are expected to develop their intended use of funds based on their FY 2007 Mental Health Block Grant allocation**.** Funds awarded under this Block Grant must be obligated and expended within the two-year period. For the FY 2008 block grant award, the period is October 1, 2007 through September 30, 2009. States are also required to submit a Financial Status Report (SF 269 Short Form) 90 days after the end of the obligation and expenditure period which is December 31, 2009. Each year and upon enactment of the President's Budget, States will receive an annual allotment table, and if necessary, will be required to modify the intended use of funds that was submitted in the annual application if the new annual allotment is significantly increased or decreased.

V. Submission Requirements and Due Dates

The Application Guidance and Instructions is available at the SAMHSA web site as www.mhbg.samhsa.gov. In FY 2008, State applications will only be submitted via WEBBGAS or to LouEllen M. Rice, Grants Management Officer, Division of Grants Management, OPS, SAMHSA, 1 Choke Cherry Road, Room 7-1091, Rockville, Maryland 20857 (for overnight/express mail, use zip code "20850". For applications submitted using WebBGAS, States must also mail an original and two copies of all of Part B to the Grants Management Office, including the signed copy of the Mental Health Planning Council letter. If applications are submitted in hard copies, States must submit the original and two copies of the entire application, including Parts B and C (Sections I, II, & III). All applications must be received by the due date of September 1. Implementation reports, including the URS Tables, are due on or before December 1. These due dates are statutorily set and waivers cannot be given. [14] If your State application and implementation report are not received in the Office of Grants Management by these mandatory dates, it will be impossible for your State to obtain a grant for the year indicated.

If copies of your State's plan are mailed, the copies should be submitted unbound, without staples, paper clips or fasteners. Do not attach or include any folded material, pasted, or in a size other than 8½" x11" on white paper. Heavy or lightweight paper should not be used, and submissions should be printed only on one side. Do not condense type closer than 15 characters per inch. 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. If the plan is submitted in hard copy, it is recommended that the State plan be limited to 120 pages.

Should you need additional information regarding submission of the application, contact LouEllen Rice at (240) 276-1404. Questions regarding the Mental Health Block Grant program should be directed to your Federal Project Officer at (240) 276-1760.

14. As required by Section 1917(a)(1) (42USC 300x-6) of the PHS Act

VI. STATE MENTAL HEALTH PLANNING COUNCILS

CMHS continues to encourage States to work with State Mental Health Planning and Advisory Councils to integrate the principles of mental heath transformation throughout the state's service delivery systems. As evidenced from the FY 2007 consultative peer reviews of State Block Grant Plans, states are increasingly involving planning council members on State wide-planning and policy making committees to provide input and guidance on mental health transformation. Involving planning council members at all levels of decision making ensures that transformation of state mental health systems will be more consumer and family driven and more responsive to the needs of adults with serious mental illness and children with serious emotional disturbance. For FY 2008-2010, States should include a brief description of the role of the Planning Council in the State's efforts to transform the mental health system.

(1). Membership Requirements

State Mental Health Planning Councils are required to conform to certain membership requirements. [15] This includes representatives of certain principal State agencies;[16] other public and private entities concerned with the need, planning, operation, funding and use of mental health services and related services; adults who are current or former consumers of mental health services; family members of adults with serious mental illness 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. 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. The law also requires that the ratio of parents of children with SED to other members of the Council be sufficient to provide adequate representation of such children in the deliberations of the Council.

(2). State Mental Health Planning Council Membership List and Composition

To demonstrate compliance with the statutory membership requirements, Tables 1 and 2 should be completed for the current fiscal year. In the Table 1 column, "Type of Membership," indicate

15. Section 1914(c) of the PHS Act

16. The principal State agencies are: Mental Health, Education, Medicaid, Vocational Rehabilitation, Housing, Social Services and Criminal Justice.

whether a member is a consumer, a family member of a child with SED, a family member of an adult with SMI, a provider, a state employee, or a representative not otherwise stated in the legislation.

(3). Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties.[17] If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

- reviewing plans and submitting to the State any recommendations for modification
- serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems,
- monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.[25]
- the role of the Planning Council in improving mental health services within the State.

(4). State Mental Health Planning Council Comments and Recommendations

With the Plan submission, States are required to submit documentation that the State Plan was shared with the Planning Council. Any comments and recommendations to the State plan received from the Planning Council must be submitted, regardless of whether the State has accepted the recommendations. In the annual implementation report, States are also required to submit documentation that the implementation report was shared with the Planning Council and must include any comments from the Council on the State's annual implementation report. The documentation, preferably in a letter signed by the Chair, should indicate that the Council has reviewed the State plan and the annual report with particular attention to the transformation activities that are highlighted and specified in the plan.

17. Section 1914(b) of the PHS Act (42 U.S.C. 300x-4)

(5). PUBLIC COMMENT ON THE STATE PLAN

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. States should describe their efforts and procedures to obtain public comment on the plan in this section.

TABLE 1.

List of Planning Council Members

Name	Type of Membership*	Agency or Organization Represented*	Address Phone & Fax	Email Address (If Available)

*Council members should be listed only once by type of membership and agency/organization represented. See type of membership in Table 2.

TABLE 2.

Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP		
Consumers/Survivors/Ex-patients (C/S/X)		
Family Members of Children with SED		
Family Members of Adults with SMI		
Vacancies (C/S/X & family members)		
Others (Not state employees or providers)		
TOTAL C/S/X, 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) State employee and provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services.

PART C. SPECIFIC GUIDANCE FOR STATE APPLICATIONS AND PLANS

SECTION I. Description of State Service System

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

- An overview of the State's mental health system: a brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.
- 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.
- New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.
- Legislative initiatives and changes, if any.
- 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.
- A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

SECTION II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

This section should be written primarily in narrative form with separate discussions of services for adults and children. In preparing the discussions, each presentation should be organized so that it follows the five criteria established in law. Within the discussion, States should separately address the following:

- A discussion of the strengths and weaknesses of the service system;
- An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them
- A statement of the State's priorities and plans to address unmet needs.

- A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.
- A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

Table 3.

Transformation Activities to be addressed in the State Plan.

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 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.

Describes mental health transformation efforts and activities in the State in Criterion 1, providing reference to specific goals of the NFC Report to which they relate.

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.

Describes mental health transformation efforts and activities in the State in Criterion 2, providing reference to specific goal(s) of the NFC Report to which they relate.

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.

Describes mental health transformation efforts and activities in the State in Criterion 3, providing reference to specific goal(s) of the NFC Report to which they relate.

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 in rural areas
- Describes how community-based services are provided to older adults.

. Describes mental health transformation efforts and activities in the State in Criterion 4, providing reference to specific goal(s) of the NFC Report to which they relate.

Criterion 5: Management Systems

- Describes financial resources, staffing and training for mental health services providers necessary for the plan.
- Provides for training of providers of emergency health services regarding mental health.
- Describes mental health transformation efforts and activities in the State in Criterion 3, providing reference to specific goal(s) of the NFC Report to which they relate.

Identifies transformation expenditures by Mental Health Block Grant funding and other State funding sources in Table 4. CMHS will work in partnership with States to obtain this important information and will allow flexibility in the way in which expenditure data is reported given the structure of the table. All States should provide an explanation of how the data is being reported in the table.

Note: Criteria 1, 2, 4, and 5 must be addressed in the Adult Plan; Criteria 1-5 must be addressed in the Children's Plan.

Table 4

FY 2008 – FY 2010 MHBG Transformation Expenditure Reporting Form
State: _____

State Transformation Activity	FY 2008 MHBG Planned Expenditure Amount	FY 2008 Other State Funding Source Amount
Improving **coordination** of care among multiple systems		
Support for **culturally competent** services		
Involving **consumers and families** fully in orienting the MH system toward recovery		
Support for **consumer- and family-operated programs**, including Statewide consumer networks		
Services for **co-occurring** mental and substance use disorders		
Eliminating **disparities** in access to and quality of care		
Support for integrated **electronic health record** and personal health information systems		
Improving consumer access to **employment and affordable housing**		
Provision of **Evidence Based Practices**		
Aligning **financing** for mental health services for maximum benefit		
Supporting **individualized plans of care** for consumers		
Supporting use of **peer specialists**		
Linking mental health care with **primary care**		
Supporting **school** mental health programs		
Supporting early mental health **screening,** assessment, and referral to services		
Suicide prevention		
Supporting reduction of the **stigma** associated with mental illness		
Use of health **technology** and telehealth to improve access and coordination of mental health care		
Supporting **workforce development** activities		
Other (specify)		

SECTION III: Performance Goals and Action Plans to Improve the Service System

1. Common Requirements for Adult and Child Plans

SAMHSA, in partnership with the States, identified data to be used to develop performance indicators that will increase accountability and demonstrate on a state-by-state basis whether community-based services lead to better outcomes for people served. SAMHSA has identified a set of National Outcome Measures (NOMS) that States are expected to integrate into their Mental Health Block Grant planning process.

This section should be organized in the same way as Section II above, with separate discussions of services for adults and children and organized so that it follows the five criteria, including the new prompts for transformation activities. Rather than focusing on strengths, needs and priorities, this section will focus on specific performance goals and action plans. State plans should include goals, targets, and action plans for the appropriate criterion using the NOMS (see Table 5 below), as well as any state-specific indicators they may choose. The State information will include specific performance goals and a description of how the State intends to achieve the performance goals. States may continue to develop and maintain state-specific performance indicators that they find useful for tracking improvements in the public mental health system.

2. National Outcome Measures (NOMS)

For each of the 5 criteria, States should continue to develop, maintain and report on state-specific performance indicators that they find useful for tracking improvements within the State and transformation of the mental health system, in addition to incorporating the NOMS discussed above. States should provide information on these indicators, including specific performance goals, target performance levels, and a description of how the State intends to achieve those performance goals.

3. State Transformation Outcome Measure

States are required to identify at least one state specific mental health transformation outcome measure and to report a performance indicator related to the measure. State

specific transformation performance indicator(s) shall be constructed according to the guidance provided in this document under Item 4 of Section III (Format of Plans) and should be labeled as transformation outcome measures.

4. All States are expected to report on nine (9) CMHS NOMS in FY 2008. (See Table 5 below). If unable to report on these measures, States should complete the State Data Level Capacity Checklist and/or provide and narrative explanation in the State plan.

Table 5.

NATIONAL OUTCOME MEASURES (NOMS)

National Outcome Measures*		Relevant Criterion	DIG/URS Tables	PART
INDICATORS REQUIRED IN 2008 – 2010				
1. Increased Access to Services	Number of Persons Served by Age, Gender, and Race/Ethnicity	Criteria 2 and 3	Tables 2A and 2B	Yes
2. Reduced Utilization of Psychiatric Inpatient Beds	Decreased Rate of Readmission to State Psychiatric Hospitals within 30 days and 180 days	Criteria 1 and 3	Table 20A	Yes
3. Use of Evidence-Based Practices	Number of Evidence-based Practices Provided by State	Criteria 1 and 3	Tables 16 and 17	Yes
	Number of Persons Receiving Evidence-based Practice Services	Criteria 1 and 3	Tables 16 and 17	Yes
4. Client Perception of Care	Clients Reporting Positively About Outcomes	Criteria 1 and 3	Table 11	Yes
5. Increase/Retained Employment or Return to/Stay in School	Profile of Adult Clients by Employment Status	Criterion 1	Table 4	No
	Increased school attendance	Criteria 1 and 3	Table 19C	No
6. Decreased Criminal Justice Involvement	Profile of Client Involvement in Criminal and Juvenile Justice Systems	Criteria 1 and 3	Table 19A and 19B	No
7, Increased Stability in Housing	Profile of client's change in living situation (including homeless status)	Criteria 1 and 3	Table 15	No
INDICATORS IN DEVELOPMENT				
8. Increased Social Supports/Social Connectedness	TO BE DETERMINED	Criteria 1 and 3	Developmental TBD	No
9. Improved Level of Functioning	TO BE DETERMINED	Criteria 1, 3, and 4	Developmental TBD	No

* If a State does not have the data available to construct a particular NOMS indicator, a narrative explanation must be provided which will include: 1) The current capacity to collect this data, 2) efforts underway to make collection of this data possible , and 3) a projected date for when the data will be available.

The selection of specific performance indicators and targets for NOMS is determined by each State. States will also determine the targets for State selected indicators that are useful for tracking improvements in the public mental health system, to include mental health transformation**.** The performance indicators and targets should be prepared for each criterion following the one-page sample in Appendix I, National Outcome Measures and State Specific Performance Indicators. For each indicator included in the State plan, a similar one-page description employing the same format should be included.

4. Format of Plans

(a) Adult Mental Health Plan

(i) Current Activities

States should describe their adult mental health service system in a narrative that addresses Criteria 1, 2, 4, & 5 of Table 3. Narratives for each criterion should convey the extent to which the services required under the criterion have been implemented.

(ii) Goals, Targets and Action Plans

If States are unable to collect and report the data for any of the tables from which the NOMS are constructed, a narrative explanation must be provided which will include: 1) The current status of the capacity to collect this data, 2) efforts underway to make collection of the data possible, and 3) a projected date for when the data will be available.

For each indicator, States must show the data for the past two years (to the extent that it is available), and project a specific target for the next year (or the next two years for multi-year plans.) The most common table format for presenting indicators is provided below.

Performance Indicator Table for State Plan

These tables are included in WebBGAS.

Name of Performance Indicator:
Population:
Criterion:

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY2005 Actual	FY2006 Actual	FY2007 Projected	FY 2008 Target	FY 2009* Target	FY 2010* Target
Performance Indicator						
Numerator**			---	---	---	---
Denominator**			---	---	---	---

*Targets for FY 2009 & FY 2010 are required only for multi-year plans.
** Numerator and Denominator are not required for Targets

Table Descriptors:
Name of Performance Indicator: Brief name of the performance indicator (*e.g.*, Increased Access to Services); **clearly label transformation outcome measures**.
Goal: broad, general description of what the States hopes to accomplish
Target: a specific, measurable, and expected outcome to be achieved within a defined period of time, and, if attained, is expected to contribute to the realization of the goal
Population: group targeted by this goal
Criterion: one or more of the five statutory criteria related to this goal
Performance Indicator Value: Numerator divided by Denominator expressed as percentage or actual number if not percentage (numerator and denominator not required).
Sources of Information: data bases from which data was reported
Special Issues: any special issues or considerations that relate to the indicator
Significance: importance of indicator to the overall State Plan
Action Plan: activity or activities to be undertaken to achieve the target.

(b) Children's Mental Health Plan

(i) Current Activities

States should describe their child mental health service system in a narrative that addresses Criteria 1, 2, 3, 4, & 5 of Table 3 above. Narratives for each criterion should convey the extent to which the services required under the criterion have been implemented.

(ii) Goals, Targets and Action Plans

States are unable to collect and report the data for any of the tables from which the NOMS are constructed, a narrative explanation must be provided which will include: 1) The current status of the capacity to collect this data, 2) efforts underway to make collection of the data possible, and 3) a projected date for when the data will be available.

For each indicator, States must show the data for the past two years (to the extent that it is available), and project a specific target for the next year (or the next two years for multi-year plans.) The most common table format for presenting indicators is provided below.

Performance Indicator Table for State Plan

These tables are included in WebBGAS.

Name of Performance Indicator:
Population:
Criterion:

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY2005 Actual	FY2006 Actual	FY2007 Projected	FY 2008 Target	FY 2009* Target	FY 2010* Target
Performance Indicator						
Numerator**			---	---	---	---
Denominator**			---	---	---	---

* Targets for FY 2009 & FY 2010 are required only for multi-year plans.
**Numerator and Denominator are not required for Targets.

Table Descriptors:
Name of Performance Indicator: Brief name of the performance indicator (*e.g.*, Increased Access to Services); **clearly label transformation outcome measures.**
Goal: broad, general description of what the State hopes to accomplish
Target: a specific, measurable, and expected outcome to be achieved within a defined period of time, and if attained, is expected to contribute to the realization of the goal.
Population: group targeted by this goal
Criterion: One of more of the five statutory criteria related to this goal

Performance Indicator Value: Numerator divided by Denominator and expressed as a percentage or actual number if not percentage (numerator and denominator not required)
Source of Information: data bases from which data was reported
Special Issues: any special issues or considerations related to the indicator
Significance: importance of indicator to the overall State Plan
Action Plan: activity or activities to be undertaken to achieve the target

PART D. Implementation Report

This section will contain the State Plan Implementation Report for FY 2008 as required by the PHS Act[18] States are requested to prepare and submit their implementation reports for the last completed FY in the format provided in this guidance. This will contain a report on the purposes for which the Community Mental Health Services Block Grant monies were expended**,** the recipients of grant funds, and a description of block grant-funded activities.[19] The report shall focus on the extent to which the State has implemented its plan for the FY, with particular attention given to the goals and performance indicators. This section should also contain any comments from the mental health planning council, preferably in the form of a letter.[20] The Data Tables (presented in Part E) are included as a component of the Implementation Report.

All States and Territories are requested to use WebBGAS to submit State implementation reports. If sending hard copies, mail the original and two copies to LouEllen M. Rice, Grants Management Officer, Division of Grants Management, OPS, SAMHSA, 1 Choke Cherry Road, Room 7-1091, Rockville, Maryland 20857 by December 1, 2008 (for overnight/express mail, use zip code "20850"). Please note that if your implementation report is not received in the Office of Grants Management by December 1, your State will not receive a grant for the year indicated.

I. Narrative Content of the Implementation Report

1) Report Summary

- Areas which the State identified in the prior FY's approved Plan as needing improvement;
- The most significant events that impacted the mental health system of the State in the previous FY; and

18. Section 1912(d)(1) of PHS Act (42 USC 300x-2)
19 As required by Section 1942(a)(1) and (2) of PHS Act (42 U.S.C. 300x-52).
20 As required by Section 1915 (a)(2) of PHS Act.

- A report on the purposes for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant,

II. Performance Indicators

1) P**erformance Indicators.** States are required to complete the Performance **Indicator Tables for the Implementation Report** as presented below**.** The purpose of this table is to show progress made toward the CMHS NOMS and data for the State-selected performance indicators. and the CMHS NOMS over time. Each indicator should include narrative regarding: Activities and strategies/changes/innovations or exemplary model; and Target Achieved or Not Achieved /If Not, Explanation of Why.

Performance Indicator Table for Implementation Plan

Name of Performance Indicator:
Population:
Criterion:

(1)	(2)	(3)	(5)	(6)	(7)
Fiscal Year	FY2005 Actual	FY2006 Actual	FY 2007 Target	FY2007 Actual	FY 2007 % Attained
Performance Indicator					
Numerator			---		---
Denominator			---		---

Table Descriptors:
Name of Performance Indicator: Brief name of the performance indicator (*e.g*., Increased Access to Services**); clearly label transformation outcome measures**.
Goal: broad, general description of what the State hopes to accomplish
Target: a specific, measurable, and expected outcome to be achieved within a defined period of time, and if attained, is expected to contribute to the realization of the goal.
Population: group targeted by this goal
Criterion: One of more of the five statutory criteria related to this goal
Performance Indicator Value: Numerator divided by Denominator and expressed as a percentage or actual number if not percentage (numerator and denominator not required)
Source of Information: data bases from which data was reported
Special Issues: any special issues or considerations related to the indicator

Attachment 4

Significance: importance of indicator to the overall State Plan activities and strategies/changes/innovations or exemplary model.
Activities and strategies/changes/innovations or exemplary model
Target Achieved or Not Achieved /If Not, Explanation of Why.

III. Accomplishments

This section should be integrated with the data presentation above. For each of the targets and corresponding performance indicators, the State should provide a brief narrative containing the following information:

- Documentation of the activities under each indicator for each criterion. This shall include data to support the State's report about its accomplishments for each target and performance indicator identified in the Plan for the prior FY.
- Description of activities and strategies the State used to address the performance indicator;
- Any changes in the implementation strategy described in the Plan for the prior State FY;
- Any innovative or exemplary model of mental health service delivery that the State developed, and its unique features;
- At the end of each indicator's narrative, the report should clearly state whether or not the particular target identified in the Plan for the prior State FY for adults with SMI or children with SED was "achieved" or "not achieved"; and
- If the targets were "not achieved," explain why.

Attachment 4
PART E: Uniform Data on Public Mental Health System

This section guides States in the reporting of uniform data on public mental health services in the State (with special focus on community mental health services) in a series of basic and developmental data tables. The completion of Part E is a term and condition for funding for States and Territories that were awarded Data Infrastructure Grants; all States and Territories that accepted the grant agreed to submit Part E as part of the FY Implementation Report. States that did not receive a Data Infrastructure Grant are encouraged to submit data under Part E of the guidance. If a State cannot provide data in tables, the State must indicate its reporting capacity in the State Level Data Reporting Capacity Checklist. To ensure uniformity, the data reported shall be based on the data definitions agreed to in the Mental Health Data Infrastructure Project. States are requested to report data based on the last completed fiscal year.

Background of CMHS Uniform Reporting System

The CMHS's Uniform Reporting System began in 2001 and has completed three rounds of state and national reporting. It is used by State mental health agencies to compile and report annual data from each State as part of the Community Mental Health Services Block rant. The reporting effort demonstrates that the state public mental health systems provide mental health services to 5.7 million persons each year. Data from the URS has shown that persons served by the SMHA systems are more often unemployed, receiving Medicaid assistance, and are frequently children and young adults. Persons served by SMHAs are most often served in community mental health settings and generally rate their access, appropriateness, and outcomes of services as positive. State mental health agencies expended over $26 billion to provide mental health services in FY 2003.

The URS comprises a set of 21 tables developed by CMHS, in consultation with state mental health agencies, that compiles annual state by state and national aggregate information including numbers and socio-demographic characteristics of persons served by the states, the outcomes of care, use of selected evidence based practices, client assessment of care, and insurance status. In addition, the URS tables compile information on the expenditures of SMHAs, local programs that receive MHBG funds, uses of MHBG funds and general questions on the SMHA system status.

Attachment 4

These tables are now used by SAMHSA to calculate the 10 mental health National Outcome Measures (NOMS) for state and national reporting. The URS also includes prevalence estimates for need of mental health services by states.

The URS reporting is the first national annual aggregate report of State mental health public systems, and is a product of the SAMHSA/CMHS State Mental Health Data Infrastructure Grants initiated in 2001. The State Mental Health Data Infrastructure Grants are part of the SAMHSA/CMHS initiative designed to support development of data infrastructure in State Mental Health Agencies across the country that will improve capacity for States to report URS measures annually. The URS measures are incorporated into the CMHS Mental Health Block Grant guidance and required to be reported to CMHS with the annual Implementation reports, which includes benchmarking or targeting of State planning.

Uniform data on the public mental health system are required to improve planning and oversight of community mental health services provided under the Community Mental Health Services Block Grant. In addition to the DIG**,** the Block Grant enhances the capacity of community mental health systems in each state. The flexible funding of the Block Grant allows States to fund gap-filling, new and innovative services. To understand the extent to which the Block Grant is valued and used, 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 described 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 outcomes of 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 is requested or should be submitted to CMHS. State identifiers are required for each table. CMHS, working with its contractor, the National Association of State Mental Health Program Directors (NASMHPD) National Research Institute (NRI), will create all derived measures from the primary data provided by the States. CMHS will also 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 the data is completed, CMHS will make State-by-State data profiles available, as well as summary tables that examine performance across all States for selected data elements. Until the development of the URS, SAMHSA/CMHS lacked a common set of reporting guidelines for the services provided by states under the Block Grant which made it difficult for SAMHSA/CMHS to summarize the activities across all the states.

Revisions to Tables in the Uniform Reporting System

The proposed revisions to the URS Tables have been developed by CMHS in conjunction with the States who report these measures to CMHS in the Implementation Report. Over the past three years, CMHS has used the DIG process to refine the URS Tables by sponsoring monthly conference meetings with the DIG grantees to review and assess changes to the URS measures. The revised tables reflect consensus on how reporting of these measures should be made more meaningful to States while providing SAMHSA/CMHS the necessary outcome data for the NOMS. The tables include one major revision to Table 9 and minor revisions to ten (10) tables, Tables 2, 4, 6, 11, 14, 16, 17, 19, 20, & 21. All revisions to the tables reflect a collaborative effort by CMHS and the States to further improve the States' capacity to collect and report data on the NOMS. The minor revisions to the tables are self-explanatory and represent a collected effort to make the data more meaningful to CMHS and the States. Table 7 below describes the revisions to the URS tables.

Table 6

Revisions to Tables in the Uniform Reporting System Table Description			
Table No.	**Table Name**	**Change**	**Revision**
Table 1	Profile of State Population by Diagnosis	No Change	
Table 2	Total Unduplicated Served by Age, Gender, & Race	Minor	Combine Age 0-3 with Age 4-12
Table 3	Total Served by Setting, by Age & Gender	No Change	
Table 4	Employment	Minor	Add Optional Table 4a. Reporting of Employment Status by 5 Diagnostic Groupings
Table 5	Medicaid Status	No Change	
Table 6	Profile of Client Flow and Turnover	Minor	Add Column for Length of Stay for clients in facility more than 1 year
Table 7	State MH Expenditures and Revenues	No Change--	
Table 8	Profile of Community MHBG Expenditures	No Change	
Table 9	Public Mental Health Service System Inventory List (Deleted in 2005)	Major	New table, Social Connectedness and Improved Functioning added for SAMHSA's newest NOMS.
Table 10	Profile of Agencies receiving MHBG Funds	No Change	
Table 11	Consumer Evaluation of Care	Minor	Add revisions to tables and questions to clarify survey instrument and methodology used to collect data for this domain if the recommended survey was not used.
Table 12	State Mental Health Agency Profile	No Change	
Table 13	Untreated Prevalence of Mental Illness	No Change	Continue as developmental until refined by DIG Workgroup
Table 14	Adults with SMI & SED served by Age, gender, Race, & Ethnicity	Minor	Combine Age 0-3 with Age 4-12
Table 15	Living Situation Profile	No Change	
Table 16	EBPs	Minor	Add two questions at the end of each EBP: 1). Did the State use the SAMHSA Toolkit to guide implementation? 2) Has staff been specifically trained to implement the EBP?
Table 17	EBPs	Minor	Add two questions at the end of each EBP: 1) Did the State use the SAMHSA Toolkit to guide implementation? 2) Has staff been specifically trained to implement the EBP?
Table 18	Use of New Generation Atypical Antipsychotics	No Change	
Table 19	Outcomes: Criminal Justice & School Attendance	Minor	Add new questions for two CMHS NOMS: Arrests, and School Attendance

Table 20	30 and 180 day state hospital readmissions	Minor	Combine Age 0-3 with Age 4-12
Table 21	30 and 180 day readmission to any psych bed	Minor	Combine Age 0-3 with Age 4-12

Rationale for Major Revisions to Table 9

Table 9 – Social Connectedness and Improved Functioning. A determination was made in FY 2005 by the DIG Workgroup and CMHS to not report the Public Mental Health Service System Inventory List due to amount of time involved and the repetitious nature of the data element. The replacement Table 9 allows States to report SAMHSA's newest NOMS, "social connectedness" and "improved functioning." Both measures are currently in developmental status and as each measure is further defined by SAMHSA, States will receive updates to support their reporting efforts in these areas.

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2008

I hereby certify that _____ agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[21] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2008, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

---

21 21. The term State shall hereafter be understood to include Territories.

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State 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 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.
(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and

(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and

(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);

(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and

(3) 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

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

_____ _____

Governor Date

Attachment B. Certifications
http://www.mhbg.samhsa.gov/certification.pdf

Attachment C. Disclosure of Lobbying Activities
http://www.mhbg.samhsa.gov/disclosure.pdf

Attachment D. Assurances
http://www.mhbg.samhsa.gov/assurance.pdf

Attachment E

FACE SHEET

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

_____ FY 2008

STATE NAME: _____ DUNS #: _____

I. AGENCY TO RECEIVE GRANT

AGENCY: _____

ORGANIZATIONAL UNIT: _____

STREET ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

TELEPHONE: _____ FAX: _____

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: _____ _____

Month Year Month Year

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME:_____ TITLE:_____

AGENCY: _____

ORGANIZATIONAL UNIT:_____

STREET ADDRESS:_____

CITY:_____STATE:_____ ZIP: _____

TELEPHONE: _____ FAX: _____ EMAIL: _____

Appendix I. Format for Table of Contents

TABLE of CONTENTS
STATE MENTAL HEALTH BLOCK GRANT APPLICATIONS and PLANS

iv. Targeted services to rural, homeless, and older adult populations
v. Management systems

2) Goals, Targets and Action Plans

Part D. Implementation Report

I. Narrative Content of the Implementation Report
II. Performance Indicators
III. Accomplishments

Part E. Uniform Data on Public Mental Health System

URS Tables

Attachments

A. Federal Funding Agreements
B. Certifications
C. Disclosure of Lobbying Activities
D. Assurances

Appendix II.

CMHS Uniform Reporting System Guidelines

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 following guidelines should be used 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 mental health services, including screening, assessment, and crisis services. Telemedicine services should be counted if they are provided to identify clients.
5 For states where a separate state agency is responsible for children's mental health, where feasible, efforts should be made to unduplicated clients between the child mental health agency and the adult mental health agency. If this induplication is not feasible, please report this potential duplication to indicate there is an overlap between the Age "0-17 group" and the Age "18 and over group" but that there is induplication 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.

URS Tables

These updated tables have been prepared by the CMHS-funded State Data Infrastructure Coordinating Center (SDICC) at the NASMHPD Research Institute, Inc. For additional information about the EBP Reporting Guidelines, please contact Vijay Ganju at vkganju@gmail.com. For other questions about the tables, please contact Ted Lutterman at 703-682-9463 (ted.lutterman@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 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)		

Note: This Table will be completed for the States by CMHS.

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 DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

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

Table 2.	
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*			More Than One Race Reported			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
0-12 Years	0	0	0	0																								
13-17 years	0	0	0	0																								
18-20 years	0	0	0	0																								
21-64 years	0	0	0	0																								
65-74 years	0	0	0	0																								
75+ years	0	0	0	0																								
Not Available	0	0	0	0																								
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Are these numbers unduplicated? ☐ Unduplicated ☐ Duplicated: between Hospitals and Community ☐ Duplicated Among Community Programs
☐ Duplicated between children and adults ☐ Other: describe: _____

Comments on Data (for Age):	
Comments on Data (for Gender):	
Comments on Data (for Race/Ethnicity):	
Comments on Data (Overall):	

Instructions for Tables 2A and 2B:

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, unduplicated between the two child and adult agency when feasible. Otherwise, recognize and indicate that there is overlap between the 0-17 group and the 18 and over group but that there is induplication within each group.

6 The "Hispanic" category on Table 2A allows for states to report if they do not currently compile Hispanic Origin as a separate question. States that track Hispanic Origin as a separate category should report on Table 2B instead of Table 2A.

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, Other Race, and Race Unknown. A separate second table will collect information on Hispanic or Latino Origin. This is the format recommended in the Basic Tables.

The OMB standard is different from the way many states historically 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 specifies 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, and 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 standard for URS/DIG grants and URS Reporting: The OMB standard means that the 3 categories discussed above must become part of SAMHSA and all other Federal data collection. However, CMHS/SAMHSA realizes 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, CMHS expects that states will start changing their MIS to reflect the new OMB guidance and will eventually be able to report the new categories.

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 "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.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

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

Table 2.													
Report Year:													
State Identifier:													
	Not Hispanic or Latino			Hispanic or Latino			Hispanic or Latino Origin Not Available			Total			
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Total
0 - 12 Years										0	0	0	0
13 - 17 years										0	0	0	0
18 - 20 years										0	0	0	0
21-64 years										0	0	0	0
65-74 years										0	0	0	0
75+ years										0	0	0	0
Not Available										0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0
Comments on Data (for Age):													
Comments on Data (for Gender):													
Comments on Data (for Race/Ethnicity):													
Comments on Data (Overall):													

Table 3: Profile of Persons served in the community mental health setting, State Psychiatric Hospitals and Other Settings

This table provides a profile for the clients that received public funded mental health services in community mental health settings, in state psychiatric hospitals, in other psychiatric inpatient programs, and in residential treatment centers for children.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 3.																			
Report Year:																			
State Identifier:																			
	Age 0-17			Age 18-20			Age 21-64			Age 65+			Age Not Available			Total			
Table 3. Service Setting	**F**	**M**	**NA**	**F**	**M**	**NA**	**F**	**M**	**NA**	**F**	**M**	**NA**	**F**	**M**	**NA**	**F**	**M**	**NA**	**Total**
Community Mental Health Programs																0	0	0	0
State Psychiatric Hospitals																0	0	0	0
Other Psychiatric Inpatient																0	0	0	0
Residential Treatment Center for Children																0	0	0	0
Comments on Data (for Age):																			
Comments on Data (for Gender):																			
Comments on Data (Overall):																			

Note: Clients can be duplicated between Rows: E.g., The same client may be served in both state psychiatric hospitals and community mental health centers during the same year and thus would be reported in counts for both rows.

Instructions:

1. States that have county psychiatric hospitals that serves 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 the Community MH Program Row.
4. Persons who receive inpatient psychiatric care through a private provider or medical provider licensed and/or contracted through the SMHA should be counted in the "Other Psychiatric Inpatient" row. Persons who receive Medicaid funded inpatient services through a provider that is not licensed or contracted by the SMHA should not be counted here.
5. A person who is served in both community settings and inpatient settings should be included in both rows.
6. RTC: 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 care for children and youth 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 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 adult 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 homemakers, care-givers, are etc and not a part of the workforce. These persons should be reported 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.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 4.																
Report Year:																
State Identifier:																
	18-20			**21-64**			**65+**			**Age Not Available**			**Total**			
Adults Served	**F**	**M**	**NA**	**F**	**M**	**NA**	**F**	**M**	**NA**	**F**	**M**	**NA**	**F**	**M**	**NA**	**Total**
Employed: Competitively Employed Full or Part Time (includes Supported Employment)													0	0	0	0
Unemployed													0	0	0	0
Not In Labor Force: Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled, etc.)													0	0	0	0
Not Available													0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

How Often Does your State Measure Employment Status? ☐ At Admission ☐ At Discharge ☐ Monthly ☐ Quarterly ☐ Other: describe:

What populations are included: ☐ All clients ☐ Only selected groups: describe:

Comments on Data (for Age):	
Comments on Data (for Gender):	
Comments on Data (Overall):	

Instructions:

1. Employed means competitively employed, part-time or full-time. Supported Employment and transitional employment, where consumer's 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 known status of employment should be reported.

Table 4a: Optional Profile of Adult Clients by Employment Status: by Primary Diagnosis Reported

This is a new table for 2006. The workgroup exploring employment found that the primary diagnosis of consumers results in major differences in employment status. The workgroup has recommended that we explore the ability of states to report employment by primary diagnosis and the impact of diagnosis on employment. The workgroup recommended 5 diagnostic clusters for reporting.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 4.					
Report Year:					
State Identifier:					
Clients **Primary Diagnosis**	**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.)**	**Employment Status Not Available**	**Total**
Schizophrenia & Related Disorders (295)					**0**
Bipolar and Mood Disorders (296, 300.4, 301.11, 301.13, 311)					**0**
Other Psychoses (297, 298)					**0**
All Other Diagnoses					**0**
No Dx and Deferred DX (799.9, V71.09)					**0**
Diagnosis Total	0	0	0	0	0
Comments on Data (for Diagnosis):					

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.

Please note that the same person may be served in both Medicaid and Non-Medicaid programs during the same reporting period.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please note that the same person may be served in both Medicaid and Non-Medicaid programs during the same reporting period.

Table 5A	
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 5b are not available.*			More Than One Race Reported			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	Female	Male	Not Availa
Medicaid (only Medicaid)	0	0	0	0																								
Non-Medicaid Sources (only)	0	0	0	0																								
People Served by Both Medicaid and Non-Medicaid	0	0	0	0																								
Medicaid Status Not Available	0	0	0	0																								
Total Served	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

☐ Data based on Medicaid Paid Services ☐ Data Based on Medicaid Eligibility, not Medicaid Paid Services ☐ Data are Duplicated

Each row should have a unique (unduplicated) count of clients: (1) Medicaid Only, (2) Non-Medicaid Only, (3) Both Medicaid and Other Sources funded their treatment, and (4) Medicaid Status Not Available).
If a state is unable to unduplicate between People whose care is paid by Medicaid, then they should report all data into the People Served by Both Medicaid and Other Sources and would check the box, People Served by Both is a duplicated count.

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.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please note that the same person may be served in both Medicaid and Non-Medicaid programs during the same reporting period.

Table 5B.													
Report Year:													
State Identifier:													
	Not Hispanic or Latino			Hispanic or Latino			Hispanic or Latino Origin Unknown			Total			
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Total
Medicaid Only										0	0	0	0
Non-Medicaid Only										0	0	0	0
People Served by Both Medicaid and Non-Medicaid Sources										0	0	0	0
Medicaid Status Unknown										0	0	0	0
Total Served	0	0	0	0	0	0	0	0	0	0	0	0	0
Comments on Data (for Age):													
Comments on Data (for Gender):													
Comments on Data (Overall):													

Each row should have a unique (unduplicated) count of clients: (1) Medicaid Only, (2) Non-Medicaid Only, (3) Both Medicaid and Other Sources funded their treatment, and (4) Medicaid Status Unknown).
If a state is unable to unduplicate between People whose care is paid by Medicaid, then they should report all data into the People Served by Both Medicaid and Other Sources and would check the box, People Served by Both is a duplicated count.

Table 6: Profile of Client Turnover

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

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)	Length of Stay (in Days): Discharged Patients		For Clients in Faclity for Less Than 1 Year: Average Length of Stay (in Days): Residents at end of year		For Clients in Facility More Than 1 Year: Average Length of Stay (in Days): Residents at end of year	
				Average (Mean)	Median	Average (Mean)	Median	Average (Mean)	Median
State Hospitals	-	-	-						
Children (0 to 17 years)									
Adults (18 yrs and over)									
Age Not Available									
Other Psychiatric Inpatient	-	-	-						
Children (0 to 17 years)									
Adults (18 yrs and over)									
Age Not Available									
Residential Tx Centers	-	-	-						
Children (0 to 17 years)									
Adults (18 yrs and over)									
Age Not Available									
Community Programs	-	-							
Children (0 to 17 years)									
Adults (18 yrs and over)									
Age Not Available									
Comments on Data (State Hospital):									
Comments on Data (Other Inpatient):									
Comments on Data (Residential Treatment):									
Comments on Data (Community Programs):									
Comments on Data (Overall):									

Instructions:

1. This table reflects client flow and turnover.

2. 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.

3. Column 2 is all additions or new admissions during the reporting period. If a person has multiple admissions during that reporting period, all admissions will be counted.

4. Again as in Table 2, there may be duplication across age categories, depending on the state's ability to unduplicate between children and adult systems of care.

5. Column 3 is all discharges during the reporting period. If a person has multiple discharges during that reporting period, all discharges will be counted.

6. As in table 3, there may be duplication across the state hospital section and the community section.

7. Changed for 2006:
   A: New Column for Length of Stay for clients in facility more than 1 year. Persons in the hospital for exactly 1 year should be reported in the prior columns of persons in hospital for less than one year.

   B: Added "Adults" and "Age Not Available" row to "Residential Treatment Centers" to allow reporting of use of Residential Treatment Centers by Adults (over age 18). This category was added because several states reported that their RTCs for Children had some persons age 18 or over in them and they lacked a place to report them. (The intent of allowing reporting of adults in RTC-Children was not to open a new reporting category of residential settings for adults, but to allow states with adults in RTC-C to report those adults.

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.

This Table will be completed by the NASMHPD Research Institute (NRI) using data from the FY 2005 SMHA-Controlled Revenues and Expenditures Study

This Table will be completed by the NASMHPD Research Institute (NRI) using data from the FY 2005 SMHA-Controlled Revenues and Expenditures Study

Table 7.				
Report Year:				
State Identifier:				
	State Hospital	**Other 24 Hour Care***	**Ambulatory/ Community Non-24 Hour Care**	**Total**
Total	**Data will come from the NRI's FY'2005 SMHA Revenues and Expenditures Study.**			
Medicaid				
Community MH Block Grant				
Other CMHS				
Other Federal (non-CMHS)				
State				
Other				

** Other 24 Hour Care: is "residential care" from both state hospitals and community ("Ambulatory/Community). Thus, "Other 24 Hour Care" expenditures are also included in the state hospital and/or "Ambulatory/Community" Columns as applicable.*

Comments on Data:

Note: The data in this table are derived from the National Association of State Mental Health Program Directors Research Institute, Inc's State Mental Health Agency-Controlled Revenues and Expenditures Study. FY 2005 Data for this table is currently being compiled by the NRI.

Note: The data in this table are derived from the National Association of State Mental Health Program Directors Research Institute, Inc's State Mental Health Agency-Controlled Revenues and Expenditures Study. FY'2005 Data for this table is currently being compiled by the NRI.

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.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 8	
Report Year:	
State Identifier:	
Profile of Community Mental Health Block Grant Expenditures for Non-Direct Service Activities	
Service	**Estimated Total Block Grant**
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	
Total Non-Direct Services	**$0**
Comments on Data:	

Instructions:

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

2. 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 in this table.

Table 9: SAMHSA NOMS: SOCIAL CONNECTEDNESS AND IMPROVED FUNCTIONING

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 9: NOMS Social Connectedness & Functioning			
Report Year (Year Survey was Conducted):			
State Identifier:			
Adult Consumer Survey Results:	**Number of Positive Responses**	**Responses**	**Percent Positive (calculated)**
1. Social Connectedness			
2. Functioning			
Child/Adolsecent Consumer Survey Results:	**Number of Positive Responses**	**Responses**	**Percent Positive (calculated)**
3. Social Connectedness			
4. Functioning			

Comments on Data:

Adult Social Connectedness and Functioning Measures

1. Did you use the recommended new Social Connectedness Questions? ☐ Yes ☐ No _____ Measure used
2. Did you use the recommended new Functioning Domain Questions? ☐ Yes ☐ No _____ Measure used

3. Did you collect these as part of your MHSIP Adult Consumer Survey? ☐ Yes ☐ No

If No, what source did you use?

Child/Family Social Connectedness and Functioning Measures

4: Did you use the recommended new Social Connectedness Questions? ☐ Yes ☐ No _____ Measure used
5: Did you use the recommended new Functioning Domain Questions? ☐ Yes ☐ No _____ Measure used

6. Did you collect these as part of your YSS-F Survey? ☐ Yes ☐ No

If No, what source did you use?

New Optional Table 9 for 2006: Optional Reporting of 2 CMHS National Outcome Measures: Social Connectedness and Functioning

This Table permits states who implemented the recommended NOMS modules on "Social Connectedness" and/or "Improved Functioning" as part of their 2006 Consumer Surveys to report results for these NOMS

Recommended Scoring Rules

Please use the same rules for reporting Social connectedness and Functioning Domain scores as for calculating other Consumer Survey Domain scores for Table 11: E.g.:

1. Recode ratings of "not applicable" as missing values.
2. Exclude respondents with more than 1/3 of the items in that domain missing.
3. Calculate the mean of the items for each respondent.
4. FOR ADULTS: calculate the percent of scores less than 2.5 (percent agree and strongly agree).
5. FOR YSS-F: calculate the percent of scores greater than 3.5 (percent agree and strongly agree).

Items to Score:

Adult MHSIP Social Connectedness Domain:

1. I am happy with the friendships I have.
2. I have people with whom I can do enjoyable things.
3. I feel I belong in my community.
4. In a crisis, I would have the support I need from family or friends.

Adult MHSIP Functioning Domain:

1. I do things that are more meaningful to me.
2. I am better able to take care of my needs.
3. I am better able to handle things when they go wrong.
4. I am better able to do things that I want to do.
5. My Symptoms are not bothering me as much (already is part of the MHSIP Adult Survey)

YSS-F Social Connectedness Domain Items:

1. I know people who will listen and understand me when I need to talk
2. I have people that I am comfortable talking with about my child's problems.
3. In a crisis, I would have the support I need from family or friends.
4. I have people with whom I can do enjoyable things

YSS-F Functioning Domain Items:

1. My child is better able to do things he or she wants to do.
2. My child is better at handling daily life. (existing YSS-F Survey item)

3. My child gets along better with family members. (existing YSS-F Survey item)
4. My child gets along better with friends and other people. (existing YSS-F Survey item)
5. My child is better able to cope when things go wrong. (existing YSS-F Survey item)

Note: the YSS-F functioning domain relies on 4 items that are also used in calculating the YSS-F "Outcomes Domain".

Table 10: Profile of Agencies Receiving Block Grant Funds Directly from the SMHA.

This table is to be used to provide an inventory of providers/agencies who directly receive Block Grant allocations**.**
Only report those programs that receive MHBG funds to provide services. Do not report planning council member reimbursements or other administrative reimbursements related to running the MHBG Program.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 10				
Report Year:				
State Identifier:				
Agency Name	**Address**	**Name of Director**	**Phone #**	**Amount of Block Grant Allocation to Agency**

Only one row for each program

* If you need more lines for additional agencies, please add rows or make copies of this table.

Table 11: Summary Profile of Client Evaluation of Care.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 11.			
Report Year (Year Survey was Conducted):			
State Identifier:			
Adult Consumer Survey Results:	**Number of Positive Responses**	**Responses**	**Confidence Interval***
1. Reporting Positively About Access.			
2. Reporting Positively About Quality and Appropriateness for Adults			
3. Reporting Positively About Outcomes.			
4. Adults Reporting on Participation In Treatment Planning.			
5. Adults Positively about General Satisfaction with Services.			
Child/Adolsecent Consumer Survey Results:	**Number of Positive Responses**	**Responses**	**Confidence Interval***
1. Reporting Positively About Access.			
2. Reporting Positively about General Satisfaction for Children.			
3. Reporting Positively about Outcomes for Children.			
4. Family Members Reporting on Participation In Treatment Planning for their Children			
5. Family Members Reporting High Cultural Sensitivity of Staff.			

**** Please report Confidence Intervals at the 95% level. See directions below regarding the calculation of confidence intervals.***

Comments on Data:

Adult Consumer Surveys

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

1.a. If no, which version:
- 1. Original 40 Item Version ☐ Yes
- 2. 21-Item Version ☐ Yes
- 3. State Variation of MHSIP ☐ Yes
- 4. Other Consumer Survey ☐ Yes

1.b. If other, please attach instrument used.

1.c. Did you use any translations of the MHSIP into another language? ☐ 1. Spanish

2. Other Language:

Adult Survey Approach:

2. Populations covered in survey? (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 Sample:

Adult Consumer Surveys (Continued)

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

☐ 1. Persons Currently Receiving Services

☐ 2. Persons No Longer 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 Serious Mental Illness

☐ 3. Adults who were Medicaid Eligible or in Medicaid Managed Care

3.4 Other: describe: (for example, if you survey anyone served in the last 3 months, describe that here):

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

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

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

☐ 1. MH Consumers

☐ 2. Family Members

☐ 3. Professional Interviewers

☐ 4. MH Clinicians

☐ 5. Non Direct Treatment Staff

6. Other: describe:

5. Are Responses Anonymous, Confidential and/or Linked to other Patient Databases?

☐ 1. Responses are Anonymous

☐ 2. Responses are Confidential

☐ 3. Responses are Matched to Client databases

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 receive "blank" surveys back from consumers (surveys with no responses on them), did you count these survey's as "completed" for the calculation of response rates? ☐ Yes ☐ No

7. Who Conducted the Survey

7.a. SMHA Conducted or contracted for the Survey (survey done at state level) ☐ Yes ☐ No

7.b. Local Mental Health Providers/County mental heatlh providers conducted or contracted for the survey (survey was done at the local or regional level) ☐ Yes ☐ No

7.c. Other: Describe:

* Report Confidence Intervals at the 95% confidence level

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

Instructions:

1) Scoring of domains: States should use the approach for calculating domain scores developed for the 16-State Study and 5-State Study. Domain scores should only be calculated using surveys that had 2/3 or more of the items complete for that domain.

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) 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).

5) 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 are: 1) random, 2) stratified random sample 3) convenience 4) all consumers.

6) Changed for 2006:
    a. If States conducted a Family survey other than the Recommended YSS-F, what survey did they use?
    b. Response categories related to method of survey were expanded to allow the option of Face-to-Face/Self Administered (requested by states that hand surveys to clients to complete and may help them answer them.)

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 questions listed below. CMHS and the MHSIP Policy Group, and the DIG Consumer Survey Workgroup also recommend 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.

f) New Module for **Social Connectedness** (reported on Table 9)
   i) I am happy with the friendships I have.
   ii) I have people with whom I can do enjoyable things.
   iii) I feel I belong in my community.
   iv) In a crisis, I would have the support I need from family or friends.

g) New Module for Adult MHSIP **Functioning** Domain: (reported on Table 9)
   i) I do things that are more meaningful to me.
   ii) I am better able to take care of my needs.
   iii) I am better able to handle things when they go wrong.
   iv) I am better able to do things that I want to do.
   v) My Symptoms are not bothering me as much (Note: This question is used in both the "Outcomes Domain" and the "Functioning Domain")

* 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. Exclude respondents with more than 1/3 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** 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.

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.

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.

New YSS-F Social Connectedness Domain Items: (reported on Table 9)

1. I know people who will listen and understand me when I need to talk
2. I have people that I am comfortable talking with about my child's problems.
3. In a crisis, I would have the support I need from family or friends.
4. I have people with whom I can do enjoyable things

New YSS-F Functioning Domain Items: (reported on Table 9)

1. My child is better able to do things he or she wants to do.
2. My child is better at handling daily life. *(also used for the YSS-F "Outcomes Domain")*
3. My child gets along better with family members. *(also used for the YSS-F "Outcomes Domain")*
4. My child gets along better with friends and other people. *(also used for the YSS-F "Outcomes Domain")*
5. My child is better able to cope when things go wrong. *(also used for the YSS-F "Outcomes Domain")*

Note: the calculation of the YSS-F "Functioning Domain" uses many of the survey items that are also used for the "Outcomes Domain".

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

Table 11a.																		
Report Year:																		
State Identifier:																		
Indicators	**Total**		**American Indian or Alaska Native**		**Asian**		**Black or African American**		**Hawaiian or Other Pacific Islander**		**White**		**More than One Race Reported**		**Other/ Not Available**		**Hispanic Origin**	
Adult Consumer Survey Results:	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**
Reporting Positively About Access.	0	0																
Reporting Positively About Quality and	0	0																
Reporting Positively About Outcomes.	0	0																
Reporting Positively about Participation in Treatment	0	0																
Reporting Positively about General Satisfaction	0	0																
6. Social Connectedness	0	0																
7. Functioning	0	0																
Child/Adolescent Family Survey Results:	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**	**# Positive**	**Responses**
Reporting Positively About Access.	0	0																
Reporting Positively About General	0	0																
Reporting Positively About Outcomes.	0	0																
Reporting Positively Participation in Treatment	0	0																
Reporting Positively About Cultural Sensitivity	0	0																
6. Social Connectedness	0	0																
7. Functioning	0	0																
Comments on Data:																		

Table 12: State Mental Health Agency Profile

The purpose of this profile is to obtain information that provides a context for the data provided in the tables. This profile covers the populations served, services for which the state mental health agency is responsible, data reporting capacities, especially related to duplication of numbers served as well as certain summary administrative information.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 12	
Report Year:	
State Identifier:	

Populations Served

1 Which of the following populations receive services operated or funded by the state mental health agency? Please indicate if they are included in the data provided in the tables. (Check all that apply.)

	Populations Covered		Included in Data	
	State Hospitals	Community Programs	State Hospitals	Community Programs
1. Aged 0 to 3	☐ Yes	☐ Yes	☐ Yes	☐ Yes
2. Aged 4 to 17	☐ Yes	☐ Yes	☐ Yes	☐ Yes
3. Adults Aged 18 and over	☐ Yes	☐ Yes	☐ Yes	☐ Yes
4. Forensics	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Comments on Data:				

2 Do all of the adults and children served through the state mental health agency meet the Federal definitions of serious mental illness and serious emotional disturbances?

☐ Serious Mental Illness
☐ Serious Emotional Disturbances

2.a. If no, please indicate the percentage of persons served for the reporting period who met the federal definitions of serious mental illness and serious emotional disturbance?

2.a.1	Percent of adults meeting Federal definition of SMI:	
2.a.2	Percentage of children/adolescents meeting Federal definition of SED	

Table 13: Profile of Unmet Needs of the State Population

This table provides estimates of adults with serious mental illness and children with serious emotional disturbances that have unmet service needs. This table is to be completed based on a standardized unmet needs estimation methodology being developed by the Center for Mental Health Services. CMHS will provide the methodology for estimating unmet needs to each State.

Table 13.		
Report Year:		
State Identifier:		
	Current Report Year	**Three Years Forward**
Adults with Serious Mental Illness (SMI)	***Note Table is Still being Operationally Defined Do not report data in 2005***	***Note Table is Still being Operationally Defined Do not report data in 2005***
Children with Serious Emotional Disturbances (SED)	***Note Table is Still being Operationally Defined Do not report data in 2005***	***Note Table is Still being Operationally Defined Do not report data in 2005***

Issue: Note States should not report data for this indicator in 2006. SAMHSA [has stated that they] will provide this estimation methodology for states.

The Workgroup for this Table will be working with CMHS on a proposed methodology. The Workgroup is currently focusing on estimating: **The number of Persons likely to use public services who are unserved?** (i.e., count of persons near the poverty level (~200%) with a SMI who are not served minus count of persons served in the public mental health system)

Table 14A: Profile of Persons with SMI/SED served by Age, Gender and Race/Ethnicity

This is a developmental table similar to Table 2A and 2B. This table requests counts for persons with SMI or SED using the definitions provided by the CMHS. Table 2A and 2B included all clients served by publicly operated or funded programs. This table counts only clients who meet the CMHS definition of SMI or SED. For many states, this table may be the same as Tables 2A and 2B.States should report using the Federal Definitions of SMI and SED if they can report them, if not, please report using your state's definitions of SMI and SED and provide information below describing your state's definition.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

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

Table 14A.	
Report Year:	
State Identifier:	

	Total				American Indian or Alaska Native			Asian			Black or African American			Native Hawaiian or Other Pacific			White			Hispanic *use only if data for Table 14b are			More Than One Race Reported			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
0-12 Years	0	0	0	0																								
13-17 years	0	0	0	0																								
18-20 years	0	0	0	0																								
21-64 years	0	0	0	0																								
65-74 years	0	0	0	0																								
75+ years	0	0	0	0																								
Not Available	0	0	0	0																								
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Comments on Data (for Age):	
Comments on Data (for Gender):	
Comments on Data (for Race/Ethnicity):	
Comments on Data (Overall):	

1. State Definitions Match the Federal Definitions:

☐ Yes ☐ No Adults with SMI, if No describe or attach state definition: _____

Diagnoses included in state SMI definition: _____

☐ Yes ☐ No Children with SED, if No describe or attach state definition: _____

Diagnoses included in state SED definition: _____

Table 14B: 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 meet the Federal definition of SMI and SED and who are Hispanic/Latino or not Hispanic/Latino. The total persons served who meet the Federal definition of SMI or SED should be the total as indicated in Table 14 A.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

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

Table 14B.													
Report Year:													
State Identifier:													
	Not Hispanic or Latino			Hispanic or Latino			Hispanic or Latino Origin Not Available			Total			
	Female	Male	Available	Female	Male	Available	Female	Male	Available	Female	Male	Available	Total
0 - 12 Years										0	0	0	0
13 - 17 years										0	0	0	0
18 - 20 years										0	0	0	0
21-64 years										0	0	0	0
65-74 years										0	0	0	0
75+ years										0	0	0	0
Not Available										0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0	0
Comments on Data (for Age):													
Comments on Data (for Gender):													
Comments on Data (for Race/Ethnicity):													
Comments on Data (Overall):													

Table 15: Living Situation Profile:

Number of Clients in Each Living Situation as Collected by the Most Recent Assessment in the Reporting Period. All Mental Health Programs by Age, Gender, and Race/Ethnicity

Please provide unduplicated counts, if possible. This table provides an aggregate profile of persons served 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.

Table 15.											
Report Year:											
State Identifier:											
	Private Residence	**Foster Home**	**Residential Care**	**Crisis Residence**	**Children's Residential Treatment**	**Institutional Setting**	**Jail/ Correctional Facility**	**Homeless/ Shelter**	**Other**	**NA**	**Total**
0-17											0
18-64											0
65 +											0
Not Available											0
TOTAL	0	0	0	0	0	0	0	0	0	0	0
Female											0
Male											0
Not Available											0
TOTAL	0	0	0	0	0	0	0	0	0	0	0
American Indian/Alaska Native											0
Asian											0
Black/African American											0
Hawaiian/Pacific Islander											0
White/Caucasian											0
Hispanic *											0
More than One Race Reported											0
Race/Ethnicity Not Available											0
TOTAL	0	0	0	0	0	0	0	0	0	0	0
Hispanic or Latino Origin											0
Non Hispanic or Latino Origin											0
Hispanic/Latino Origin Not Available											0
TOTAL	0	0	0	0	0	0	0	0	0	0	0
Comments on Data:											

How Often Does your State Measure Living Situation? ☐ At Admission ☐ At Discharge ☐ Monthly ☐ Quarterly ☐ Other: describe:

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

Living Situation Definitions:

Private Residence: Individual lives in a house, apartment, trailer, hotel, dorm, barrack, and/or Single Room Occupancy (SRO).

Foster Home: Individual resides in a Foster Home. A Foster Home is a home that is licensed by a County or State Department to provide foster care to children, adolescents, and/or adults. This includes Therapeutic Foster Care Facilities. Therapeutic Foster Care is a service that provides treatment for troubled children within private homes of trained families.

Residential Care: Individual resides in a residential care facility. This level of care may include a Group Home, Therapeutic Group Home, Board and Care, Residential Treatment, or Rehabilitation Center, or Agency-operated residential care facilities.

Crisis Residence: A residential (24 hours/day) stabilization program that delivers services for acute symptom reduction and restores clients to a pre-crisis level of functioning. These programs are time limited for persons until they achieve stabilization. Crisis residences serve persons experiencing rapid or sudden deterioration of social and personal conditions such that they are clinically at risk of hospitalization but may be treated in this alternative setting.

Children's Residential Treatment Facility: Children and Youth Residential Treatment Facilities (RTF's) provide fully-integrated mental health treatment services to seriously emotionally disturbed children and youth. 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 care for children and youth. The services are provided in facilities which are certified by state or federal agencies or through a national accrediting agency.

Institutional Setting: Individual resides in an institutional care facility with care provided on a 24 hour, 7 day a week basis. This level of care may include a Skilled Nursing/Intermediate Care Facility, Nursing Homes, Institutes of Mental Disease (IMD), Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), Veterans Affairs Hospital, or State Hospital.

Jail/ Correctional Facility: Individual resides in a Jail and/or Correctional facility with care provided on a 24 hour, 7 day a week basis. This level of care may include a Jail, Correctional Facility, Detention Centers, Prison, Youth Authority Facility, Juvenile Hall, Boot Camp, or Boys Ranch.

Homeless: A person should be counted in the "Homeless" category if he/she was reported homeless at their most recent (last) assessment during the reporting period (or at discharge for patients discharged during the year). The "last" Assessment could occur at Admission, Discharge, or at some point during treatment. A person is considered homeless if he/she lacks a fixed, regular, and adequate nighttime residence and/or his/her primary nighttime residency is:

A) A supervised publicly or privately operated shelter designed to provide temporary living accommodations,
B) An institution that provides a temporary residence for individuals intended to be institutionalized, or
C) A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (e.g., on the street).

Not Available: Information on an individual's residence is not available.

DATA INFRASTRUCTURE GRANTS

Guidelines for Reporting Evidence-Based Practices

Table 16: Profile of Adults with Serious Mental Illnesses and Children with Serious Emotional Disturbances Receiving Specific Services:

Table 17: Profile of Adults with Serious Mental Illnesses Receiving Specific Services during the Year:

PURPOSE

The purpose of this document is to provide guidelines for reporting evidence-based practices (EBPs) on the Uniform Reporting System (URS) that is part of SAMHSA's Center for Mental Health Services (CMHS) Community Mental Health Block Grant Reporting. Up to this point, guidelines have been relatively broad: states have elected to report their activities in the evidence-based practices categories if they were providing services that conformed to the definitions provided. In some cases, states that were implementing EBPs with fidelity did not report data because they thought that comparisons with states (or the national averages produced) that were not implementing the EBP with fidelity could be interpreted negatively. In other cases, states that were not monitoring fidelity chose not to report. The purpose of these guidelines is to help states assess whether their particular services align with the critical components of specific EBPs for DIG reporting.

DEVELOPMENT OF GUIDELINES

To get data that were more systematically uniform and that conformed better with the evidence-based form of the practice, CMHS charged the DIG Coordinating Center to convene a sub-group of state representatives to develop a set of guidelines for reporting EBPs recognizing that many states were not monitoring fidelity for many of the EBPs.

That is, at this stage, requiring fidelity was considered too stringent and restrictive for purposes of reporting EBPs on the URS tables. Many states are currently moving forward with the implementation of EBPs and the objective of these guidelines is to facilitate reporting of these state activities. The charge to the group essentially was to develop guidelines based on fidelity that could remove some of the ambiguity of what could be counted under this category.

To proceed with this task, a subset of state representatives involved with the Data Infrastructure Grants initiative was identified as the EBP workgroup. They convened several times on conference calls; draft recommendations were presented and reviewed by all states on the regional monthly DIG calls. Based on these activities, draft guidelines that are provided in this report were developed.

Please note: In no sense are these intended to be a revised definition of the practice or an identification of a new set of fidelity measures or critical elements. These guidelines are to help states identify whether they should report their activities in these tables or not. The intent is to obtain information if states are moving forward with implementation of the evidence-based form of the practice.

USE OF GUIDELINES FOR DIG REPORTING

As stated above, the intent of these guidelines is to provide guidance for states to decide whether they should report data on EBPs. They are not intended to be prescriptive or to set inflexible boundaries, but to indicate whether the services being reported conform broadly to the evidence-based practices. As reporting takes place, these guidelines are expected to be revised and refined over time.

ASSERTIVE COMMUNITY TREATMENT

I. DEFINITION

A team based approach to the provision of treatment, rehabilitation and support services. ACT/PACT models of treatment are built around a self-contained multi-disciplinary team that serves as the fixed point of responsibility for all patient care for a fixed group of clients. In this approach, normally used with clients with severe and persistent mental illness, the treatment team typically provides all client services using a highly integrated approach to care. Key aspects are low caseloads and the availability of the services in a range of settings. The service is a recommended practice in the PORT study (Translating Research Into Practice: The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations, Lehman, Steinwachs and Co-Investigators of Patient Outcomes Research Team, Schizophrenia Bulletin, 24(1):1-10, 1998) and is cited as a practice with strong evidence based on controlled, randomized effectiveness studies in the Surgeon General's report on mental health (Mental Health: A Report of the Surgeon General, December, 1999, Chapter 4, "Adults and Mental Health, Service Delivery, Assertive Community Treatment"). Additionally, CMS (formerly HCFA) recommended that state Medicaid agencies consider adding the service to their State Plans in HCFA Letter to State Medicaid Directors, Center for Medicaid and State Operations, June 07, 1999.

II. FIDELITY MEASURE

http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/

III. MINIMUM REQUIREMENTS FOR REPORTING ACT

- Small caseload: Client/ provider ratio of 10:1 or fewer is the ideal.
- Multidisciplinary team approach: This is a team approach rather than an approach which emphasizes services by individual providers. The team should be multidisciplinary and could include a psychiatrist, nurse, substance abuse specialist. For reporting purposes, there should be at least 3 FTE on the team
- Includes clinical component: In addition to case management, the program directly provides services such as: psychiatric services, counseling / psychotherapy, housing support, substance abuse treatment, employment/rehabilitative services.
- Services provided in community settings: Program works to monitor status, develop community living skills in the community rather than the office.
- Responsibility for crisis services: Program has 24-hour responsibility for covering psychiatric crises.

IV. ACT IS NOT INTENSIVE CASE MANAGEMENT

Note: If specific EBPs are provided as a component of ACT, they should be reported under ACT and not separately under other practices. In the revised version of the tables, please check off the EBPs that are provided under ACT. (Please note that to report these as EBPs; they should conform to the reporting guidelines for each EBP provided in this document.)

SUPPORTED EMPLOYMENT

I. DEFINITION

Mental Health Supported Employment (SE) is an evidence-based service to promote rehabilitation and return to productive employment for persons with serious mental illnesses. SE programs use a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to public), in normalized settings, and utilize multiple employers. The SE team has a small client: staff ratio. SE contacts occur in the home, at the job site, or in the community. The SE team is assertive in engaging and retaining clients in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others when appropriate. SE services are frequently coordinated with Vocational Rehabilitation benefits.

II. FIDELITY MEASURE

http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/employment/

III. MINIMUM REQUIREMENTS FOR REPORTING SUPPORTED EMPLOYMENT

- Competitive employment: Employment specialists provide competitive job options that have permanent status rather than temporary or time-limited status. Employment is competitive so that potential applicants include persons in the general population.

- Integration with treatment: Employment specialists are part of the mental health treatment teams with shared decision making. They attend regular treatment team meetings (not replaced by administrative meetings) and have frequent contact with treatment team members.

- Rapid job search: The search for competitive jobs occurs rapidly after program entry.

- Eligibility based on consumer choice (not client characteristics): No eligibility requirements such as job readiness, lack of substance abuse, no history of violent behavior, minimal intellectual functioning, and mild symptoms.

- Follow–along support: Individualized follow-along supports are provided to employer and client on a time-unlimited basis. Employer supports may include education and guidance. Client supports may include crisis intervention, job coaching, job counseling, job support groups, transportation, treatment changes (medication), and, networked supports (friends/family).

IV. SUPPORTED EMPLOYMENT IS NOT:

- Prevocational training
- Sheltered work
- Employment in enclaves (that is in settings, where only people with disabilities are employed)
- [If an employment specialist is part of an ACT team, this should be reported under ACT and not separately as supported employment.]

SUPPORTED HOUSING

I. DEFINITION

Services to assist individuals in finding and maintaining appropriate housing arrangements. This activity is premised upon the idea that certain clients are able to live independently in the community only if they have support staff for monitoring and/or assisting with residential responsibilities. These staff assists clients to select, obtain, and maintain safe, decent, affordable housing and maintain a link to other essential services provided within the community. The objective of supported housing is to help obtain and maintain an independent living situation.

Supported Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. Criteria identified for supported housing programs include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), and right to tenure, service choice, service individualization and service availability.

II. FIDELITY MEASURE (Not currently available)

III. MINIMUM REQUIREMENTS FOR REPORTING SUPPORTED HOUSING

- Target population: Targeted to persons who would not have a viable housing arrangement without this service.
- Staff assigned: Specific staff are assigned to provide supported housing services.
- Housing is integrated: That is, supported housing provided for living situations in settings that are also available to persons who do not have mental illnesses.
- Consumer has the right to tenure: The ownership or lease documents are in the name of the consumer.
- Affordability: Supported housing assures that housing is affordable (consumers pay no more than 30-40% on rent and utilities) through adequate rent subsidies, etc.

IV. SUPPORTED HOUSING IS NOT:

- Residential treatment services.
- A component of case management or ACT.

FAMILY PSYCHO-EDUCATION

I. DEFINITION

Family psycho-education is offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through the active involvement of family members in treatment and management and to alleviate the suffering of family members by supporting them in their efforts to aid the recovery of their loved ones. Family psycho-education programs may be either multi-family or single-family focused. Core characteristics of family psycho-education programs include the provision of emotional support, education, resources during periods of crisis, and problem-solving skills.

II. FIDELITY MEASURE

http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/family/

III. MINIMUM REQUIREMENTS FOR REPORTING FAMILY PSYCHO-EDUCATION

- A structured curriculum is used.
- Psycho-education is a part of clinical treatment.

IV. FAMILY PSYCHO-EDUCATION IS NOT:

Several mechanisms for family psycho-education exist. The evidence-based model, promoted through SAMHSA's EBP implementation resource kit ("toolkit") involves a clinician. For DIG reporting, do not include family psycho-education models not involving a clinician as part of clinical treatment.

Note: Some states are providing NAMI's Family-to-Family program and not the family psycho-education EBP described above. If a state is providing NAMI's Family-to-Family program, this should be reported under family psycho-education with an asterisk and a note indicating that the numbers reflect the NAMI program and not the EBP described above.

INTEGRATED TREATMENT FOR CO-OCCURRING DISORDER (MENTAL HEALTH / SUBSTANCE ABUSE)

I. DEFINITION

Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Hence, integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. In other words, the caregivers take responsibility for combining the interventions into one coherent package. For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems disappears. The goal of dual diagnosis interventions is recovery from two serious illnesses.

II. FIDELITY MEASURE

http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/

III. MINIMUM REQUIREMENTS FOR REPORTING INTEGRATED TREATMENT

- Multidisciplinary team: A team of clinical, working in one setting provides MH and SA interventions in a coordinated fashion.

- Stagewise interventions: That is, treatment is consistent with each client's stage of recovery (engagement, motivation, action, relapse prevention)

IV. INTEGRATED TREATMENT IS NOT:

- Coordination of clinical services across provider agencies

ILLNESS MANAGEMENT / RECOVERY

I. DEFINITION

Illness Self-Management (also called illness management or wellness management) is a broad set of rehabilitation methods aimed at teaching individuals with mental illness, strategies for collaborating actively in their treatment with professionals, for reducing their risk of relapses and re-hospitalizations, for reducing severity and distress related to symptoms, and for improving their social support. Specific evidence-based practices that are incorporated under the broad rubric of illness self-management are psycho-education about the nature of mental illness and its treatment, "behavioral tailoring" to help individuals incorporate the taking of medication into their daily routines, relapse prevention planning, teaching coping strategies to managing distressing persistent symptoms, cognitive-behavior therapy for psychosis, and social skills training. The goal of illness self-management is to help individuals develop effective strategies for managing their illness in collaboration with professionals and significant others, thereby freeing up their time to pursue their personal recovery goals.

II. FIDELITY MEASURE

http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/illness/

III. MINIMUM REQUIREMENTS FOR REPORTING ILLNESS MANAGEMENT & RECOVERY

- Service includes a specific curriculum that includes mental illness facts, recovery strategies, using medications, stress management and coping skills. It is critical that a specific curriculum is being used for these components to be counted for reporting.

IV. EVIDENCE-BASED ILLNESS MANAGEMENT IS NOT:

- Advice related to self-care but a comprehensive, systematic approach to developing an understanding and a set of skills that help a consumer be an agent for his or her own recovery.

MEDICATION MANAGEMENT

I. DEFINITION

In the toolkit on medication management there does not appear to be any explicit definition of medication management. However the critical elements identified for evidence-based medication management approaches are the following:

1. Utilization of a systematic plan for medication management
2. Objective measures of outcome are produced
3. Documentation is thorough and clear
4. Consumers and practitioners share in the decision-making

II. FIDELITY MEASURE

http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/

III. MINIMUM REQUIREMENTS FOR REPORTING MEDICATION MANAGEMENT

- Treatment plan specifies outcome for each medication.
- Desired outcomes are tracked systematically using standardized instruments in a way to inform treatment decisions.
- Sequencing of antipsychotic medication and changes are based on clinical guidelines.

IV. EVIDENCE-BASED MEDICATION MANAGEMENT IS NOT:

- Medication prescription administration that occurs without the minimum requirements specified above.

MULTISYSTEMIC THERAPY (MST)

I. DEFINITION

Multisystemic Therapy (MST) is an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior. The multisystemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems. The goal is to facilitate change in this natural environment to promote individual change. The caregiver is viewed as the key to long-term outcomes.

II. FIDELITY MEASURE (Contact Vijay Ganju at vkganju@gmail.com)

III. MINIMUM REQUIREMENTS

- Services take into account the life situation and environment of the child / adolescent and involve peers, school staff, parents, etc.
- Services are individualized
- Services are provided by MST Therapists or masters-level professional
- Services are time-limited
- Services are available 24/7

THERAPEUTIC FOSTER CARE

I. DEFINITION

Children are placed with foster parents who are trained to work with children with special needs. Usually, each foster home takes one child at a time, and caseloads of supervisors in agencies overseeing the program remain small. In addition, therapeutic foster parents are given a higher stipend than traditional foster parents, and they receive extensive pre-service training and in-service supervision and support. Frequent contact between case managers or care coordinators and the treatment family is expected, and additional resources and traditional mental health services may be provided as needed."

II. FIDELITY MEASURE (Contact Vijay Ganju at vkganju@gmail.com)

III. MINIMUM REQUIREMENTS FOR REPORTING

- There is an explicit focus on treatment
- There is an explicit program to train and supervise treatment foster parents
- Placement is in the individual family home

IV. THERAPEUTIC FOSTER CARE IS NOT:

- An enhanced version of regular foster care.

FUNCTIONAL FAMILY THERAPY (FFT)

I. DEFINITION

Functional Family Therapy (FFT) is an outcome-driven prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting out behaviors and related syndromes. Treatment occurs in phases where each step builds on one another to enhance protective factors and reduce risk by working with both the youth and their family. The phases are engagement, motivation, assessment, behavior change, and generalization.

II. FIDELITY MEASURE (Contact Vijay Ganju at vkganju@gmail.com)

III. MINIMUM REQUIREMENTS

- Services are provided in phases related to engagement, motivation, assessment, behavior change, etc.
- Services are short-term, ranging from 8-26 hours of direct service time
- Flexible delivery of service by one and two person teams to clients in-home, clinic, juvenile court, and at time of re-entry from institutional placement.

INSTRUCTIONS for Table 16:

1. Please enter the unduplicated number of adults with serious mental illness and children with serious emotional disturbances who received each service category during the reporting year.
2. Please enter the unduplicated number of adults with serious mental illness and children with SED served in each of the age, sex and race/ethnicity categories during the reporting period.
3. States are using a variety of instruments to monitor fidelity, some of which are more standardized than others. If fidelity is being monitored in your state, please indicate the instrument being used for each service category.

Changed for 2006: Add 2 questions at the end of each EBP:

1) Did you use the SAMHSA Toolkit to guide implementation?
2) Have staffs been specifically trained to implement the EBP?
3) Combined Age 0-3 with Age 4-12.

Table 17: Profile of Adults with Serious Mental Illnesses Receiving Specific Services during the Year:

Table 17.				
Report Year:				
State Identifier:				
	ADULTS WITH SERIOUS MENTAL ILLNESS			
	Receiving Family Psychoeducation	Receiving Integrated Treatment for Co-occurring Disorders (MH/SA)	Receiving Illness Self Management	Receiving Medication Management
Age				Provisional Pending Review by OMB: Please Report if Possible
18-20				
21-64				
65-74				
75+				
Not Available				
TOTAL	0	0	0	0
Gender				
Female				
Male				
Not Available				
Race				
American Indian/ Alaska Native				
Asian				
Black/African American				
Hawaiian/Pacific Islander				
White				
Hispanic*				
More than one race				
Unknown				
Hispanic/Latino Origin				
Hispanic/Latino Origin				
Non Hispanic/Latino				
Hispanic origin not available				

Do You monitor fidelity for this service?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
IF YES,								
What fidelity measure do you use?								
Who measures fidelity?								
How often is fidelity measured?								
	Yes	No	Yes	No	Yes	No	Yes	No
Is the SAMHSA EBP Toolkit used to guide EBP Implementation?	☐	☐	☐	☐	☐	☐	☐	☐
Have staff been specifically trained to implement the EBP?	☐	☐	☐	☐	☐	☐	☐	☐

* Hispanic is part of the total served. ◯ Yes ◯ No

Comments on Data:	

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

INSTRUCTIONS for Table 17:

1. Please enter the unduplicated number of adults with serious mental illness who received each service category during the reporting year.
2. Please enter the unduplicated number of adults with serious mental illness (or children with SED) in each age, sex and race/ethnicity category that received any service during the year.
3. States are using a variety of instruments to monitor fidelity, some of which are more standardized than others. If fidelity is being monitored in your state, please indicate the instrument being used for each service category.

Changed for 2006: New 2 questions at the end of each EBP:

1) Did you use the SAMHSA Toolkit to guide implementation?
2) Have staffs been specifically trained to implement the EBP?

Table 18: Profile of Adults with Schizophrenia Receiving New Generation Medications during the Year

Table 18.						
Report Year:						
State Identifier:						
	STATE HOSPITALS		**COMMUNITY SETTINGS**		**STATE MENTAL HEALTH SYSTEM**	
	Unduplicated N of Adults with Schizophrenia Receiving New Generation Meds	Unduplicated N of Adult with Schizophrenia Served	Unduplicated N of Adults with Schizophrenia Receiving New Generation Meds	Unduplicated N of Adult with Schizophrenia Served	Unduplicated N of Adults with Schizophrenia Receiving New Generation Meds	Unduplicated N of Adult with Schizophrenia Served
Age						
18-20						
21-64						
65-74						
75+						
Not Available						
TOTAL	0	0	0	0	0	0
Gender						
Female						
Male						
Not Available						
Race						
American Indian/ Alaska Native						
Asian						
Black/African American						
Hawaiian/Pacific Islander						
White						
Hispanic*						
More than one race						
Unknown						
Hispanic/Latino Origin						
Hispanic/Latino Origin						
Non Hispanic/Latino						
Hispanic origin not available						
Are specific clinical guidelines followed?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
If Yes, which one?						

* Hispanic is part of the total served. ◯ Yes ◯ No

Comments on Data:	

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

INSTRUCTIONS:

1 Please enter the unduplicated number of adults with schizophrenia that received the new generation medications in each setting.

2 Please enter the unduplicated number of all adults with a primary diagnosis of schizophrenia that received any service in the specified setting during the year.

3 Some clinical guidelines used:

- American Psychiatric Association
- Consensus "Tri-University" Project
- Schizophrenia Patient Outcome Research Team (PORT)
- Texas Medications Algorithm Project (TMAP)

DEFINITIONS

Adults with Schizophrenia Receiving New Generation Medications:
Adults with a primary diagnosis of schizophrenia who received Aripiprazole (Abilify), Clozapine, Quetiapine, Olanzonpine, Risperdone or Ziprasidone during the reporting year in the specified setting.

Attachment 4

Table 19A. Profile of Criminal Justice or Juvenile Justice Involvement:

1. This is a developmental measure. To assist in the development process, we are asking states to report information on the arrest histories of mental healht consumers with their December 2006 MHBG submission.

2. The SAMHSA National Outcome Measure for Criminal Justice measures the change in Arrests over time. The DIG Outcomes Workgroup pilot tested 3 consumer self-report items that can be used to provide this information. If your state has used the 3 Consumer Self-Report items on Arrest, you may report them here.

3. If your SMHA has data on Arrest records from alternatives sources, you may also report that here. If you only have data for arrests for consumers in this year, please report that in the T2 columns. If you can calculate the change in Arrests from T1 to T2, please use all those columns.

4. Please complete the check boxes at the bottom of the table to help explain the data sources that you used to complete this table.

5. Please tell us anything else that would help us to understand your indicator (eg., list survey or MIS questions; describe linking methodology and data sources; specify time period for criminal justice involvement; explain whether treatment data are collected

Table 19A. Profile of Adult Criminal Justice and Youth Juvenile Justice Contacts

State: _____ **Time period in which services were received:** _____

For Consumers in Service for at least 12 months

	T1			T2			T1 to T2 Change				Assessment of the Impact of Services				
	"T1" Prior 12 months (more than 1 year ago)			"T2" Most Recent 12 months (this year)			If Arrested at T1 (Prior 12 Months)		If Not Arrested at T1 (Prior 12 Months)		Over the last 12 months, my encounters with the police have…				
	Arrested	Not Arrested	No Response	Arrested	Not Arrested	No Response	# with an Arrest in T2	# with No Arrest at T2	# with an Arrest in T2	# with No Arrest at T2	(fewer encounters)	# Stayed the Same	# Increased	# Not Applicable	Total Responses
Total															
Total Children/Youth (under age 18)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Male															
Female															
Gender NA															
Total Adults (age 18 and over)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Male															
Female															
Gender NA															

For Consumers Who Began Mental Health Services during the past 12 months

	T1			T2			T1 to T2 Change				Assessment of the Impact of Services				
	"T1" 12 months prior to beginning services			"T2" Since Beginning Services (this year)			If Arrested at T1 (Prior 12 Months)		If Not Arrested at T1 (Prior 12 Months)		Since starting to receive MH Services, my encounters with the police have…				
	Arrested	Not Arrested	No Response	Arrested	Not Arrested	No Response	# with an Arrest in T2	# with No Arrest at T2	# with an Arrest in T2	# with No Arrest at T2	(fewer encounters)	# Stayed the Same	# Increased	# Not Applicable	Total Responses
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Children/Youth (under age 18)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Male															
Female															
Gender NA															
Total Adults (age 18 and over)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Male															
Female															
Gender NA															

State Comments/Notes:

See Page 2 for additional Questions about the source of this data.

Please Describe the Sources of your Criminal Justice Data

Source of criminal justice information: __ 1) Consumer survey (recommended questio __ 2) Other Consumer Survey: Please send copy of questic __ 3) Mental health MIS
__ 4) State criminal justice agency __ 5) Local criminal justice agency __ 6) Other (specify) _____

Measure of criminal justice involvement: __ 1) Arrests __ 2) Other: specify

Mental health programs included: __ 1) Adults with SMI only __ 2) Other adults (specify) __ 3) Both (all adults)
__ 1) Children with SED only __ 2) Other Children (specify) __ 3) Both (all Children)

Region for which data are reported: ___ 1) The whole state ___ 2) Less than the whole state (please describe)

What is the Total Number of Persons Surveyed or for whom CrimInal Justice Data Are Reported

	Child/Adolescents	Adults
1. If data is from a survey, What is the total Number of people from which the sample was drawn?		
2. What was your sample size? (How many individuals were selected for the sample)?		
3. How many survey Contacts were made? (surveys to valid phone numbers or addresses)		
4. How many surveys were completed? (survey forms returned or calls completed) If data source was not a Survey, How many persons were CJ data available for?		
5. What was your response rate? (number of Completed surveys divided by number of Contacts):		

Instructions:

If you have responses to a survey by person not in the expected age group, you should include those responses with other responses from the survey. E.g. if a 16 or 17 year old responds to the Adult MHSIP survey, please include their responses in the Adult categories (since that was the survey they used).

Table 19b. Profile of Change in School Attendance

1. This is a developmental measure. To assist in the development process, we are asking states to report information on the school attendance outcomes of mental healht consumers with their December 2006 MHBG submission.

2. The SAMHSA National Outcome Measure for School Attendance measures the change in days attended over time. The DIG Outcomes Workgroup pilot tested 3 consumer self-report items that can be used to provide this information. If your state has used the 3 Consumer Self-Report items on School Attendance, you may report them here.

3. If your SMHA has data on School Attendance from alternatives sources, you may also report that here. If you only have data for School attendance for consumers in this year, please report that in the T2 columns. If you can calculate the change in Attendance from T1 to T2, please use all these columns.

4. Please complete the check boxes at the bottom of the table to help explain the data sources that you used to complete this table.

5. Please tell us anything else that would help us to understand your indicator (eg., list survey or MIS questions; describe linking methodology and data sources; specify time period for criminal justice involvement; explain whether treatment data are collected

Table 19b. Profile of Change in School Attendance

State: _____ **Time period in which services were received:** _____

For Consumers in Service for at least 12 months

	T1			T2			T1 to T2 Change				Impact of Services				
	"T1" Prior 12 months (more than 1 year ago)			"T2" Most Recent 12 months (this year)			If Suspended at T1 (Prior 12 Months)		If Not Suspended at T1 (Prior 12 Months)		Over the last 12 months, the number of days my child was in school have				
	# Suspended or Expelled	# Not Suspended or Expelled	No Response	# Suspended or Expelled	# Not Suspended or Expelled	No Response	# with an Expelled or Suspended in T2	# with No Suspension or Expulsion at T2	# with an Expelled or Suspended in T2	# with No Suspension or Expulsion at T2	# Greater (Improved)	# Stayed the Same	# Fewer days (gotten worse)	# Not Applicable	Total Responses
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gender															
Male															
Female															
Gender NA															
Age															
Under 18															

For Consumers Who Began Mental Health Services during the past 12 months

	T1			T2			T1 to T2 Change				Impact of Services				
	"T1" 12 months prior to beginning services			"T2" Since Beginning Services (this year)			If Suspended at T1 (Prior 12 Months)		If Not Suspended at T1 (Prior 12 Months)		Since starting to receive MH Services, the number of days my child was in school have				
	# Suspended or Expelled	# Not Suspended or Expelled	No Response	# Suspended or Expelled	# Not Suspended or Expelled	No Response	# with an Expelled or Suspended in T2	# with No Suspension or Expulsion at T2	# with an Expelled or Suspended in T2	# with No Suspension or Expulsion at T2	# Greater (Improved)	# Stayed the Same	# Fewer days (gotten worse)	# Not Applicable	Total Responses
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gender															
Male															
Female															
Gender NA															
Age															
Under 18															

State Comments/Notes _____

See Page 2 for additional Questions about the source of this data.

Source of School Attendance Information __ 1) Consumer survey (recommended items) __ 2) Other Survey: Please send us items __ 3) Mental health MIS
__ 4) State Education Department __ 5) Local Schools/Education Agencies __ 6) Other (specify) _____

Measure of School Attendance __ 1) School Attendance __ 2) Other: _____

Mental health programs include: __ 1) Childern with SED only __ 2) Other Children (specify) _____ __ 3) Both.

Region for which data are reported: ___ 1) The whole state ___ 2) Less than the whole state (please describe)

What is the Total Number of Persons Surveyed or for whom School Attendance Data Are Reported

	Child/Adolescents
1. If data is from a survey, What is the total Number of people from which the sample was drawn?	
2. What was your sample size? (How many individuals were selected for the sample)?	
3. How many survey Contacts were made? (surveys to valid phone numbers or addresses)	
4. How many surveys were completed? (survey forms returned or calls completed) If data source was not a Survey, How many persons were data available for?	
5. What was your response rate? (number of Completed surveys divided by number of Contacts):	

Note these are still developmental:
Tables 19a-d have been extensively modified for 2006 URS Reporting. There are now only 2 tables: 19a: Criminal Justice/Juvenile Justice and 19b: School Attendance. These tables have been designed to allow states that have implemented the new Consumer Survey Modules for Criminal Justice and School Attendance to report results by age and gender.

If you did not use the new consumer survey modules, but have administrative data available for these indicators, you may use these tables to submit this data. If your state has administrative data for arrests or school attendance, please report arrests this year, in the cells for "T2 Most Recent 12 Months" and arrests in the prior year under T1: Prior 12 months".

The DIG/URS workgroup on Outcome Measures will be analyzing the information submitted this year. Therefore, we would like as complete information as possible about your information sources for these tables. Please use the check boxes and footnote spaces to tell us additional information about how you collected data for this indicator.

URS DEVELOPMENTAL TABLE: 20A, 20B, and 21: READMISSION TO ANY STATE PSYCHIATRIC INPATIENT HOSPITAL WITHIN 30/180 DAYS OF DISCHARGE

Table 20A: Readmissions of Non-Forensic Patients to Any State Psychiatric Hospitals within 30/180 Days of Discharge

Table 20B: Readmissions of Forensic Patients to Any State Psychiatric Hospitals within 30/180 Days of Discharge

Table 21: Readmissions to Any Psychiatric Inpatient Unit within 30/180 Days of Discharge

RATIONALE FOR USE: 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 and better coordination of care between hospitals and community mental health systems. The goal is to decrease the number of consumers who are readmitted to psychiatric inpatient care within 30 and 180 days of being discharged.

APPROACH TO MEASURE: The total number of admissions to any state psychiatric inpatient care that occurred within 30 and 180 days of a discharge from a psychiatric inpatient care during the past year divided by the total number of discharges during the year.

Percent readmitted is derived by dividing the number of episodes of readmission by the total number of discharges during a year in a state. Percent readmitted is presented by state, and for age, gender, race, and Hispanic/Latino Origin.

Since admissions and discharges of Forensic Patients are usually determined by the courts, rather than the SMHA, there is a separate Table 20B for reporting the readmission experiences of Forensic Patients.

MEASURE(S):

Table 20A and 20B Numerator: The number of readmissions to a state operated psychiatric hospital inpatient unit within a specified time period after discharge. Readmitted is defined as returned to any state hospital without contingency; this would exclude those who were not discharged, including on leave, visits, leaves without consent, and elopements. Persons who are discharged for the purpose of receiving medical treatment in another facility who return to the state psychiatric hospital should not be counted as a readmission when they return to the psychiatric hospital.

Optional Table 21 Numerator: The number of readmissions to either a state psychiatric hospital or an Other Psychiatric Inpatient Hospital bed in programs that are funded by the SMHA (part of the SMHA system and reported on Table 3 as Other Psychiatric Hospitals).

Denominator: The total number of discharges from a state operated psychiatric hospital inpatient unit (not unduplicated). Discharged is defined as released from the hospital without contingency; this would exclude those who are released on leave, including visits, leaves without consent, discharges for medical treatment.

Optional Table 21 Denominator: The total number of discharges from a state operated psychiatric hospital inpatient unit or another psychiatric hospital inpatient unit (not unduplicated). Discharged is defined as released from the hospital without contingency; this would exclude those who are released on leave, including visits, leaves without consent, discharges for medical treatment.

Data Note: For the 30 day readmission rate the numerator is based on readmissions in a 13 month period. For the 180 day readmission rate, the numerator is based on readmissions in an 18 month period.

Changed for 2006**:** Combined Age 0-3 with Age 4-12.

ISSUES:

When reporting by age categories: if there are different ages between the first admission and the readmission, use the discharge age from the first admission.

Ideally, this indicator would be expanded to include all readmissions to any hospital, not just state psychiatric hospitals. With the increased use of local general hospital psychiatric units, it will become important over time to expand this indicator beyond the current focus on state psychiatric hospitals.

DEFINITION:

FORENSIC CLIENTS: are mental health consumers who come to the mental health system due to their contact with the criminal justice systems. Specific forensic activities may include, but are not limited to: a) diagnosis of individuals placed in an inpatient unit for short-term psychiatric observation; b) provision of diagnostic and treatment support for correctional populations on an inpatient basis; providing security up to maximum levels; and provision of security staff in secure units for the rehabilitation and management of behaviorally problematic individuals. Forensic patients include:

NGRI/GBMI: "Not guilty by reason of insanity" (NGRI) and/or "guilty but mentally ill" (GBMI) have been referred by legal and law enforcement agencies for emergency psychiatric evaluations; and persons who are to be evaluated for dangerousness. Provision of Forensic services may occur within any of the separate state mental hospital services, other hospital programs, community-based programs, and/or through the SMHA administrative offices.

COMPETENCY: Defendants who are detained and evaluated as to their mental competence to stand trial.

TRANSFERS FROM CRIMINAL JUSTICE/JUVENILE JUSTICE: Services to adult or juvenile prisoners who have been transferred to the state hospital to receive services.

SEXUALLY VIOLENT PREDATORS: An increasing population in many state mental health systems is persons deemed to be "Sexually Violent Predators". These persons have been convicted of a sexual offence and been sent to the mental health system for treatment and control.

Table 20A. Profile of Non-Forensic (Voluntary and Civil-Involuntary) Patients Readmission to Any State Psychiatric Inpatient Hospital Within 30/180 Days of Discharge

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 20A.					
Report Year:					
State Identifier:					
	Total number of Discharges in Year	Number of Readmissions to ANY STATE Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
TOTAL	0	0	0		
Age					
0-12					
13-17					
18-20					
21-64					
65-74					
75+					
Not Available					
Gender					
Female					
Male					
Gender Not Available					
Race					
American Indian/ Alaska Native					
Asian					
Black/African American					
Hawaiian/Pacific Islander					
White					
Hispanic*					
More than one race					
Race Not Available					
Hispanic/Latino Origin					
Hispanic/Latino Origin					
Non Hispanic/Latino					
Hispanic/Latino Origin Not Available					

Are Forensic Patients Included? ◯ Yes ◯ No

Comments on Data:	

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

Table 20B. Profile of Forensic Patients Readmission to Any State Psychiatric Inpatient Hospital Within 30/180 Days of Discharge

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 20B.					
Report Year:					
State Identifier:					
	Total number of Discharges in Year	Number of Readmissions to ANY STATE Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
TOTAL	0	0	0		
Age					
0-12					
13-17					
18-20					
21-64					
65-74					
75+					
Not Available					
Gender					
Female					
Male					
Gender Not Available					
Race					
American Indian/ Alaska Native					
Asian					
Black/African American					
Hawaiian/Pacific Islander					
White					
Hispanic*					
More than one race					
Race Not Available					
Hispanic/Latino Origin					
Hispanic/Latino Origin					
Non Hispanic/Latino					
Hispanic/Latino Origin Not Available					
Comments on Data:					

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

Table 21. Profile of Non-Forensic (Voluntary and Civil-Involuntary Patients) Readmission to Any Psychiatric Inpatient Care Unit (State Operated or Other Psychiatric Inpatient Unit) Within 30/180 Days of Discharge

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 21.					
Report Year:					
State Identifier:					
	Total number of Discharges in Year	Number of Readmissions to ANY Psychiatric Inpatient Care Unit Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
TOTAL	0	0	0		
Age					
0-12					
13-17					
18-20					
21-64					
65-74					
75+					
Not Available					
Gender					
Female					
Male					
Gender Not Available					
Race					
American Indian/ Alaska Native					
Asian					
Black/African American					
Hawaiian/Pacific Islander					
White					
Hispanic*					
More than one race					
Race Not Available					
Hispanic/Latino Origin					
Hispanic/Latino Origin					
Non Hispanic/Latino					
Hispanic/Latino Origin Not Available					

1. Does this table include readmission from state psychiatric hospitals?	☐ Yes	☐ No
2. Are Forensic Patients Included?	☐ Yes	☐ No

Comments on Data:	

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethinic Origin are not available

Table 20A, 20B, and 21 Questions and Answers:

I. Several states asked about whom should they count: Only persons served in the community. Only persons served in state hospitals? Or all persons?

Answer: *This indicator focuses on the persons who are served in the state hospitals and thus are the persons who are reported on URS Basic Table 3 and Table 6 as served in the state hospital during the year.*

II. What about Other Psychiatric Inpatient Programs? Should they be reported?

Answer: *The Optional Table 21 for this indicator compiles information on persons who are served in the other psychiatric inpatient programs reported on URS Basic Table 3b and Table 6. Persons served in these programs would only be reported on the Optional Table 21, not on Table 20 (which focuses on state psychiatric hospitals).*

III. Should the 30 and 180 day readmissions be unduplicated or duplicated? e.g., during the readmissions within 30/180 days of discharges, is it 0-30 days and 31-180 days or is it 0-30 days and 0-180 days thus making the 0-30 day group a subset of the 0-180 group to some degree?

Answer: *The 16 State Study calculated them as 0-30 and 0-180 days, thus making the 0-30 days group a subset of the 0-180 day measure. Since the 16 State Study group conceived of the 180 day measure as a separate indicator of care (measuring community tenure), it is desirable to calculate the 0-180 rate as a complete rate and not have to add the 31-180 day numbers together with the 0-30 day numbers to calculate the desired rate.*

IV. If we split out the forensics, how are we determining who is a forensic readmission? Are we looking at their forensic status at discharge and readmission, just discharge or just readmission? There are four possible combinations of forensic status

Answer: *If a person's forensic status or age changes between their discharge and their readmission, it is recommended that you report them in the category from their last discharge. This is consistent with the 16 State Study that recommended that states use the discharge client status, since that was thought to be more reliable (coming at the end of a hospital stay) than the readmission status.*

V. Optional Table 21: Other Psychiatric Hospital Inpatient readmissions: Should the Optional Table include only readmissions to non-state psychiatric hospitals, or should the table include all readmissions (include data from both state psychiatric hospital readmissions and other psychiatric inpatient readmissions)?

Answer: *The workgroup recommends that states should report the combined data of all readmissions to any psychiatric hospital. Each state should report the data as they can and describe if they are reporting combined data or data that excludes state psychiatric hospitals. Comparisons could be made over time for a single state, and rates can be calculated for output tables that make appropriate national comparisons (e.g., a state that supplied integrated data for both state hospitals and other inpatient would get the national rate of states that reported such data).*