

## **Fiscal Year 2002 CMHS Uniform Reporting System: Guidelines For Basic Tables:**

**October 2002**

### **Decisions Affecting All Tables: Scope of Reporting:**

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

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

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

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

- 1 Include all persons served directly by the state mental health agency (including persons who received services funded by Medicaid)
- 2 Include all persons in the system for whom the state mental health agency contracts for services (including persons whose services are funded by Medicaid).
- 3 Include any other persons who are counted as being served by the state mental health agency or come under the auspices of the state mental health agency system. This includes Medicaid waivers, if the mental health component of the waiver is considered to be part of the SMHA system.
- 4 Count all identified persons who have received a mental health services, including screening, assessment, and crisis services. Telemedicine services should be counted if they are provided to identified clients.
- 5 For states where a separate state agency is responsible for children’s mental health, where feasible, efforts should be made to unduplicate clients between the child mental health agency and the adult mental health agency. If this unduplication is not feasible, please report this potential duplication to indicate there is an overlap between the “0-17 group” and the “18 and over group” but that there is unduplication within each group.

**Persons who would not be included in the URS tables:**

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

**October 2002**

**Appendix A**

## **Basic Tables**

**These updated tables have been prepared by the CMHS-funded State Data Infrastructure Coordinating Center (SDICC) at the NASMHPD Research Institute. For additional information or questions about these tables, please contact Ted Lutterman at 703-739-9333 ext.121 ([ted.lutterman@nasmhpd.org](mailto:ted.lutterman@nasmhpd.org)) or Vijay Ganju at 703-739-9333 ext.132 ([vijay.ganju@nasmhpd.org](mailto:vijay.ganju@nasmhpd.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*<sup>1</sup> and the State level estimates for both adults with SMI and children with SED.**

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

**DIG Workgroup Notes:**

**No change to table.**

**CMHS will provide this data to each SMHA.**

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

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

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

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

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

**State DIG Workgroup Recommendations:**

- 1 Include all persons served directly by the state mental health agency (including persons whose services are funded by Medicaid)
- 2 Include all persons in the system for whom the state mental health agency contracts for services (including persons whose served are funded by Medicaid).
- 3 Include any other persons who are counted as being served by the state mental health agency or come under the auspices of the state mental health system. This includes Medicaid waivers, if the waiver is run by the SMHA.
- 4 Count all identified persons who have received a mental health services, including screening, assessment, and crisis services.
- 5 For state where a separate state agency is responsible for children’s mental health, unduplicate between the two child and adult agency when feasible. Otherwise, recognize and indicate that there is overlap between the 0-17 group and the 18 and over group but that there is unduplication within each group.
- 6 Add unknown by Gender to this table (note this adds 72 cells to the table)
- 7 Add “Hispanic” category to Table 2A to allow for states to report if they do not currently compile Hispanic Origin as a separate question. This recommendation would be for the FY’02 and FY’03 reporting, as OMB, HIPAA, and the US Census finalize race/ethnicity reporting guidelines for the future. States that track Hispanic Origin as a separate category should report on Table 2B instead of Table 2A.

**Persons who would not be included in the URS tables:**

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

**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.

<b>Table 2.B</b>
<b>Report Year</b>
<b>State Identifier:</b>

Persons Served by Age	Not Hispanic or Latino			Hispanic or Latino Origin			Hispanic or Latino Origin Unknown		
	F	M	Unk	F	M	Unk	F	M	Unk
0-3									
4-12									
13-17									
18-20									
21-64									
65-74									
75 +									
Not Available									
<b>Total</b>									

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

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

This table provides a profile for the clients that received public funded mental health services in community mental health setting by Homeless and Non-Homeless status. A person receiving services in the community should be counted in the "Homeless" category if he/she was reported homeless at any point during the year even though at the last assessment during the reporting period the person was in a stable living situation.

<b>Table 3.</b>															
<b>Report Year:</b>															
<b>State Identifier:</b>															

TABLE 3.A.	Age 0-17			Age 18-20			Age 21-64			Age 65+			Total		
	F	M	Unk	F	M	Unk	F	M	Unk	F	M	Unk	F	M	Unk
Homeless															
Non-Homeless															
<b>Total</b>															

How Often does the State Measures Homeless Status?  At Admission  At Discharge  Monthly  Quarterly  Other: \_\_\_\_\_

1. Use homeless status any point in reporting period for community. e.g., if a person receiving services in the community is homeless at any point during the year, then they are counted as homeless.
2. Do Not Report Homeless status for Inpatient Care Settings

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

This table provides a profile of the patients that received public funded mental health services in state hospital and/or other inpatient settings that are part of the SMHA mental health system. Persons admitted to hospitals more than once during the fiscal year should be counted only once in either one or both (if applicable) rows.

TABLE 3.B.	Age 0-17			Age 18-20			Age 21-64			Age 65+			Total		
	F	M	Unk	F	M	Unk	F	M	Unk	F	M	Unk	F	M	Unk
<b>Psychiatric Inpatient</b>															
State Psychiatric Hospitals															
Other Psychiatric Inpatient															

**State DIG Workgroup Recommendations:**

1. For states that have county psychiatric hospitals that serve as "surrogate" state hospitals, should report persons served in such settings as receiving services in state hospitals.
2. If forensic hospitals are part of the state mental health agency system include them.
3. Persons who receive non-inpatient care in state psychiatric hospitals should be included in Table 3.A
4. A persons who is served in both community settings, and inpatient settings should be included in both Table 3.A and 3.B.

#### Table 4. Profile of Adult Clients by Employment Status

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

Table 4.								
Report Year:								
State Identifier:								
	18-20		21-64		65+		Total	
Adults served:	F	M	F	M	F	M	F	M
<b>Employed:</b> Full or Part Time (includes Supported Employment)								
<b>Unemployed</b>								
<b>Not in Labor Force</b> Retired, Sheltered Employment, Other (homemaker, student, volunteer, disabled, etc.)								
<b>No data available</b>								

Total

#### DIG Workgroup Recommendations:

Four categories are proposed:

- Employed
- Unemployed
- Not in labor force (retired, sheltered work, homemaker, student, etc.)
- Unknown/no data available

‘Employed’ would be competitively employed, part-time or full-time.

Supported Employment and transitional employment, where consumers work in competitive employment situations should be reported as “employed”.

Sheltered employment should be reported as Not in Labor Force.

Employment status would be reported for persons served in community settings.

Latest status of employment reported would be used.





**Table 6. Profile of Client Turnover**

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

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

**State DIG Workgroup Recommendations:**

1. This table reflects clients 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.
3. Column 2 are all additions or new admissions during the reporting period. If a person has multiple admissions during that reporting period, all admissions will be counted.
4. Again as in Table 2, there may be duplication across age categories, depending on the state’s ability.
  - a. Change first column to ‘Persons being served at beginning of year’.
  - b. Additions are admissions and readmissions during year.
  - c. Drop Average LOS for community programs.
5. Column 3 are 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 will be duplication across the state hospital section and the community section.
7. Consistent with Table 3: Add rows for Other Hospital Inpatient clients:
8. Length of Stay Column needs to be collected for 2 different groups: a. Patients discharged during the year and b. patients still resident in the hospital at the end of the year.

**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.

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

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

- 1 Data will come from the NASMHPD Research Institute's (NRI) FY'2001 SMHA-Controlled Revenues and Expenditures Study
- 2 Note: Total Expenditures for Other 24-Hour Care are available from the NRI Study, but details by funding source are only available for the categories State Hospitals, Community mental health programs, and Total

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

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

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

**State DIG Workgroup Recommendations**

1. States should only report on the expenditures of the CMHBMG by the SMHA or programs that they directly contract with.
  - States should not report on expenditures by programs more than one-level down from the State in funding: e.g., if a state provides CMHBMG funds to county mental health authorities, which in turn contract with private, not-for-profit mental health providers, only the expenditures by the SMHA and the county mental health authorities should be reported on this table.
2. The Western State DIG proposed splitting into two Columns: Non-Direct Service Expenditures by SMHAs and Expenditures by Regional Entities. This would allow states to separate out expenditures by county mental health authorities from SMHA expenditures.

The current recommendation is that states to have every state report on SMHA expenditures, but to provide an option for states that desired to report the additional information for regional entities

**Table 9. Public Mental Health System Service Inventory Checklist**

This table is used to provide an overview of the range of services currently operated or funded by the State mental health agency. Indicate by a checkmark the extent to which the services listed below are available in the State.

<b>Table 9.</b>			
<b>Report Year:</b>			
<b>State Identifier:</b>			
<b>Service Available Statewide</b>	<b>Service Available in Parts of the State</b>	<b>Service Not Available in State</b>	<b>Services Inventory Other Services</b>
			Intensive Case Management
			Intensive Outpatient
			Assertive Community Treatment
			Emergency
			Services for persons with mental illness and mental retardation/developmental disabilities
			Integrated Services for Persons with Mental Illness and Substance Abuse
			Employment/Vocational Rehabilitation
			In Home Family Services
			School-based Services
			Consumer Run Services
<b>Intake, Diagnostic, and Screening Services</b>			
			Intake/ Screening
			Diagnostic Evaluation
			Information and Referral Services
<b>Treatment Services</b>			
			Individual Therapy
			Family/Couple Therapy
			Group Therapy
			Collateral Services
			Electro-convulsive Therapy
			Medication Therapy
			New Generation Medications
			Activity Therapy
			Behavioral Therapy
			Mobile Treatment Team
			Peer Support
			Psychiatric Emergency Walk-in
			Telephone Hotline



**Table 9 Continued:**

**Model/Innovative Programs Provided (these may overlap with services listed above).**

<b>Services Available Statewide</b>	Service Available in Parts of the State	Service Not Available in State	Program Inventory

**State DIG Workgroup Recommendations:**

- 1      Need to define “Available in Parts of State” and “Available Statewide”. The recommendation was to leave this worded as is for Year 1 reporting, but to develop operationalizations for year 2 and beyond. In year one, if a service is offered in at least one program in the state, the column “Available in Parts of State” should be checked.
- 2      In Year 2 of Grants, these services should be matched against HIPAA procedure Codes for consistency
- 3      In Year 2 of grants, operational definitions of what constitutes “Service Available Statewide” and what constitutes “Service Available Parts of State” will be developed.



**Table 11. Summary Profile of Client Evaluation of Care**

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

Table 11.		
Report Year:		
State Identifier:		
Indicators	Adults	Children and Adolescents
Percent Reporting Positively About Access.		
Percent Reporting Positively About Quality and Appropriateness for Adults / Reporting Positively about Satisfaction for Children.		
Percent Reporting Positively About Outcomes.		
Percent of Family Members Reporting on Participation In treatment Planning.		
Percent of Family Members Reporting High Cultural Sensitivity of Staff. (Optional)		(Optional)
Percent of Adults Reporting on Participation In Treatment Planning. (Optional)	(Optional)	
Percent of Adults Positively about General Satisfaction with Services. (Optional)	(Optional)	

**Adult Consumer Surveys**

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

a. If no, which version:

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

b. If other, please attach instrument used.

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

- 1. \_\_\_ Spanish
- 2. \_\_\_ Other: \_\_\_\_\_

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. \_\_\_ Multi-Stage
- 4. \_\_\_ Convenience Sample
- 5. \_\_\_ Other: Describe: \_\_\_\_\_

3a. Methodology of collecting data? (Check all that apply)

	Self-Administered	Interview
Phone		
Mail		
Face-to-face		

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

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

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

\_\_\_\_\_

\_\_\_\_\_

- 5.a. Are responses Anonymous? \_\_\_\_\_ Yes \_\_\_\_\_ No
- 5.b. Are Responses Confidential? \_\_\_\_\_ Yes \_\_\_\_\_ No
- 5.c. Were survey responses matched to mental health client databases? \_\_\_\_\_ Yes \_\_\_\_\_ No

6. How many responses are the results based on? \_\_\_\_\_ #

7. How Many consumers were sampled? \_\_\_\_\_ #, What was your response rate \_\_\_\_\_ %

7.b. What were the Confidence Interval and Confidence Levels of your Survey? (Note these can be calculated online at a site such as <http://www.surveysystem.com/sscalc.htm>)

1. Confidence Interval: \_\_\_\_\_ 2. Confidence Level: \_\_\_\_\_

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

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

*When you put the confidence level and the confidence interval together, you can say that you are 95% sure that the true percentage of the population is between 43% and 51%. (From [www.surveysystems.com](http://www.surveysystems.com))*

### **Children/Adolescents Consumer Surveys:**

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

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

1. \_\_\_ Spanish
2. \_\_\_ Other: \_\_\_\_\_

2. Populations covered 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. \_\_\_ Multi-Stage
4. \_\_\_ Convenience Sample
5. \_\_\_ Other: Describe: \_\_\_\_\_

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

	Self-Administered	Interview
Phone		
Mail		
Face-to-face		

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

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

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

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- 5.a. Are responses Anonymous? \_\_\_\_\_ Yes \_\_\_\_\_ No
- 5.b. Are Responses Confidential? \_\_\_\_\_ Yes \_\_\_\_\_ No
- 5.c. Were survey responses matched to mental health client databases? \_\_\_\_\_ Yes \_\_\_\_\_ No

6. How many responses are the results based on? \_\_\_\_\_ #

7. How Many consumers were sampled? \_\_\_\_\_ #, What was your response rate \_\_\_\_\_ %

7.b. What were the Confidence Interval and Confidence Levels of your Survey? (Note these can be calculated online at a site such as <http://www.surveysystem.com/sscalc.htm>)

1. Confidence Interval: \_\_\_\_\_
2. Confidence Level: \_\_\_\_\_

## State DIG Workgroup Recommendations:

### Adult Consumer Surveys:

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

1. Statewide Surveys: States should only report consumer survey results from surveys that are conducted on a statewide basis—preferably surveys conducted with a “scientific” sampling technique.
  - a. States that only have pilot data or only data from a few providers or a region of the state should not report data on Table 11
  - 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. Survey Methods: States are currently using a variety of methods to conduct the survey. The workgroup does not recommend a single methodology at this time. States should report on what methodology they use: e.g., mail, phone, face-to-face interviews, etc.
4. Specific Questions to Use: Based on the assumption that most states (currently over 40 states) are using a 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 were 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 were sensitive to my cultural/ethnic background.
    - vi. Staff helped me obtain the information needed so I could take charge of managing my illness.
    - vii. I was give information about my rights
    - viii. Staff encouraged me to take responsibility for how I live my life. \*
    - ix. I was encouraged to use consumer-run programs. \*
  - c. MHSIP Consumer Survey: **Perceptions of Outcomes:**
    - i. I deal more effectively with daily problems.
    - ii. I am better able to control my life.
    - iii. I am better able to deal with crisis.
    - iv. I am getting along better with my family.

- v. I do better in social situations.
  - vi. I do better in school and/or work.
  - vii. My symptoms are not bothering me as much.
  - viii. My housing situation has improved. \*
- d. MHSIP Consumer Survey: **Perception of Participation in Treatment Planning** (Optional)
- i. I felt comfortable asking questions about my treatment and medications.
  - ii. I, not staff, decided my treatment goals.
- e. MHSIP Consumer Survey: **General Satisfaction** (Optional)
- i. I liked the services that I received here.
  - ii. If I had other choices, I would still get services at this agency.
  - iii. I would recommend this agency to a friend or family member.

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

Scoring:

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

**Additional Reporting to add to Table 11: The workgroup has suggested adding an optional the reporting of consumer survey results by consumer characteristics.**

1. States should report Consumer Survey Results for each domain by Race/ethnicity in addition to the Total rate currently requested in Table 11.
2. States should use the same categories as in other URS Tables.
3. Patient categories should not be cross tabs: e.g., report results for age, then for race, not age by race.
4. 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 is recommending that states use the Youth Services Survey (YSS) and Youth Services Survey for Families (YSS-F) developed in Virginia during the 16 State Study.

1. 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.
2. The final Child/Adolescent Survey: YSS-F came out with slightly different factors than are shown on the originally published URS Table 11. For example the YSS-F does not calculate a score for Perception of Quality/Appropriateness, but does get assessment of the Cultural Sensitivity of Staff. The workgroup recommended modifying the row headings to reflect the 5 factors generated by the YSS-F: Family Perception of:
  1. Good Access to Services
  2. Participation in Treatment
  3. Cultural Sensitivity of Staff
  4. Satisfaction with Services
  5. Positive Outcome of Service
3. Issues of Sampling, methodology, and scoring will be similar to those recommended for the adult survey.

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

**1. Good Access to Service:**

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

**2. 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.

**3. Participation in Treatment:**

- I helped to choose my child's services.
- I helped to choose my child's treatment goals.
- I participated in my child's treatment.

**4. 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.

**5. Positive Outcomes of Services:**

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

**Scoring:**

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

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

**Denominator:** Total number of respondents.



**Table 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.

**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
Aged 0 to 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aged 4 to 17	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adults Aged 18+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forensics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	Yes	No
Serious Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Serious Emotional Disturbances	<input type="checkbox"/>	<input type="checkbox"/>

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?

1. Percentage of adults meeting Federal definition of SMI: \_\_\_\_\_%

2. Percentage of children/adolescents meeting Federal definition of SED: \_\_\_\_\_%

**3. Co-Occurring Mental Health and Substance Abuse:**

A. What percentage of persons served by the SMHA for the reporting period had a dual diagnosis of mental illness and substance abuse?

1. Percentage of adults served by the SMHA who also has a diagnosis of substance abuse problem: \_\_\_\_\_%

2. Percentage of children/adolescents served by the SMHA who also has a diagnosis of substance abuse problem: \_\_\_\_\_%

B. What percentage of persons served for the reporting period who met the Federal definitions of adults with SMI and children/adolescents with SED had a dual diagnosis of mental illness and substance abuse.

1. Percentage of adults meeting Federal definition of SMI who also has a diagnosis of substance abuse problem: \_\_\_\_\_%

2. Percentage of children/adolescents meeting the Federal definition of SED who also has a diagnosis of substance abuse problem: \_\_\_\_\_%

**4. State Mental Health Agency Responsibilities**

**a. Medicaid**

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

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

**b. Managed Care (Mental Health Managed Care)**

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

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

- 3 Direct contractual responsibility and oversight of MCOs or BHOs
- 4 Setting standards for mental health services
- 5 Coordination with state health and Medicaid agencies
- 6 Resolving mental health consumer complaints
- 7 Input in contract development
- 8 Performance monitoring and measurement
- 9 Other   
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Are the data reported in the tables: Yes    No

- a. **Unduplicated** :counted once even if they were served in both State hospitals and community programs and if they were served in community mental health agencies responsible for different geographic or programmatic areas.
- b. **Duplicated:** across state hospital and community programs
- c. **Duplicated:** within community programs
- d. **Duplicated:** Between Child and Adult Agencies
- e. **Plans for Unduplication:** If you if you are not currently able to provide unduplicate d client counts across all parts of your mental health system, please describe your plans to get unduplicated client counts by the end of your Data Infrastructure Grant.

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**6. Summary administrative data**

Report Year: .....

State Identifier: .....

Summary Information on Data Submitted by State MHA:

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

Person Responsible for Data Submission:

Contact Phone Number: .....

Contact Address: .....

.....

E-mail Address: .....