

Mental Health Services Provided Across State Government Agencies



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
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**Mental Health
Services Provided
Across State
Government
Agencies**

Acknowledgments

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Executive Summary

In 2004, the Center for Mental Health Services (CMHS) within the Substance Abuse and Mental Health Services Administration (SAMHSA) began funding the Other State Agency (OSA) Project. This was the first cooperative, multistate project to develop and refine standard procedures and protocols to guide states in their attempts to identify mental health expenditures and resources and the number of consumers¹ being served by agencies other than the state mental health agency (SMHA). The goal of the project was to help states more rationally approach the coordination and financing of comprehensive services and supports for mental health consumers and family members by increasing interagency cooperation and planning and decreasing fragmentation of services. The agencies included in the project were Medicaid, criminal justice/corrections, juvenile justice, housing, education, vocational rehabilitation, early intervention, child welfare, and substance abuse.

Current overlapping jurisdiction for mental health services contributes to confusion and fragmentation of services for consumers and limits policymakers' ability to finance services efficiently, administer programs, and allocate funds to meet policy objectives. The large number of services provided by OSAs in the project highlights the importance of state policymakers' taking a systems-wide approach to developing overall state mental health policy and plans.

¹ For consistency, the term consumer is used throughout this report to refer to adults, youth, and children who use or have used mental health services. Similar terminology includes mental health consumer, psychiatric survivor, expatient, client, and recipient.

Benefits of and Challenges to Participating in the OSA Project

Although experiences varied, all nine participating states reported definite benefits from the project. Benefits included quantifying the extent of mental health services in their states, improving SMHA relationships with OSAs, and increasing SMHA understanding of how OSAs operate. Many OSAs said the project clarified the magnitude of their role in the delivery of mental health services and supports. Several states expressed an interest in continuing the work they had started and indicated the project was critical to their efforts to transform their state mental health systems.

Significant challenges to implementing the project included difficulty engaging the OSAs and keeping them on board. Some OSAs were initially concerned about the use of the information to be identified and especially about protecting consumer confidentiality. However, the use of data sharing agreements and assurances by SMHA leadership allayed these concerns.

Differences in the way multiple agencies count services, their levels of technology, and their ability to devote staff to the effort presented major challenges. Some states indicated the use of advanced technology was critical to the success of their projects, but not all participating states had this technology.

Facilitating Factors

Factors that facilitated the project included a common interest among SMHAs and OSAs to better understand the overall state mental health service delivery system and the willingness of the OSAs to commit resources to the project. Existing relationships among staff of the different agencies fostered effective collaboration, as did the OSAs' passion for addressing mental health issues and their interest in evaluating their role in state mental health systems. Strong SMHA and OSA leadership was essential to the project's success, and the benefit derived from having a state data warehouse was described as "extraordinary."

Conclusions of the OSA Project

- The OSA project demonstrated it is feasible to share data across state agencies that serve mental health consumers.
- Participating states reported significant benefits from the project, and they

indicated these benefits outweighed the multiple difficult challenges of the project.

- Participating states found that current OSA accounting practices and data systems often did not lend themselves to an easy and straightforward identification of mental health and related support services or the number of consumers OSAs served.
- State data warehouses that routinely combine client or service data from multiple state agencies are extremely useful; they generate and analyze complex data for policymakers and other stakeholders and help generate cross-agency reports that provide a broad overview of state-funded programs.
- The role of Medicaid in the funding of mental health services cannot be overestimated.
- Medicaid's dual positions as a direct funder of services and as a resource for OSAs made it difficult to distinguish between which services Medicaid funded directly and which services Medicaid funded through OSAs.
- Criminal justice/corrections agencies in this project served the largest number of consumers of any of the OSAs except Medicaid.
- For future projects, participating states recommended that several additional OSAs and Federal agencies be included.
- Participating states said that future OSA projects might use Federal data systems to analyze and link SMHA and OSA data.



Introduction

The President's New Freedom Commission highlighted the difficulty mental health consumers, providers, and administrators have struggled with for years:

The [mental health] system is fragmented and in disarray not from lack of commitment and skill of those who deliver care, but from underlying structural, financing, and organizational problems. Many of the problems are due to the "layering on" of multiple, well-intentioned programs without overall direction, coordination, or consistency. The system's failings lead to unnecessary and costly disability, homelessness, school failure, and incarceration (President's New Freedom Commission on Mental Health, 2002).

1.1 "Fragmented and in Disarray"

The blunt declaration cited above regarding the mental health system being "fragmented and in disarray" describes the challenge. State mental health agencies (SMHAs) are the designated organizations within each state that have the primary responsibility for providing public mental health services. However, people with mental illnesses often find these services are not easily and readily accessible when they need them.

One consequence of consumers' not being able to access mental health services when they need them is that people who work in settings such as prisons, juvenile justice facilities, schools, and child welfare offices find themselves serving increasing numbers of people with mental illnesses, a task for which they often are ill-prepared. While SMHAs are responsible for the traditional mental health system, these other settings constitute what has come to be called the de facto mental health service system (Regier, et

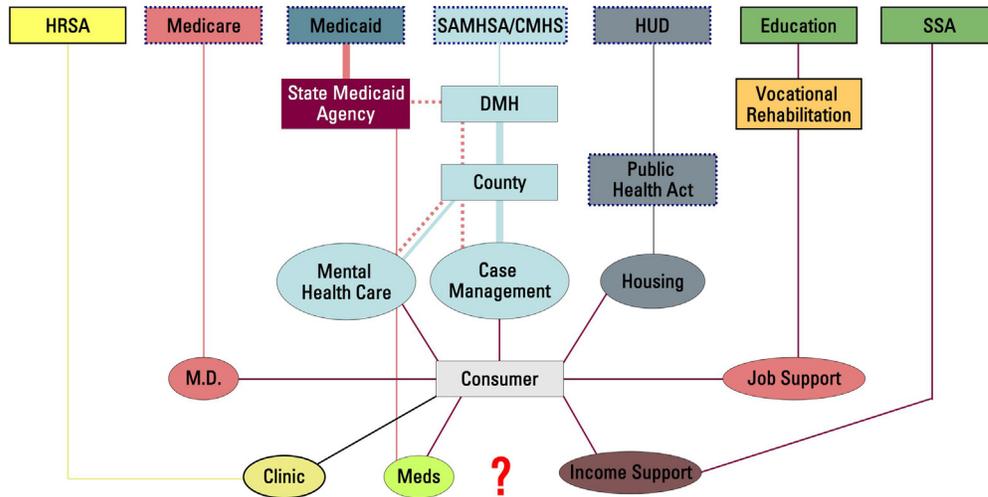
al., 1993). Various agencies do their best to provide mental health services and supports, but their efforts often are not coordinated across all relevant state agencies. Dr. Michael Hogan, Chairman of the New Freedom Commission, noted the difficulty of coordinating the "layering on of multiple, well-intentioned programs," and he depicted the fragmentation graphically, as shown in Figure 1 (Hogan, 2003).

The fragmented system poses enormous challenges for mental health consumers and their family members. A tremendous amount of perseverance is necessary to navigate the maze from a therapist's office to the psychiatrist, to the Social Security office, to the housing office, to vocational rehabilitation, to Medicaid, and so on (Hogan, 2003).

1.2 Calls for Collaboration and Coordination

The call to improve the lives of consumers by collaborating and coordinating services

Figure 1. Coordination of Mental Health and Related Services in Reality



across Federal, state, and local agencies is not new. It goes back at least as far as 1977 when President Jimmy Carter established the first President’s Commission on Mental Health. When the Community Mental Health Services Block Grant Program was established in 1982, a key expectation was (and continues to be) that representatives from state agencies such as mental health, vocational rehabilitation, housing, Medicaid, social services, criminal justice, and education serve on the Mental Health Planning Council that participates in the development of the annual State Mental Health Plan (SMHP) (Public Health Act, 42 USC §§300x-1–300x-9 (2009)).

The call for interagency collaboration and coordination was repeated in 1999 when *Mental Health: A Report of the Surgeon General* encouraged agencies to facilitate consumers’ entry into treatment:

Public and private agencies have an obligation to facilitate entry into mental health care and treatment through the multiple “portals of entry”

that exist: primary health care, schools, and the child welfare system. To enhance adherence to treatment, agencies should offer services that are responsive to the needs and preferences of service users and their families. At the same time, some agencies receive inappropriate referrals. For example, an alarming number of children and adults with mental illness are in the criminal justice system inappropriately (HHS, 1999).

In April 2002, President George W. Bush issued yet another call to action to improve mental health care. He spoke of multiple obstacles to quality care, one of which, he described as:

... [our] “fragmented mental health service delivery system. Mental health centers and hospitals, homeless shelters, the justice system, and our schools all have contact with individuals suffering from mental disorders.... Many Americans fall through the cracks of the current system. Many years and lives are lost before help, if it is given at all, is given” (Bush, 2002a).

President Bush then issued an Executive Order establishing the New Freedom Commission on Mental Health. The order listed five major principles the Commission

was to follow, one of which was the following:

The Commission shall focus on community-level models of care that efficiently coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and delivery of services (Bush, 2002b).

In July 2003, the Commission issued its final report—*Achieving the Promise: Transforming Mental Health Care in America*. The report noted early on that most of the nation’s people with mental health problems are not in the formal mental health system led by SMHAs. Rather, the report indicated, they are in the de facto mental health system, made up of agencies other than SMHAs, or are homeless and living on the streets. The Commission concluded that nothing short of a complete transformation that ensured all these systems work together would give the nation a truly effective mental health system.

1.3 The Response of the Substance Abuse and Mental Health Services Administration

The Substance Abuse and Mental Health Services Administration (SAMHSA) in the U. S. Department of Health and Human Services (HHS) has undertaken several projects to advance the goals and objectives of the New Freedom Commission’s report. Among these projects are the Federal Transformation Working Group, the Mental Health Transformation State Incentive Grant (MHT SIG) Program, and the Other State Agency (OSA) Project, all of which share the goals of increasing interagency collaboration and planning and decreasing the fragmentation of the national and/or state mental health systems.

1.3.1 The Federal Transformation Working Group

SAMHSA’s Center for Mental Health Services (CMHS) leads the effort to transform the nation’s mental health system to one that comprehensively meets the multiple needs of people with mental illnesses. With the understanding that “collaboration is the lifeblood of mental health transformation,” a Federal Transformation Working Group convened that included senior staff from 7 Federal departments and 14 HHS agencies, all of which provide services to children and/or adults with mental illnesses.

The Federal Transformation Working Group members conducted an inventory of their organizations’ mental health activities and developed a Federal Agenda for Action of measurable steps the different departments and agencies are taking and will take at the Federal level as part of a 5-year process of transformation. The ultimate goal is to have a transformed system in which each of these systems works together to provide a seamless mental health care delivery system that serves the multiple needs of consumers (SAMHSA, 2005a).

1.3.2 The Mental Health Transformation State Incentive Grant Program

In 2005, Congress began funding the MHT SIG program, which enables nine states—Connecticut, Ohio, Washington, Maryland, Oklahoma, Texas, New Mexico, Hawaii, and Missouri—to transform the infrastructure of their respective mental health systems over the 5 years of the grant. The program requires the state Governor to appoint a Mental Health Transformation Working Group that ultimately “involves all

departments/agencies/offices that deliver, fund, or administer services and supports used or needed by people with a mental illness and/or their families” (SAMHSA, 2005b). Representatives of some of the MHT SIG states said that a major factor in their success in securing this grant was their participation in a pilot program for another project, the SAMHSA/CMHS OSA Project, which is the subject of this document.

1.3.3 The Other State Agency Project

The OSA Project was the first cooperative, multistate project with standard procedures and protocols to guide states in their attempts to identify the expenditures and resources for mental health and related support services and the number of consumers being served by agencies other than the SMHA. Among the questions the OSA Project sought to answer were:

- What agencies other than the mental health agency pay for and/or deliver mental health services?
- What types of services do they provide?
- How much do they spend on these services?
- Where do the funds come from?
- How many consumers receive these services?
- How many consumers receive services from multiple agencies?
- How feasible is it to gather information about mental health and related services from agencies other than mental health?
- How do we begin the process of gathering these data?

- What are the facilitators of—and challenges to—gathering the data?

1.4 Goal of the OSA Project

The overarching goal of the OSA Project was to help states more rationally approach the coordination and financing of comprehensive services and supports for mental health consumers and family members. Accomplishing this goal offers the potential to increase interagency cooperation and planning and decrease fragmentation of services. These results should improve consumer outcomes by facilitating the development and implementation of individualized service plans that meet the diverse needs of consumers served by multiple agencies. The OSA Project focused on the initial steps of this long-term process. While the SAMHSA/CMHS Community Mental Health Services Block Grant already required some OSAs to serve on the State Mental Health Planning Councils, the OSA Project helped state agencies identify and share data, which in turn can guide policymakers as they attempt to transform their systems.

1.5 Agencies Designated for the OSA Project

Nine agencies across multiple state government departments were chosen for the OSA Project. These agencies were selected after a literature review indicated which state government agencies provided significant amounts of mental health services and supports and in which agencies it would be possible to identify the expenditures and clients. The agencies selected for this project are discussed below.

1.5.1 Medicaid

Medicaid holds a unique position in state mental health services. It is both a separate state agency that directly funds mental health services and a funding source of mental health services provided through other OSAs. In fact, it provides the vast majority of state funds for mental health and related support services. One program administered by Medicaid and counted separately for this project is the State Children's Health Insurance Program (SCHIP). SCHIP provides low-cost health insurance for low-income children and families that do not qualify for traditional Medicaid services. Medicaid programs are jointly financed by the Federal and state governments and administered by the states.

1.5.2 Criminal Justice/Corrections

State criminal justice/corrections agencies serve adults in prisons. In some states, they also serve adults in jails and those on parole or probation; in other states, jails, parole, and probation are run by local governments. The U.S. Department of Justice reports that at midyear 2005, more than half of all prison and jail inmates (i.e., 56 percent of state prisoners and 64 percent of jail inmates) had a mental health problem (James & Glaze, 2006). It is extremely expensive to incarcerate a person with a serious mental illness (SMI). The Pennsylvania Department of Corrections estimates that it costs about \$140 per day to incarcerate a person with SMI, compared to about \$80 per day for other inmates (Council of State Governments, 2002).

1.5.3 Juvenile Justice

Juvenile justice researchers report that between 50 and 75 percent of incarcerated

youth have diagnosable mental health problems. About two-thirds of all juvenile justice dollars are spent on housing these young people in costly lock-ups that are said to provide little more than warehousing (Coalition for Juvenile Justice, 2000).

1.5.4 Housing Agencies

Providing housing obviously is not a mental health treatment service. However, housing agencies were included in the OSA Project because they have special programs and supports to help consumers find and maintain housing in their local communities. Lack of adequate housing in the community is a chronic problem for people with SMI (Newman, 2001). Such individuals must compete with others for housing subsidies or units, and their illness may place them at a disadvantage in this process. Lack of stable housing also interferes with a person's treatment and with the ability to participate in community-based services or employment. Housing agencies spend considerable funds on housing for people with SMI, but they manage to serve only about 5 percent of the estimated 18–30 percent of homeless people who have SMI (Goldman, 2003; Newman & Goldman, 2008). Furthermore, housing agencies frequently are able to provide only transitional, not permanent, housing (U. S. Department of Housing and Urban Development [HUD], 2006, cited in Newman & Goldman, 2008).

1.5.5 Education Agencies

Eighty-three percent of elementary and secondary schools now provide case management services for students with behavioral or social problems (Brenner, Martindale, & Weist, 2000). Seventy to eighty percent of mental health care for

children and adolescents is delivered in the school setting, while other schools arrange for community-based organizations to provide mental health or social services to students (Burns et al., 1995).

1.5.6 Vocational Rehabilitation

Vocational rehabilitation agencies provide psychological assessments and services, as well as assessments of an individual's skills, attitudes, behaviors, and interests relevant to work. These agencies also provide vital support services such as job training, and they help consumers find appropriate jobs in state-supported programs or the general workforce.

1.5.7 Early Intervention

Early intervention programs provide mental health services to children aged 0 to 3 years, or in some states, 0 to 5 years. The programs are usually located either in the state department of health or in the state department of education.

1.5.8 Child Welfare

A national study of children aged 2 to 14 in the child welfare system found that nearly half had clinically significant emotional or behavioral problems, but only about one-quarter received mental health treatment (Edelman, 2008).

1.5.9 Substance Abuse

Many people who have a mental illness also have a co-occurring substance use disorder, and this was the population of focus for the OSA Project. While identifying relevant data was complicated in all the agencies, it was especially complicated for substance abuse because many of the nine participating states have integrated their

mental health and substance abuse services into a single agency, thus impeding their ability to look at substance abuse separately.

1.6 Technical Support Panel

To provide overall guidance for the OSA Project, a Technical Support Panel (TSP) was convened. The panel was composed of representatives of SMHAs, OSAs, universities, Federal agencies, independent consultants, consumers, and family members. The TSP guided the development and implementation of standard procedures and protocols for states to identify existing data sources, determine the amount of OSA resources for and expenditures on mental health and related services, count the number of consumers the OSAs served, and report the data. Some participating states created comparable panels to oversee their projects.

1.7 Two Cycles of the OSA Project

The OSA Project consisted of two cycles. The pilot cycle began in 2004. The SMHAs of nine states volunteered to participate in the project, and within each state, the SMHA took the lead. The pilot states then tested the effectiveness of the standard procedures and protocols that were developed for the project. Lessons learned by the pilot states enabled the TSP to improve the procedures and protocols for the next cycle, which began in 2006. Some, but not all, of the pilot states participated in Cycle Two. Nine states were able to complete the entire data identification project, and their data are the subject of Chapter III. (See Appendix B for contact information of participating states.)

Throughout the implementation period, technical assistance was provided to states individually and in monthly conference calls.

A project listserv was also established, and a website provided project-related information, announcements, meeting minutes, and other relevant material.

1.8 Chapter Summary

In response to the New Freedom Commission’s call to transform the nation’s mental health system, SAMHSA/CMHS has undertaken several significant projects, among them the OSA Project. The OSA Project was the first major federally funded, collaborative project across states to try to document the revenue sources and expenditures on mental health and related support services in state agencies other than

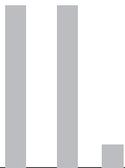
the SMHA. The goal of the project was to help states more rationally approach the service coordination and financing of comprehensive services and supports for mental health consumers and family members.

The OSA Project consisted of two cycles, and nine states participated in each of the cycles. Each of the states examined existing mental health data sources in nine different OSAs. A national TSP oversaw the project and guided the development of procedures and protocols for the participating states.

1.9 Structure of this Document

The remaining chapters of this document provide details of the OSA Project. Chapter II (Implementing the OSA Project: A “How To” Guide) discusses the benefits, challenges, and facilitating factors of the OSA Project. Following this information is guidance for the decisionmaking process that states might follow in deciding whether to undertake their own OSA project. Chapter III (Results from the OSA Project) details the major findings of the project and discusses the limitations of the data. Chapter IV provides conclusions.

Cycle One	Cycle Two
Arizona	Alabama
Colorado	Colorado
Maryland	Florida
Maine	Indiana
New Mexico	Kentucky
Oklahoma	Maryland
South Carolina	Oklahoma
Utah	Pennsylvania
Washington	Washington, DC



Implementing the OSA Project: A “How To” Guide

While some individual states had undertaken cross-agency data identification projects on their own, the OSA Project was the first cooperative, multistate effort to assist participating states in identifying relevant SMHA and OSA data to use as a basis for transforming their mental health systems. OSAs were not expected to collect any new data for this project. Rather, they were asked to provide only archival data that was available, accessible, and reportable. Data from Federal sources could also be used.

After examining the benefits, challenges, and facilitating factors of the OSA Project, this chapter describes a decisionmaking process that other states might follow in deciding whether to undertake an OSA project in their states. For those who decide to do so, the chapter then provides detailed implementation guidelines the OSA Project’s TSP approved for agencies to follow in the original project.

2.1 Benefits of Implementing the OSA Project

All participating states reported the project was beneficial despite the hard work and multiple challenges. Their hope is that what they learned and the relationships developed among the participating agencies eventually will be beneficial to mental health

consumers. As noted in the final report from Washington, DC:

The study participants acknowledged the relevance of the process for discerning mental health related services. They, in turn, would like to explore ways in which funds can be pooled in an effort to better serve consumers receiving services from two or more agencies (District of Columbia, 2008).

The Maryland Mental Hygiene Administration reported the project was very “useful and informative” (State of Maryland, 2007). The agency appreciated that the project provided knowledge of overall services to mental health consumers and the ability to track which agencies see these consumers. The staff took a closer look at the SMHA’s own data, obtained more specialized reports, and got a general view of mental health expenditures in OSAs. They

believe these factors will in turn enable them to make better decisions on overall consumer care. They especially appreciated their new ability to communicate more effectively with the OSAs (State of Maryland, 2007).

Similarly, Indiana reported:

The results of the OSA Project have, and will be, of great benefit to the [Indiana] Transformation Work Group as the system transformation process moves forward. ...The Project helped complete the picture of who provides mental health (and addiction) services in the state, what services are provided, to whom the services are provided, and the expenditures by each of the agencies. ...A second benefit was the opportunity to identify and develop relationships with key persons in the other agencies. In most cases it was necessary to work with both program and data people and to bridge the gap between the two. Several agencies indicated that the Project had identified data that they should have had but didn't. The Project also led to an exchange of information that was of benefit to both SMHAs and OSAs (State of Indiana, 2008).

Kentucky said the project:

- *Increased our understanding of how other systems operate*
- *Enabled us to quantify the extent of mental health needs in our state*
- *Improved our relationships with other state agencies*
- *Set the groundwork for other data sharing projects*

Kentucky further reported that the project seemed to “validate other agencies’ feeling of burden in serving individuals with mental illness and increased their understanding of how the public mental health system operates” (State of Kentucky, 2008).

Oklahoma reported:

The OSA Project provided us an opportunity to strengthen existing interagency relationships, was a vehicle for establishing new relationships with expectations of long-term collaboration, offered opportunities to share OSA-related work with leadership at the SMHA and OSAs and gain recognition for the work being done among

partners, and was the impetus for the creation of a model interagency reciprocal data sharing agreement that is now the foundation for several important projects (State of Oklahoma, 2008).

Finally, Pennsylvania described the benefits derived from the project as follows:

Overall, the process has been a tremendous learning experience and has aided us in identifying types of data necessary for reporting on the federal level. We learned that buy-in for a project of this magnitude begins at the highest level possible and ends with access to line staff with knowledge and understanding of data nuances. The OSA conference calls provided us an opportunity to learn about the experiences that other states were confronted with in this project and enabled us to glean information to resolve some of our own issues. Discussions with other states also provided some level of comfort knowing we shared many of the same issues (State of Pennsylvania, 2008).

The OSA Project could be especially beneficial in enabling policymakers to shift from viewing programs in agency “silos,” to see gaps in their systems, and to identify services not being provided. Such information would enable the development of more complete SMHPs that coordinate publicly funded service delivery across agencies and provide “no wrong door” through which consumers can access services (Frank, Garfield, & McGuire, 2007). A truly comprehensive plan would also include expenditures and consumers served by local and county government agencies and the private mental health sector. However, collecting such data was far beyond the goal and capacity of this project.

The broader perspective provided by the project could also help states make more effective use of their overall funds by minimizing cost-shifting from one agency to another (Frank et al., 2007). Individual state agencies often attempt to make their budgets go as far as possible, even to the extent of passing some costs on to another agency. For

example, an agency may direct “risky” consumers whose needs are most costly and difficult to treat to services funded by sources other than its own budget (Wolff, 1998). Cost-shifting may be in the best interest of an individual agency, but it is not in the best overall interest of either mental health consumers or the state. The practice does not reduce state costs, and any resources used to shift costs, or any distortions caused by cost-shifting, are losses to the state. Cost-shifting may also lead to programs that serve consumers poorly by diluting the quality of services, overwhelming the agencies that eventually serve the consumers, or placing consumers in inappropriate settings (Sinaiko & McGuire, 2006).

2.2 Challenges to Implementing the OSA Project

None of the states that participated in the OSA Project said it was easy. However, they all agreed the benefits outweighed the challenges. The challenges reported fell roughly into three groups: the challenge of “selling” the project to OSAs, human resources limitations, and technical difficulties.

2.2.1 The Challenge of “Selling” the Project

It was sometimes difficult for SMHAs to obtain buy-in for the project from OSAs. In some cases, the SMHAs had difficulty identifying the appropriate OSA contact at the beginning of the project. In other cases, OSAs reported the SMHA was not clear about the purpose of the project and how the data were to be used. One state reported:

The most challenging thing was trying to get the other agencies to buy in to the project. For the most part, they did not seem to see the value. With the exception of Medicaid, the others just

saw it as an inconvenient regurgitation of data that did not mean anything to them in sharing. They did not think that we were comparing apples to apples but quite the opposite (State of Maryland, 2007).

Several SMHAs reported that OSAs needed to be better educated about the extent to which mental illness affects their service population and the implementation of their agency’s mission.

Some OSAs were reluctant to join the project because they were concerned about the possible misrepresentation and/or misuse of the data, especially data regarding consumers. To address these concerns, state legal offices ensured privacy and confidentiality of consumers were strictly protected, and consumer protection measures were written into data sharing agreements between the SMHAs and OSAs. All states worked to ensure that the state and Federal laws and statutes related to protection of consumer information were strictly followed.

Another reason some OSAs were reluctant to join the project was their fear that once the SMHA learned what resources the OSA had for mental health services, the SMHA would try to take control over the resources. One mental health commissioner addressed this concern in an early project meeting. He said he wanted to be clear that the SMHA did not intend to try to take over any of the OSA services or resources. Rather, he saw the project as an important vehicle for the SMHA and the OSAs to partner more effectively and be responsible stewards of the state’s limited resources. Explicitly stating that no SMHA or OSA had adequate resources to meet all the state’s mental health needs, but that together they could provide the best possible services to their state’s residents, seemed to defuse this issue. The result was a lively discussion about better

coordination of services going to the same consumers.

2.2.2 Human Resources Limitations

As an ad hoc activity, the OSA Project competed with existing state and staff priorities for scarce state human resources. Most staff members already had heavy workloads, and many said they simply did not have enough time to devote to the OSA Project. At the end of the project, one state observed that “there remain issues with garnering sufficient support of other agencies to commit their valuable resources to this project” (State of Colorado, 2008).

Once the project was under way, the commitment from both SMHA and OSA leadership wavered from time to time in some states. Some SMHAs had a change in the agency’s leadership that led to changes in priorities, and others changed project

managers. Several states encountered major economic difficulties and budget shortfalls that led to a reallocation of available staff across the state government.

Human resources limitations were further evident in the extent to which staff members were available to work on the project from beginning to end. It was difficult early on to identify OSA staff who understood the relevant information and who could help determine the appropriate process to document the requested data. As stated in the final OSA report from Oklahoma:

Often, the task involved a group of staff from various offices within the OSA. Sometimes several people at the OSA needed to be questioned to get the information that was needed. One person may know about how to get the data. Another person may understand the finances and another person may understand the services (State of Oklahoma, 2007).

Highlights of States’ Experiences Engaging OSAs

In Colorado, e-mails and phone calls were relatively successful, though not universally so. A possible strategy for future efforts may involve a kickoff event or presentation that would assist in developing a common understanding and commitment to the project.

In Indiana, the project began with a letter from the Governor to the directors of the agencies. The agency was asked to participate in the project and to identify a contact person. All responded initially or after a follow-up call or e-mail. An individual meeting was held to explain the project, establish deadlines for submitting the data, and answer any questions.

Pennsylvania’s participation letters were sent to the Deputy Secretary/Director for each OSA followed by telephone calls to all agencies or offices. Individual agency-specific packets describing the OSA Project were created and sent to each agency. Technical assistance regarding table completion was provided to the responding agencies. For those agencies that did not respond, multiple phone calls were attempted to various individuals within the agency. This approach was effective.

Kentucky made personal contact using existing mental health staff with a relationship with the OSA. The SMHA first attempted to make contact with a letter from the Mental Health Commissioner to commissioners of other departments. Only one department responded to these letters, so the SMHA then contacted individuals staff knew within those agencies. The SMHA also tried to use Mental Health Block Grant Planning Council OSA representatives to gain access. That SMHA also tried to anticipate what motivation the OSA might have to participate (e.g., access to other information within the public mental health databases).

There was considerable turnover of staff in both the SMHA and OSAs as a result of attrition, retirement, and changes in state administration, and this sometimes led to a standstill in project implementation. Despite an extended time line, some states were still late in reporting data because adequate personnel had not been committed by either the SMHA or the OSAs.

One state summed up its challenges with regard to human resources as follows:

Keeping a consistent focus on the project is difficult given my other job duties. Keeping up interest among leadership and other managers as a transformation tool or a foundation for planning and change is difficult. The project is considered to be a static, one-time initiative. However, I believe it to be a valuable way to begin to share data over time for mutually beneficial purposes (State of Kentucky, 2007).

Providing adequate staff is critical if states are to work toward a sound, integrated, and efficient system of care. Six states were able to quantify the approximate analyst staff time, programming staff time, equipment, software applications, and consultant contracts required for the OSA Project. A summary of the estimated resources used by six of the nine states is presented in Table 1.

2.2.3 Technical Difficulties

Gathering and understanding the data posed major challenges. One state noted that “sometimes it was hard to find the right person in an agency with the correct information and knowledge. Sometimes getting the data sharing agreement was a challenge. Sometimes it was busy schedules of staff. There were different challenges with each OSA” (State of Oklahoma, 2007). The technical difficulties came about largely because state agencies have different missions and organizational structures, and they have developed information technology systems and accounting practices appropriate to their missions.

2.2.3.1 Differences in How SMHAs and OSAs Record and Report Data

With regard to information technology systems, some participating states still relied on paper-based reporting, while others used multiple stand-alone data systems whose differences in computer programs and databases limited their capacity to link data. Agency systems also often differed in the data elements and definitions they included.

Table 1. Project Personnel, Equipment, and Software Resources Used by SMHAs

State	Analyst Staff (Hours)	Programming Staff (Hours)	Others: Contracted Hours	Equipment and Software
1	Varied
4	281	210	...	Excel, Word, state Fraud and Abuse database, state claims payment system, Mercer Consulting Data Cubes
5	56	20	...	Phones, PCs, MS Access, MS Excel, e-mail, conference calls
6	900	250	...	Software developed by the SMHA for probabilistic matching and Link Plus, a probabilistic matching program developed by the CDC; SQL, SQL servers, Excel, Word, Access, and PCs; Business Objects (a query tool for Medicaid claims data warehouse; Medicaid Management Information Systems (MMIS) software (to access MMIS Medicaid system)
7	150	N/A
9	200	...	54.5	...

Some OSA databases lacked mental health identifiers, and others lacked mental health service categories. Some OSAs did not have a centralized information system. Rather, they had unique systems at different sites, providers, or school districts. Yet other agencies had only aggregate data available at the state level.

Different accounting practices also posed a significant barrier to determining mental health expenditures and counts of consumers. Some agencies such as housing, early intervention, and education identify consumers with disabilities but not the specific types of disability such as “mental illness.” Across state agencies, service definitions sometimes varied, resulting in ambiguity as to which services to report.

Preexisting state data warehouses that routinely combine client and service data from multiple state agencies were found to be a major facilitating factor for this project. States that could tap into an existing data warehouse were able to analyze data much more efficiently; whereas, states without data warehouses had to do much more work to combine data systems.

Finally, agencies’ ability to fit data into the templates provided for the project varied, and these predefined service categories restricted the capacity of some agencies to report all the mental health and related support services they provided or the number of consumers they served. One state concluded that “it was frustrating when OSAs weren’t able to collect/share requested data or ‘bucket’ the data as requested” (State of Pennsylvania, 2007). All states agreed there is a continuing need for interagency alignment of technology as well as definitions of services and mental health consumers.

2.2.3.2 Reporting Duplicated and Unduplicated Counts of Mental Health Consumers

Identifying and reporting consumers who receive mental health and related support services from the OSAs were not straightforward processes. Once the OSA had identified its mental health consumers, it had to decide how to report the count in a meaningful way. The OSAs were allowed to report either duplicated or unduplicated counts of consumers, whichever was available, provided the data were appropriately labeled.

Duplicated counts signify the same consumer is counted each time he or she receives a service as if he or she were a separate consumer. In unduplicated counts, the consumer is counted only once, regardless of the number of times he or she receives the same service throughout the reporting period. For example, suppose a person receives “inpatient hospital care” for a week and then is provided another episode of “inpatient hospital care” 2 weeks later. If this person is counted twice in the total number of consumers who receive “inpatient hospital care” because of two separate service episodes, the total count of consumers who receive “inpatient hospital care” is said to be duplicated. An unduplicated count would occur when this person is counted only once, regardless of the number of times (service episodes) he or she receives the service. To report the unduplicated count, the person must be identified using a unique identifier such as a client identification, name, or other means.

An unduplicated count of consumers would be more meaningful than a duplicated count in the above example for identifying the number of individuals who received a

particular service (“inpatient hospital care” in this example). The duplicated count of clients is not as useful as it overstates the number of consumers who actually received the service.

The concept of duplicated and unduplicated counts changes slightly, however, when looking at the number of consumers across service types. Suppose a person receives “inpatient hospital care” and later receives “24-hour care” and “housing support.” If the individual is counted and reported once under each of the three types of service, the total count of consumers across service type is said to be duplicated because the person was reported three times, once for each service received.

In this example, the duplicated count of consumers across service type is meaningful (as long as the counts are unduplicated within each service type) since these data will facilitate comparison of the number of consumers who received each type of service. The unduplicated count of consumers across service type becomes important, however, to knowing the number of consumers served by the OSA regardless of the types of services received.

In the customized OSA reporting templates, the OSA was encouraged to report the unduplicated count in addition to the duplicated count of consumers across service types. However, the lack of unique consumer identifier often posed a challenge. This type of data represents the number of persons who received any service from the OSA and is critical in the determination of overlap across OSAs. One state summed up the challenge of dealing with the data as follows: “The single most challenging part of the project is attempting to reconcile all the data, both within an agency (e.g., ensuring that it

captures the correct data) and across agencies (attempting to unduplicate the data)” (State of Colorado, 2007). (See Appendix C for instructions on how to determine duplicated and unduplicated counts of consumers.)

2.3.2.3 Determining Overlap

It is likely that many people who receive mental health or related support services from one OSA also receive services from the SMHA and possibly from other OSAs. In order for the state to determine overlap (i.e., the extent to which one agency serves a population that is also being served by another agency), it should have the unduplicated count of consumers who received any service from the OSA. This means a person is counted only once regardless of the number of times he or she received the same service (service events) and/or regardless of the types of services received from the OSA.

States were directed to try to determine the overlap between, at a minimum, the SMHA and other OSAs. Doing so not only identified SMHA consumers who also received services from an OSA but also identified consumers who received services from an OSA but not from the SMHA. The relative number of individuals, services, and dollars in these two categories provides important information about the functioning of agency systems and the state’s overall system of care.

When determining the overlap across agencies, it is important to investigate whether the consumer receives uniquely different services from each agency. If so, the services are likely to be beneficial supplements to SMHA services in an integrated service system. If not, the overlap may be the result of inefficient duplication of

services and may be indicative of a “silo” approach to services. (See Appendix C for instructions on how to determine overlap of consumers served by SMHAs and OSAs.)

2.4 What Made It Work: Factors that Facilitated the OSA Project

SMHAs reported that OSAs were more likely to want to participate in the OSA Project if the following were in place:

- A common belief by both the SMHA and the OSA in collaboration, transparency, and efficiency, and a common interest in understanding the overall state mental health service delivery system
- Long-term relationships between SMHA and OSA staff
- A Governor’s mandate
- Quid pro quo relations for existing, past, and future projects
- A passion among OSA staff for addressing mental health issues
- An OSA’s interest in evaluating its own role in overall state mental health
- An OSA’s willingness and ability to commit resources to the project
- Existing data sharing agreements between the SMHA and the OSA
- Existing methods of matching data sets
- Availability of a data warehouse
- Reliable electronic databases
- Sophisticated technology

OSAs reported being attracted to the project because it enabled them, in order of importance, to:

- Identify consumer overlap

- Improve allocation of resources
- Gain a better understanding of revenues and expenditures
- Determine the number of consumers receiving mental health services in their agencies
- Determine future areas for collaboration and data sharing

Once the project was under way, certain actions the SMHA took helped facilitate the project. These included:

- Use of established project procedures and protocols
- Convening meetings on OSAs’ home turf
- Consistent contact and follow-through with technical assistance to the OSAs
- Remaining clear about the purpose of the project
- Allaying concerns that resources could be transferred to the SMHA

2.5 Deciding Whether to Undertake an OSA Project

States that participated in the OSA Project indicated other states should not take on a comparable project before thinking it through carefully and discussing the following questions with relevant managers and staff:

- Do we pass the readiness test? That is, is the SMHA leadership fully on board, and is it really feasible for us to implement the project? What will be the likely impact on SMHA staff resources? What will be the technological requirements? What are

the potential legal and political ramifications?

- What is the purpose of engaging OSAs? What do we hope to gain from the project?
- What is the internal capacity of the SMHA to initiate and successfully complete the project? That is, what staffing and financing resources can we commit to the project?
- Who are the key staff within the SMHA who will take the lead in coordinating with the OSAs we plan to engage?
- Do we have past or existing activities with OSAs we can leverage to get the project started?

For the OSA Project, the SMHA had overall managerial responsibility. However, the lead office within the SMHA differed across states and included information technology, evaluation research, planning, and quality improvement offices. Offices of the commissioner, budget, clinical/programs, and contracts/procurement/grants were also consulted prior to the launching of the project. States did not report any preference for which SMHA office had the lead, but they stressed that consultation with different SMHA offices was often critical to identifying appropriate OSA contacts.

2.6 Guidelines for Implementing an OSA Project: A Six-Step Process

Project developers said that states wishing to pursue an OSA project on their own might want to follow the six-step process developed for the original OSA Project. They noted that after Step 1, the steps do not need to be followed sequentially. For example, participating states collected contextual

information (Step 5) at both the beginning and the end of the project. Similarly, they employed a feedback loop (Step 6) throughout the project, and the order in which they identified data on expenditures, resources, and consumers (Steps 2, 3, and 4) varied from one state to another. The steps developed for the OSA Project follow.

2.6.1 Step 1: Establishing a Collaborative Process

1. Send an initial contact letter to the chief executive of each OSA introducing the project and summarizing how the project will benefit the OSA. The OSA executive will most likely respond promptly if this initial letter is signed by the SMHA administrator, or better still, by the Governor if she/he is endorsing the project. (See Appendix D for a sample letter.)
2. Determine who in the OSA will be assigned to coordinate with the SMHA, whether to accept or decline the invitation to participate.
3. Once the OSA has agreed to participate, plan a face-to-face meeting with the relevant OSA staff (e.g., program staff, planners, management information systems [MIS], budget personnel). At the meeting, explain the project's benefits, requirements, and time line. Be sure to spend adequate time discussing what data you want the OSA to report and what the OSA wants to get out of this effort.
4. Provide the SMHA lead's contact information, and secure the contact information from the key OSA staff.
5. Together with OSA staff, identify the OSA database or other sources of information on OSA mental health resources, expenditures, and consumers

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- served. As the project lead, the SMHA must have a solid, “big picture” understanding of what the project intends to achieve, what is required to achieve the stated goal, and what the OSAs expect to provide and receive from the project.
6. Together with OSA staff, determine the best method(s) to use in identifying clients who received mental health services, mental health service expenditures, and the corresponding sources of funds.
 7. Clarify which data can be reported as duplicated and which data should be unduplicated. Explore options for unduplicating consumers across all the service types reported.
 8. Explain the concept of overlap to the OSA staff. Together, determine if it is possible to identify consumer overlap and explore the various methods of identifying it between the SMHA and the OSA. (See Appendix C for a discussion of methods of identifying consumer overlap.)
 9. Identify the reporting period for the data (e.g., fiscal year, calendar year) and the time frame in which data can be compiled and reviewed and the results analyzed.
 10. Determine if the SMHA or OSA requires a data sharing agreement. If so, draft an agreement for review by both parties to ensure all pertinent terms relevant to data that were agreed upon are explicitly stated. Be sure all applicable state and Federal laws and statutes regarding confidentiality are included. Then execute the data sharing agreement. (See Appendix E for a sample data sharing agreement.)

11. Work with OSAs to complete the report, and provide technical assistance via conference calls, a listserv, and periodic meetings.

In four of the nine states, the SMHA enlisted the support of the Governor to encourage OSAs to participate. In some cases, the Governor or his/her designee and the SMHA administrator both signed the letters of invitation to the directors of the OSAs. In the states that had received MHT SIG funds, the OSA Project was introduced through the Transformation Working Groups the Governors were required to establish for that grant.

As might be expected, the responses from the OSAs varied considerably. When SMHAs made their initial contact with the OSA through a letter, they often had to follow up with phone calls and/or e-mails, either to track the letter and make sure the director had received it, or to set up meetings with appropriate staff. Once the initial contact had been made, however, states reported an average of 2 weeks to move forward with the project.

2.6.2 Step II: Calculating Expenditures on Mental Health and Related Support Services

1. Determine exactly what mental health and related support services you want to include in the project. Determine similarities and differences in service definitions used by the various agencies, and develop a crosswalk if necessary.
2. Determine the types of expenditures; for example, actual expenditures versus budgeted/planned expenditures.
3. With the OSA, agree on a time period for the project.

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4. Determine/define population of interest (e.g., only adults, only children and adolescents, both adults and children and adolescents; only adults with serious mental illnesses [SMI] or adults with SMI plus other consumers; only children and adolescents with serious emotional disturbances [SED] or children and adolescents with SED plus other consumers).
 5. Compile all expenditures for mental health and related support services provided by OSAs to individuals with mental illnesses who may or may not be served by the SMHA.
 6. To begin to analyze the data, juxtapose the OSA and SMHA expenditures by service types or population categories.

Specific definitions were created for the OSA Project. For example, the OSAs were asked to report “all mental health and related support services that are provided, expended, or funded by the OSA.” For the project, mental health services were defined in broad categories such as “inpatient hospital care” and “pharmacy.”

The definition of support services depended on the types of services provided within each OSA. For example, vocational rehabilitation agencies reported expenditures for support services such as assessing a client’s skills, attitudes, behaviors, and interests relevant to work, providing training, and helping a client find work. Similarly, housing agencies reported expenses related to supports such as the actual acquisition and maintenance of the housing structure, as well as mental health services such as individual and/or group psychotherapy provided at the residence.

The developers of the OSA Project created these definitions by reviewing standard reporting forms and requirements for each OSA and consulting with the TSP. The goal was to develop definitions using nomenclature that would be relevant to each OSA. However, they found that definitions that worked well for the states represented on the TSP sometimes broke down when used by another state with its own unique definitions. They recommended that states wishing to replicate the OSA Project review the applicability of the definitions provided for the original project to their own state. They might need to customize the definitions to ensure appropriateness for their purposes.

OSAs provided data to SMHAs either in datasets that had to be analyzed and sorted to fit the project’s standard data templates or in datasets that were already sorted and fitted into the templates. Detailed instructions and templates to report data were customized for each OSA. For example, the templates for Medicaid provided data by Medicaid eligibility groups. The templates for vocational rehabilitation collected data by age and primary health condition, while the templates for corrections categorized data by placement such as jails, prisons, and parole. The remaining participating OSAs, particularly the child-serving agencies, could only report total expenditure data. In cases where the OSA contracted with the SMHA for it to provide services, the expenditure was reported as “contracted to SMHA.” When the OSA data were combined with the mental health expenditures of the SMHA, policymakers had a general picture of the state government’s total mental health

expenditures. (See Appendix F for each agency’s instructions and reporting template.)

agencies; include cash receipts, in-kind, and/or matching funds

2.6.3 Step III: Identifying Sources of OSA Revenue for Mental Health and Related Support Services

For the OSA Project, sources of revenue included the following:

- Medicaid
- “Other state” sources: general state appropriations for specific agencies, special state appropriations, and any other funds states receive from grants from local foundations, grant institutions, gifts from local donors, etc.
- “Other Federal” sources: any Federal funds other than Medicaid
- “Local/County” funds: from counties, parishes, cities, or multicounty

2.6.4 Step IV: Identifying Mental Health Consumers

2.6.4.1 Population of Interest

States implementing OSA projects need to define exactly those who will be counted as “consumers.” They must decide whether to include only adults with SMI and children and youth with SED, or to expand the definitions to include consumers who have mental disorders other than SMI and SED.

The protocol for the OSA Project defined the consumer population of interest as follows:

Any individual who receives mental health and/or related support services (e.g., employment, housing) through an OSA. The individual may or may not be receiving services from the SMHA.

Other Federal Sources of Funding

- Medicare
- Social Services Block Grant or Other Block Grants
- Social Security Act Title IV-B, subpart 1, Child Welfare services
- Social Security Act Title IV-B, subpart 2, Promoting Safe and Stable Families
- Social Security Act Title IV-E Foster Care
- Federal Demonstration Grants
- National Institute of Mental Health
- Education Programs such as P.L. 94-142 (i.e., “Education for all Handicapped Children Act” for mental health services, workers, and teachers in special education settings) and P.L. 89-313 (i.e., Federal tuition assistance funds for basic aid for children in mental institutions)
- The Department of Veterans Affairs
- Indian Health Service
- Other Federal Agencies

This definition did not limit the population to adults with SMI or children and youth with SED. The protocol did, however, exclude people with developmental disabilities unless they also had a mental illness. The substance abuse agencies were directed to focus on clients dually diagnosed with both mental illnesses and substance use disorders.

An OSA may identify consumers in several different ways. However, for the best identification of clients for analysis and planning purposes, the project developers recommended OSAs use one or a combination of the following categories:

- Types of services received
- Diagnoses that identify persons with mental health disorders (ICD-9-CM Codes)
- Current Procedural Terminology (CPT-4) procedures codes set forth by the American Medical Association that identify mental health consumers
- Provider-related codes
- Approved codes and modifiers that relate to mental health from the Healthcare Common Procedure Coding System (HCPCS) established by the Federal Centers for Medicare & Medicaid Services (CMS)
- Pharmaceuticals potentially indicative of mental health disorders

2.6.5 Step V: Capturing Contextual Information

Contextual information at the beginning of the project included:

SMHA project structure

- The lead SMHA office that manages the project

- The SMHA divisions or offices that participate or are consulted in launching the project

Establishing the initial OSA contact

- Whether the Governor's office approves or endorses the project
- Types of communication used to introduce the project to the OSAs (e.g., e-mail, letter, telephone calls)
- Rank of the person to whom the letter of invitation or e-mail is addressed or rank of person the SMHA director/ commissioner calls
- Techniques used to orient the OSA about the project

Engaging the OSAs

- Factors that facilitate or help promote the project to the OSAs
- The precise reasons the OSAs cite for engaging in the project
- The estimated average time involved in establishing a partnership with OSAs

Contextual information gathered at the end of the project included:

- OSAs that declined to participate
- Reasons the OSA(s) cited for not participating
- Approach(es) used to collect data from the OSAs
- The approximate SMHA resources (analytic and programming staff, software, etc.) used in working with the OSA to extract, report, and analyze the requested data
- Specific procedures or methods used to identify mental health and related services

-
- Secure copies of computer programs used by the OSA to extract the data (if available) and detailed notes on items included and items excluded (with reasons for exclusion)

(See Appendix G for forms for collecting contextual information at the beginning and end of the project.)

2.6.6 Step VI: Creating a Feedback Loop

SMHAs provided feedback to OSAs at the following stages of implementation:

- After data extraction
- After data were sorted into the report templates
- After initial data analysis
- Prior to sharing the results of the project with other stakeholders
- When comments were received after the release of data

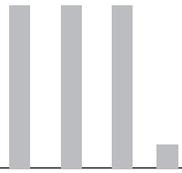
For the OSA Project, the SMHAs analyzed the data, presented the findings to the OSAs during in-state meetings, and solicited OSA feedback. These meetings enabled everyone to take a collective look at the overall mental health and related support service expenditures of the state government, and in the process, learn how each agency tracks these services. One of the positive

by-products of the project was that many OSAs discovered how essential their own agency was in delivering mental health and related services in the state.

2.7 Chapter Summary

This chapter details the benefits and challenges of implementing an OSA project and significant factors that facilitate the project. Direction is given to SMHAs to hold thoughtful and detailed discussions to determine if they want a comparable project in their own state and if they are ready to embark on it. The detailed six-step guidelines developed for the OSA Project are presented in the event they are needed.

The first step helps SMHAs engage OSAs and establish a collaborative process. Steps two, three, and four guide states through the complicated processes of identifying and reporting the revenue and expenditures for and related support services, as well as the number of consumers served by the OSAs. Step five provides guidance on how to capture contextual information at the beginning and end of the project. Step six describes how to create a feedback loop with the OSAs to ensure their continued engagement in this and future collaborative projects.



Results from the OSA Project

All participants in the OSA Project believed that identifying expenses for mental health and related support services and the number of consumers they were serving was essential to using their limited resources efficiently and creating truly comprehensive mental health systems. While the OSA Project was difficult, two messages came through clearly: Agencies other than the SMHA are providing a substantial amount of mental health and related support services, and the type of information generated by the project could be of considerable benefit to policymakers as they allocate statewide resources to serve mental health consumers and their families more effectively.

It was never the intention of the OSA Project to compare data across the nine participating states because, as Table 2 indicates, they were diverse in size, population, and resources. Their populations ranged from 550,521 to 17.8 million people. The number of consumers served by the nine SMHAs ranged from 11,428 to 262,038, and in 2005, the total SMHA expenditures for mental health services ranged from \$157 million to \$2.5 billion (See Table 2). Trying to compare data across such diverse entities is neither appropriate nor informative.

It is important to note that the organizational structure of the SMHAs varied from state to state. One SMHA was also the state Medicaid agency for carved-out behavioral health services, but in the other eight states, Medicaid was a separate state agency. Five of the states had integrated

mental health and substance abuse agencies, and four states had substance abuse agencies separate from the SMHA.

Not all states were able to report data from each of the OSAs. All, however, were able to report data from Medicaid. The number of states reporting data by OSA is shown in Table 3.

3.1 Potential Federal Sources of OSA Data

One by-product of this project was the identification of possible sources of OSA data other than state agencies themselves. At the Federal level, two departments provide such data. The U.S. Department of Education's Office of Special Education and Rehabilitation Services collects a case service report called RSA 911 from all state vocational rehabilitation agencies. The

Table 2: State Population, Unduplicated Count of Mental Health Consumers Served by SMHAs, Total SMHA Revenue, and SMHA Revenue from Medicaid

States	State Population 2005*	Unduplicated Mental Health Consumers Served by SMHA 2006**	Total SMHA Revenue (2005) in Millions***	Total SMHA Medicaid Revenue (2005) in Millions***	Percent SMHA Revenue Provided by Medicaid
State 1	5,600,388	91,238	\$776	\$181	23%
State 2	6,271,973	86,647	\$518	\$393	76%
State 3	550,521	11,428	\$233	\$32	14%
State 4	12,429,616	213,769	\$2,540	\$710	28%
State 5	17,789,864	262,038	\$647	\$119	18%
State 6	3,547,884	42,484	\$157	\$19	12%
State 7	4,665,177	72,639	\$343	\$176	51%
State 8	4,557,808	105,113	\$273	\$92	34%
State 9	4,173,405	127,691	\$208	\$60	29%

* United States Census, 2005 Resident Population

** CMHS Uniform Reporting System

*** NRI Fiscal Year 2005 Revenues and Expenditure Study

Table 3. Number of States Reporting Data, by OSA

State Agency	Number of States Reporting
Medicaid	9
SCHIP	5
Vocational Rehabilitation	6
Child Welfare	5
Criminal Justice/Corrections	5
Education	4
Juvenile Justice	4
Housing	3
Early Intervention	3
Substance Abuse	2

resulting database receives annual updates for states' closed cases. The U.S. Department of Housing and Urban Development (HUD) also maintains a database in which state grantees for three of HUD's housing programs report aggregate data annually that identify persons with mental illnesses. The three programs are the Supportive Housing Program, the Shelter Plus Care Program, and Section 8 Moderate Rehabilitation for Single Room Occupancy Dwellings (SRO).

Although these data are available at a consumer level from program grantees, it is more difficult and challenging to gather the information at the grassroots level. States noted that interagency collaboration at the Federal level to access the Federal databases would be extremely useful to future OSA projects.

Data reported by each of the OSAs are detailed below. Blank spaces indicate the state(s) did not report data to the OSA Project for that particular category; they do not necessarily indicate the state(s) did not have any expenditures, resources, or consumers in those categories.

3.1.1 Medicaid

As noted above, all nine states reported data for Medicaid. While Medicaid can be a funding resource for mental health services provided through OSAs such as child welfare and juvenile justice, it is also a separate state agency underwriting direct or indirect mental health services in any given state. For this reason, states stressed that caution must be observed when interpreting the expenditures

reported by the Medicaid agency vis-à-vis the Medicaid-funded expenditures reported by another OSA.

3.1.1.1 Expenditures on Mental Health and Related Support Services by Medicaid

The Medicaid data were the only data collected by three age categories—children (0–17), adults (18–64), and older adults (>64)—and by eligibility criteria. As shown in Table 4, total Medicaid expenditures for children ranged from \$7 million to \$991 million. For adults, the range was from \$32 million to \$698 million. For older adults, expenditures ranged from \$10 million to \$104 million (see Table 4).

Medicaid also provided data according to five categories that designate why a person is eligible for Medicaid: “Social Security Income (SSI),” “Temporary Assistance to Needy Families (TANF),” “Dual Eligibility for Medicaid and Medicare,” “Foster Care and Adoption Assistance,” and “Other (e.g., Medically Needy, Refugees).” The group of people receiving SSI generally had the highest expenditures for Medicaid-funded mental health and related support services. The SSI group includes low-income individuals who are aged, blind, or disabled. Persons with SMI generally qualify for Medicaid under this eligibility status (see Table 5).

3.1.1.2 Mental Health Consumers Served by Medicaid

While a majority of the states reported unduplicated counts of consumers within

each service type, only five states reported unduplicated counts across services. The total number of consumers who received Medicaid-funded mental health and related support services ranged from 42,088 to 1.7 million (see Table 6).

Project developers noted that caution should be observed when comparing Medicaid expenditures with the SMHA total expenditures because of the varying relationships between the two agencies across states. For example, one of the OSA Project’s SMHAs was also the state Medicaid agency, and comparison between the two should be avoided. One state was able to link Medicaid data with OSA data, but the other states cited the possibility of double-reporting of Medicaid-funded services—once by Medicaid and again by other OSAs.

While the OSA Project clearly demonstrated the importance of Medicaid to the overall state mental health system, participating states stressed that Medicaid cannot meet all of a state’s mental health needs. The program is targeted to specific low-income populations, and it must adhere to Federal rules regarding allowable populations and reimbursable services. Even so, Medicaid funding enables states to “do more with less” and target their state-only dollars to services and populations excluded by Medicaid.

Table 4. Expenditures on Mental Health and Related Support Services by Medicaid, by Population, State, and Type of Service

Population	State 1	State 2	State 3	State 4	State 5	State 6	State 7	State 8	State 9
	Millions								
Inpatient Hospital									
Children (<18)	\$28.18	\$21.10	\$9.45	\$75.14	\$27.71	\$22.23		\$4.51	\$49.56
Adults (18 through 64)	\$57.74	\$16.77	\$52.71	\$222.73	\$108.86	\$11.11		\$.73	\$15.49
Older Adults (>=64)	\$7.10	\$5.54	\$3.43	\$3.84	\$6.69	\$1.27		\$.23	\$.74
Column Subtotal	\$93.02	\$43.40	\$65.59	\$301.71	\$143.26	\$34.61		\$5.47	\$65.79
Less than 24-Hour Care									
Children (<18)	\$82.34	\$149.96	\$21.64	\$665.48	\$319.57	\$49.43		\$85.40	\$87.38
Adults (18 through 64)	\$158.28	\$207.33	\$46.87	\$258.70	\$489.80	\$53.65		\$57.02	\$77.75
Older Adults (>=64)	\$7.85	\$13.40	\$7.17	\$7.43	\$32.32	\$4.69		\$9.63	\$10.44
Column Subtotal	\$248.47	\$370.69	\$75.68	\$931.60	\$841.68	\$107.77		\$152.05	\$175.57
Pharmacy									
Children (<18)	\$32.07	\$54.03		\$29.39	\$17.97	\$10.32	\$7.30	\$26.48	\$31.94
Adults (18 through 64)	\$82.27	\$157.69		\$197.58	\$69.45	\$20.99	\$32.12	\$75.69	\$112.47
Older Adults (>=64)	\$14.21	\$24.95		\$92.44	\$29.47	\$3.40	\$9.89	\$10.63	\$16.65
Column Subtotal	\$128.55	\$236.68		\$319.41	\$116.88	\$34.70	\$49.30	\$112.80	\$161.05
Other 24-Hour Care									
Children (<18)	\$62.91	\$25.40	\$12.29	\$221.48		\$82.84			\$6.23
Adults (18 through 64)	\$19.98	\$.69	\$5.08	\$8.61		\$.66		\$6.47	\$12.54
Older Adults (>=64)	\$39.54	\$.00	\$1.79			\$.09		\$27.84	\$5.61
Column Subtotal	\$122.44	\$26.10	\$19.16	\$230.09		\$83.59		\$34.31	\$24.38
Other									
Children (<18)					\$24.77				
Adults (18 through 64)					\$29.72				
Older Adults (>=64)					\$.96				
Column Subtotal					\$55.46				
No Breakdown							\$144.26		
Column Grand Total, Children	\$205.50	\$250.49	\$43.38	\$991.50	\$390.02	\$164.82	\$7.30	\$116.39	\$175.10
Column Grand Total, Adults	\$318.27	\$382.49	\$104.66	\$687.62	\$697.83	\$86.41	\$32.12	\$139.90	\$218.26
Column Grand Total, Older Adults	\$68.70	\$43.90	\$12.39	\$103.70	\$69.44	\$9.45	\$9.89	\$48.34	\$33.44

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

Table 5. Expenditures on Mental Health and Related Support Services by Medicaid, by Eligibility Category and Population

Population	State 1	State 2	State 3	State 4	State 5	State 6	State 7	State 8	State 9
	Millions								
SSI									
Children (<18)	\$36.57	\$11.11	\$7.89	\$504.46	\$142.53	\$24.72		\$35.27	\$66.83
Adults (18 through 64)	\$175.97	\$169.37	\$60.42	\$383.20	\$385.50	\$68.64	\$30.35	\$94.61	\$190.89
Older Adults (>=64)	\$2.67	\$05	\$2.90	\$25.57	\$7.86	\$6.23		\$4.48	\$32.61
No Breakdown							\$45.71		
Column Subtotal	\$215.21	\$180.54	\$71.21	\$913.24	\$535.90	\$99.59	\$76.06	\$134.36	\$290.33
TANF									
Children (<18)	\$65.77	\$147.48	\$4.66	\$264.90	\$112.93	\$129.67	\$1.12	\$5.19	\$66.00
Adults (18 through 64)	\$24.59	\$44.07	\$1.54	\$69.61	\$24.67	\$9.26	\$1.68	\$6.58	\$21.56
Older Adults (>=64)		\$00		\$00	\$01	\$00			\$79
No Breakdown							\$38.54		
Column Subtotal	\$90.36	\$191.56	\$6.21	\$334.51	\$137.61	\$138.93	\$41.33	\$11.77	\$88.35
Dual Eligibility for Medicaid and Medicare									
Children (<18)		\$00		\$49	\$10	\$00		\$00	\$6.87
Adults (18 through 64)	\$85.27	\$150.26	\$03	\$98.50	\$153.98	\$6.91		\$32.28	\$49
Older Adults (>=64)	\$61.85	\$40.43	\$01	\$78.02	\$41.78	\$3.07	\$9.89	\$33.72	\$04
No Breakdown							\$5.07		
Column Subtotal	\$147.11	\$190.69	\$04	\$177.01	\$195.86	\$9.98	\$14.96	\$66.00	\$7.39
Foster Care and Adoption Assistance									
Children (<18)	\$35.72	\$91.64	\$28.91	\$220.15	\$114.90	\$10.33	\$5.69	\$40.35	\$29.64
Adults (18 through 64)	\$4.79	\$4.75	\$4.99	\$8.03	\$3.78	\$1.12		\$3.97	\$55
No Breakdown							\$54.54		
Column Subtotal	\$40.51	\$96.38	\$33.90	\$228.17	\$118.68	\$10.44	\$60.22	\$44.32	\$30.19
Other (e.g., Medically Needy, Refugees)									
Children (<18)	\$67.45	\$26	\$1.92	\$1.50	\$19.56	\$10	\$49	\$35.57	\$5.77
Adults (18 through 64)	\$27.65	\$14.03	\$37.67	\$128.28	\$129.89	\$1.49	\$09	\$2.47	\$4.76
Older Adults (>64)	\$4.19	\$3.41	\$9.48	\$11	\$19.78	\$14		\$10.13	\$00
No Breakdown							\$41		
Column Subtotal	\$99.29	\$17.71	\$49.07	\$129.89	\$169.23	\$1.73	\$1.00	\$48.17	\$10.54
Column Grand Total, Children	\$205.50	\$250.49	\$43.38	\$991.50	\$390.02	\$164.82	\$7.30	\$116.39	\$175.10
Column Grand Total, Adults	\$318.27	\$382.49	\$104.66	\$687.62	\$697.83	\$86.41	\$32.12	\$139.90	\$218.26
Column Grand Total, Older Adults	\$68.70	\$43.90	\$12.39	\$103.70	\$69.44	\$9.45	\$9.89	\$48.34	\$33.44
Grand Total, No Breakdown							\$144.26		
Overall Column Total	\$592.48	\$676.88	\$160.43	\$1782.8	\$1157.2	\$260.68	\$193.57	\$304.63	\$426.79

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

Table 6. Number of Mental Health Consumers Served by Medicaid Agencies, by Population and Type of Service

Population	State 1	State 2	State 3	State 4	State 5	State 6	State 7	State 8	State 9
Children									
Inpatient Hospital	2,069	3,007	428	9,511	2,972	3,583	400	695	4,398
Less than 24-Hour Care	39,273	87,729	11,594	325,376	118,452	46,419	18,863	42,122	58,549
Pharmacy	30,523	65,643		145,036	75,006	10,564	14,130	31,101	37,569
Other 24-Hour Care	1,046	711	321	5,871		5,218	171		159
Other					207,235				
Column Subtotal for Children, Duplicated Across Services	72,911	157,090	12,343	485,794	403,665	65,784	33,564	73,918	100,675
Unduplicated Count of Children Across Services		113,206			157,526	48,942	33,033		59,175
Adults									
Inpatient Hospital	8,414	6,252	4,027	33,149	8,196	5,680	255	1,714	4,419
Less than 24-Hour Care	54,318	100,935	23,966	261,494	124,254	42,864	18,280	27,277	63,659
Pharmacy	67,959	130,890		735,809	222,765	32,836	33,392	86,919	131,079
Other 24-Hour Care	678	185	110	253		700	764	273	1,348
Other					84,256				
Column Subtotal for Adults, Duplicated Across Services	131,369	238,262	28,103	1,030,705	439,471	82,080	52,691	116,183	200,505
Unduplicated Count for Adults Across Services		155,597			260,128	57,003	51,704		134,612
Older Adults									
Inpatient Hospital	568	568	192	1,376	232	1,747	10	147	262
Less than 24-Hour Care	9,050	17,590	1,419	11,493	21,105	8,515	1,090	3,520	7,536
Pharmacy	28,173	39,332		202,614	144,381	12,668	18,711	33,178	37,288
Other 24-Hour Care	1,256	351	31			974	9	1,278	260
Other					6,417				
Column Subtotal for Older Adults, Duplicated Across Services	39,047	57,841	1,642	215,135	172,135	23,904	19,820	38,123	45,346
Unduplicated Count for Older Adults Across Services		42,493			147,300	19,063	19,806		37,820
Column Grand Total, Duplicated Across Services	243,327	453,193	42,088	1,731,982	1,015,271	171,768	106,075	228,224	346,526
Grand Total Unduplicated Count Across Services		311,296			564,954	125,008	104,543		231,607

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

3.1.2 State Children Health Insurance Program (SCHIP)

As noted in Chapter I, SCHIP is a Medicaid program that provides low-cost health insurance for low-income children and families who are not eligible for regular Medicaid services. Five states were able to report SCHIP data.

3.1.2.1 Expenditures on Mental Health and Related Support Services by SCHIP

Five states reported expenditures ranging from \$865,000 to \$25 million on SCHIP services. Expenditures for four of the states were mostly for “less than 24-hour care,” while state 5 expenditures were mostly for “pharmacy” (see Table 7).

3.1.2.2 Mental Health Consumers Served by SCHIP

Only four of the five states reported data on the number of consumers served by the SCHIP program. The numbers ranged from 12,418 to 29,374. Two of these four states were able to determine unduplicated counts of consumers served by SCHIP (see Table 8).

3.1.3 Vocational Rehabilitation Agencies

3.1.3.1 Expenditures on Mental Health and Related Support Services by Vocational Rehabilitation Agencies

Data on expenditures by vocational rehabilitation agencies on mental health and related support services may be found in two

Table 7. Expenditures on Mental Health and Related Support Services by SCHIP, by Type of Service

Agency/Services	State 1	State 2	State 3	State 5	State 6
SCHIP					
Inpatient Hospital	\$3,046,024	\$1,839,537	\$380,112		\$2,624,126
Less than 24-Hour Care	\$14,468,624	\$13,456,888	\$378,864		\$7,140,514
Pharmacy	\$5,750,832	\$7,359,523		\$5,870,885	\$1,166,289
Other 24-Hour Care	\$418,974	\$2,342,299	\$105,750		\$5,342,841
Other				\$3,978,250	
Column Total	\$23,684,454	\$24,998,247	\$864,726	\$9,849,135	\$16,273,770

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

Table 8. Number of Mental Health Consumers Served by the SCHIP Program, by Type of Service

Agency/Services	State 1	State 2	State 5	State 6
SCHIP				
Inpatient Hospital	389	418		591
Less than 24-Hour Care	10,260	15,906		9,464
Pharmacy	8,143	12,970	13,073	1,898
Other 24-Hour Care	41	80		465
Other			11,573	
Column Total, Duplicated Across Services	18,833	29,374	24,646	12,418
Total Unduplicated Count Across Services		20,856		9,936

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

possible sources: the state vocational rehabilitation agency and the U.S. Department of Education’s (DOE) Office of Special Education and Rehabilitative Services. For this project, states were encouraged to use the data from their state’s vocational rehabilitation agency because these data were current, within the reporting time frame, and more complete in that they included both open and closed cases. Data from the DOE contains only closed cases, and expenditures reported are for the lifetime of the case.

Six states reported data gathered from their respective state vocational rehabilitation offices. However, states took different approaches to identifying expenditures and the counts of consumers. One state identified mental health and related expenditures through vocational rehabilitation-funded services provided by SMHA-funded community mental health centers (CMHCs). Another state used probabilistic matching to identify expenditures for consumers in both its SMHA and its vocational rehabilitation agency. (See Appendix C for an explanation of probabilistic matching.) Yet another state reported matching of its vocational rehabilitation database to the SMHA community-based programs and state hospital databases. Data from vocational rehabilitation agencies are shown in Table 9.

Except for one state, expenditures for both children and adults who were eligible to receive vocational rehabilitation services because of a psychiatric disability were proportionately higher than expenditures for children and adults whose eligibility was the result of a nonpsychiatric disability but who still received mental health services (e.g., people for whom mental illness was a secondary diagnosis).

3.1.3.2 Sources of Mental Health Revenue for Vocational Rehabilitation Agencies

Five states reported data on the sources from which their vocational rehabilitation agencies received funding to cover mental health and related support services. One state provided no breakdown for children and adults, while another state was able to report sources for only a portion of total expenditures (see Table 10). “Other Federal funds” accounted for the vast majority of vocational rehabilitation agencies’ mental health resources.

3.1.3.3 Mental Health Consumers Served by Vocational Rehabilitation Agencies

Three of the six reporting states were able to provide unduplicated counts of consumers served. The type of service most frequently provided by these agencies was “vocational rehabilitation training.”

3.1.4 *Child Welfare Agencies*

3.1.4.1 Expenditures on Mental Health and Related Support Services by Child Welfare Agencies

Five states reported data from their child welfare agencies, and the expenditures showed a wide range—from \$860,000 to \$60 million. One state limited expenditures primarily to allowable Medicaid services; it excluded some state-funded and other grant-funded mental health services. Another state included both Medicaid and non-Medicaid expenditures in its reporting. The only way some states were able to count children served by child welfare was by matching the child welfare list to the SMHA list. This limited the data to children served by both the SMHA and child welfare and excluded children served only by child welfare. This

Table 9. Expenditures on Mental Health and Related Support Services by Vocational Rehabilitation Agencies, by Age, Type of Service, and Disability

Population	State 1	State 2	State 5	State 6	State 7	State 9
Eligible for Vocational Rehabilitation (VR) due to Psychiatric Disability						
Children (<18)						
Supported Employment	\$513		\$18,762	\$157,702	\$235	\$71,515
VR Training	\$13,772	\$696	\$575,658	\$1,063,616	\$49,058	\$309,773
Others	\$22,153		\$28,805			\$283,364
Column Subtotal	\$36,438	\$696	\$623,225	\$1,221,318	\$49,293	\$664,652
Adults (>18)						
Supported Employment	\$288,248	\$5,121,949	\$195,143	\$5,159,588	\$349,169	\$839,173
VR Training	\$1,186,913	\$3,193,915	\$3,627,577	\$17,232,017	\$3,736,705	\$4,532,049
Others	\$1,071,447	\$1,195,464	\$602,696		\$29,267	\$3,602,423
Column Subtotal	\$2,546,608	\$9,511,328	\$4,425,416	\$22,391,605	\$4,115,141	\$8,973,645
Total Eligible for VR due to Psychiatric Disability	\$2,583,046	\$9,512,024	\$5,048,641	\$23,612,923	\$4,164,434	\$9,638,297
Eligible for VR due to Nonpsychiatric Disability (Receiving Mental Health Services)						
Children (<18)						
Supported Employment			\$44,174		\$3,495	
VR Training		\$484	\$496,523	\$69,377	\$90,385	
Others			\$3,353		\$96,073	\$2,258
Column Subtotal		\$484	\$544,050	\$69,377	\$189,953	\$2,258
Adults (>18)						
Supported Employment	\$53,159		\$289,037	\$458,601	\$306,931	\$8,550
VR Training	\$26,231	\$740,637	\$2,326,269	\$5,337,471	\$15,789,149	\$32,994
Others	\$111,364	\$63,140	\$1,272,149			\$163,445
Column Subtotal	\$190,754	\$803,777	\$3,887,455	\$5,796,072	\$16,096,080	\$204,989
Total Eligible for VR due to Nonpsychiatric Disability	\$190,754	\$804,261	\$4,431,505	\$5,865,449	\$16,286,033	\$207,247
Column Grand Total, Children	\$36,438	\$1,180	\$1,167,275	\$1,290,695	\$143,173	\$666,910
Column Grand Total, Adults	\$2,737,362	\$10,315,105	\$8,312,871	\$28,187,677	\$20,307,294	\$9,178,634

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

Table 10. Sources of Mental Health Revenue for Vocational Rehabilitation Agencies

Population	State 1	State 2	State 6	State 7	State 9
SMHA					
Eligible for Vocational Rehabilitation (VR) due to Psychiatric Disability					\$75,000
Adults (>18)					
Other State Funds					
Eligible for VR due to Psychiatric Disability					
Children (<18)	\$7,288	\$148	\$244,264		\$141,571
Adults (>18)	\$509,322	\$2,025,913	\$4,478,321		\$1,895,411
Column Subtotal	\$516,610	\$2,026,061	\$4,722,585		\$2,036,982
Eligible for VR due to Nonpsychiatric Disability (Receiving Mental Health Services)					
Children (<18)		\$103	\$13,875		\$481
Adults (>18)	\$38,151	\$171,205	\$1159,214		43663
No Breakdown				\$843,346	
Column Subtotal	\$38,151	\$171,308	\$1173,089	\$843,346	\$44,144
Other Federal Funds					
Eligible for VR due to Psychiatric Disability					
Children (<18)	\$29,151	\$548	\$977,054		\$523,083
Adults (>18)	\$2,037,287	\$7,485,416	\$17,913,284		\$7,003,234
Column Subtotal	\$2,066,438	\$7,485,964	\$18,890,338		\$7,526,317
Eligible for VR due to Nonpsychiatric Disability (Receiving Mental Health Services)					
Children (<18)		\$381	\$55,502		\$1,777
Adults (>18)	\$152,603	\$632,573	\$4,636,858		\$161,326
No Breakdown				\$16,160,468	
Column Subtotal	\$152,603	\$632,954	\$4,692,360	\$16,160,468	\$163,103
Local/County Funds					
No Breakdown				\$3,446,652	
Column Grand Total, Children	\$36,439	\$1,180	\$1,290,695		\$666,912
Column Grand Total, Adults	\$2,737,363	\$10,315,107	\$28,187,677		\$9,103,634
Grand Total, No Breakdown				\$20,450,466	
Overall Total	\$2,773,802	\$10,316,287	\$29,478,372	\$20,450,466	\$9,770,546

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

Table 11. Number of Mental Health Consumers Served by Vocational Rehabilitation Agencies, by Age, Type of Service, and Disability

Population	State 1	State 2	State 5	State 6	State 7	State 9
Eligible For Vocational Rehabilitation (VR) due to Psychiatric Disability						
Children (<18)						
Supported Employment	5		31	22	3	30
VR Training	11	1	877	604	325	255
Others	20					368
Column Subtotal (Children); Duplicated Across Services	36	1	908	626	328	653
Total Unduplicated Consumers Across Services (Children)	22	1		605		
Adults (>18)						
Supported Employment	845	3,841	329	596	943	354
VR Training	657	5,176	6,102	4,011	5,631	3,008
Others	1,493	1,930			10	4,823
Column Subtotal (Adults); Duplicated Across Services	2,995	10,947	6,431	4,607	6,584	8,185
Total Unduplicated Count Across Services (Adults)	1,940	4,783		4,049		
Grand Total, Duplicated Across Services due to Psychiatric Disability (Children and Adults)	3,031	10,948	7,339	5,233	6,912	8,838
Total Unduplicated Count Across Services due to Psychiatric Disability (Children and Adults)	1,962	4,784		4,654		
Eligible for VR due to Nonpsychiatric Disability (Receiving Mental Health Services)						
Children (<18)						
Supported Employment			73		4	
VR Training		1	791	39	586	
Others						2
Column Subtotal (Children), Duplicated Across Services*		1	864	39	590	2
Total Unduplicated Count Across Services (Children)		1		39		2
Adults (=>18)						
Supported Employment	44		518	55	557	3
VR Training	11	1,891	3,831	943	10,683	21
Others	25	148			179	79
Column Subtotal (Adults), Duplicated Across Services*	80	2,039	4,349	998	11,419	103
Total Unduplicated Count Across Services (Adults)	80	1,964		947		69
Grand Total, Duplicated Across Services due to Nonpsychiatric Disability (Children and Adults)	80	2,040	5,213	1,037	12,009	105
Total Unduplicated Count Across Services due to Nonpsychiatric Disability (Children and Adults)	80	1,965		986		
Overall Total, Duplicated Across Services	3,111	12,988	12,552	6,270	18,921	8,943

Note: Blank spaces indicate the state(s) did not report data for this category to the USA Project.

Table 12. Expenditures on Mental Health and Related Support Services by Child Welfare Agencies, by Type of Service

Population/Services	State 1	State 2	State 6	State 7	State 9
Child Welfare					
Inpatient Hospital			\$2,390		
Less than 24-Hour Care			\$226,834		
Pharmacy			\$2,273,280		
Other 24-Hour Care			\$25,785,112	\$60,298,900	
Other	\$7,778,038	\$25,557,755			\$860,190
Column Total	\$7,778,038	\$25,557,755	\$28,287,616	\$60,298,900	\$860,190

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

Table 13. Sources of Mental Health Revenue for Child Welfare Agencies

Agency/Sources	State 6	State 9
Child Welfare		
Other State Funds	\$235,492	\$860,190
Medicaid	\$28,052,123	
Column Total	\$28,287,615	\$860,190

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

process no doubt underestimates the actual number of children and adolescents the child welfare agency served.

3.1.4.2 Sources of Mental Health Revenue for Child Welfare Agencies

Only two of the five states were able to provide data on revenue sources for the mental health services of their child welfare agencies. For one state, Medicaid was the primary source of funding, while the second state's sole revenue source was "other state funds" (see Table 13).

3.1.4.3 Mental Health Consumers Served by Child Welfare Agencies

All five states reported counts of consumers who received services through child welfare agencies. The count reached a high of 5,145 (duplicated) or a low of 274

(unduplicated). Of these five states, three were able to report unduplicated counts of consumers who received services (see Table 14).

3.1.5 Criminal Justice/Corrections Agencies

State departments of criminal justice/corrections serve adults in prisons, and in some cases adults in jails as well as those on parole or probation. In some states, however, jails, parole, and probation are run by local governments and therefore were outside the scope of the OSA Project. The place where services are provided to persons in correctional settings may also differ from state to state. For example, in some states, inpatient care may be provided in a certified psychiatric hospital facility other than the corrections facility, while in other states, inpatient care may be provided within the correctional facilities that have designated medical and/or psychiatric units. This makes comparison of costs per patient and other data challenging.

For the OSA Project, state departments of criminal justice/corrections were the primary sources of data on expenditures and consumers served in the criminal justice/corrections systems. Five of the nine states reported data, although for different settings.

Table 14. Number of Mental Health Consumers Served by Child Welfare Agencies, by Type of Service

Agency/Services	State 1	State 2	State 6	State 7	State 9
Child Welfare					
Inpatient Hospital			1		
Less than 24-Hour Care			935		
Pharmacy			1,885		
Other 24-Hour Care			2,324	2,423	
Other	306	1,189			274
Column Total, Duplicated Within/Across Services	306		5,145	2,423	
Total Unduplicated Count Across Services		1,189	3,984		274

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

Most states reported data on prisons, and only one state reported data from prisons, jails, and parole.

3.1.5.1 Expenditures on Mental Health and Related Support Services by Criminal Justice/Corrections Agencies

The mental health and related expenditures for state prisons ranged from \$15 million to about \$31 million. In three of the four states, the majority of expenditures in prisons were accounted for by “professional personnel” (see Table 15).

3.1.5.2 Sources of Mental Health Revenue for Criminal Justice/Corrections Agencies

Only two of the five states were able to report sources of revenues. One state reported “other state funds” as the source of revenue, while the other state reported “other Federal funding” and “local/county funds” (see Table 16).

3.1.5.3 Mental Health Consumers Served by Criminal Justice/Corrections Agencies

All five states were able to report counts of consumers by service types. However, only two were able to provide an unduplicated count of consumers who received any mental

health and related services in prison, and two reported unduplicated counts for services provided in jail and parole offices (See Table 17).

Data for the number of consumers were typically, but not always, unduplicated counts within each service type, but they were usually duplicated counts across service types.

Exactly which consumers were counted by the criminal justice/corrections agencies varied from one state to another. For example, state 2 data included about 11,000 persons with co-occurring mental health and substance use disorders, as well as some persons with only a mental health diagnosis. State 4 data included all inmates treated in the mental health units of the state’s criminal justice/corrections agency, regardless of their diagnoses. State 7 data included all mental health treatment services provided by the state’s criminal justice/corrections agency to inmates, whether or not they had a diagnosed mental illness.

The method of identifying persons with mental illnesses also differed across states. State 9, for example, used a database that links criminal justice/corrections, SMHA,

Table 15. Expenditures on Mental Health and Related Support Services by Criminal Justice/ Corrections Agencies, by Setting and Type of Service

Criminal Justice Setting/Services	State 2	State 3	State 4	State 7	State 9
Prisons					
Inpatient Hospital	\$206,448		\$6,953,000	\$2,889,561	\$3,042,000
Less than 24-Hour Care					\$1,056,000
Professional Personnel	\$4,795,609		\$17,332,000	\$7,131,938	\$17,613,000
Pharmacy	\$8,521,309		\$6,981,000	\$4,223,384	\$1,428,971
Other	\$1,055,033				\$8,026,000
Column Subtotal	\$14,578,399		\$31,266,000	\$14,244,883	\$31,165,971
Jails					
Inpatient Hospital		\$563,918			\$147,281
Less than 24-Hour Care		\$1,392,667			\$19,453
Professional Personnel		\$4,083,240			
Pharmacy		\$500,000			
Column Subtotal		\$6,539,825			\$166,734
Parole					
Inpatient Hospital					\$833,553
Less than 24-Hour Care					\$378,780
Professional Personnel					\$554,525
Other					\$81,368
Column Subtotal					\$1,848,226
Column Grand Total	\$14,578,399	\$6,539,825	\$31,266,000	\$14,244,883	\$33,180,931

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

Table 16. Sources of Mental Health Revenue for Criminal Justice/Corrections Agencies, by Setting

Sources/Criminal Justice Setting	State 3	State 9
Other State Funds		
Prisons		\$32,576,000
Jails		\$166,734
Paroles		\$1,848,000
Column Subtotal		\$34,590,734
Other Federal Funds		
Jails	\$1,382,962	
Local/County Funds		
Jails	\$5,156,863	
Column Grand Total	\$6,539,825	\$34,590,734

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

and state hospital data, while states 2, 4, and 7 used either “services provided” data or counted persons who participated in the mental health program of the criminal justice/corrections’ agencies.

3.1.6 Education Agencies

Four states reported data for their education agencies’ spending on mental health and related support services, as well as the number of consumers they served. Unfortunately, aggregated state-level data on mental health expenditures were not available, but these data could have been collected at the school district level, or in some cases, at the school level. One state

Table 17. Number of Mental Health Consumers Served by Criminal Justice/Corrections Agencies, by Setting and Type of Service

Criminal Justice Setting/Services	State 2	State 3	State 4	State 7	State 9
Prisons					
Inpatient Hospital	90		730	287	368
Less than 24-hour Care	6,550				505
Professional Personnel				6,700	6,073
Pharmacy	6,000		7,439	4,725	2,827
Column Total, Duplicated Across Services	12,640		8,169	11,712	9,773
Unduplicated Count Across Services	6,550				6,073
Jails					
Inpatient Hospital		240			32
Less than 24-Hour Care		7,360			9
Pharmacy		1,712			
Others					3,875
Column Total, Duplicated Across Services		9,312			3,916
Unduplicated Count Across Services		7,600			3,875
Parole					
Inpatient Hospital					357
Less than 24-Hour Care					10,874
Professional Personnel					10,874
Column Total, Duplicated Across Services					22,105
Unduplicated Count Across Services					10,874
Column Total, Duplicated Across Services	12,640	9,312	8,169	11,712	35,794
Total Unduplicated Count Across Services		7,600			20,822

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

Table 18. Expenditures on Mental Health and Related Support Services by Education Agencies, by Type of Service

Population/Services	State 2	State 4	State 5	State 6
Education				
Less than 24-Hour Care	\$1,854,793	\$902,902	\$15,910,423	\$732,253
Other 24-Hour Care	\$5,978,059			
Column Total	\$7,832,852	\$902,902	\$15,910,423	\$732,253

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

used the Medicaid claims file to identify mental health expenditures provided through schools. Another state used aggregate numbers from the state department of education’s special education tracking system. The other two states did not provide information on the methods and data sources they used.

3.1.6.1 Expenditures on Mental Health and Related Support Services by Education Agencies

All four states reported “less than 24-hour care” and “other 24-hour care” as the types of mental health services provided by schools. Total expenditures ranged from

\$732,000 to \$16 million (see Table 18). One state reported expenditures based only on mental health claims filed by schools for Medicaid reimbursement, while another state was able to report only expenditures for children with Individual Education Plans (IEPs).

3.1.6.2 Sources of Mental Health Revenue for Education Agencies

Of the four reporting states, only two were able to provide funding sources. One state reported only Medicaid-funded services, while the other reported several sources of funds (see Table 19).

3.1.6.3 Mental Health Consumers Served by Education Agencies

All four reporting states provided counts of consumers served (see Table 20). As noted

earlier, one state used Medicaid data to identify mental health expenditures claimed by schools. Therefore, its data were limited to Medicaid-funded, school-based services. Another state used aggregate data by disability type, which was submitted by school districts on children with an IEP. Both approaches had limitations. One state's data were underreported because some of its mental health services in schools were funded by sources other than Medicaid. In the other state, data were probably overreported because all children with a disability who have an IEP, not just children with SED, would have been counted.

3.1.7 Housing Agencies

While providing housing is not a mental health treatment service, housing agencies were included in the OSA Project because

Table 19. Sources of Mental Health Revenue for Education Agencies

Agency/Sources	State 5	State 6
Education		
Other State Funds	\$3,605,353	
Medicaid	\$2,446,943	\$732,253
Other Federal Funds	\$5,766,295	
Local/County Funds	\$4,091,832	
Column Total	\$15,910,423	\$732,253

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

Table 20. Number of Mental Health Consumers Served by Education Agencies

Agency/Services	State 2	State 4	State 5	State 6
Education				
Less than 24-Hour Care		38,965	35,965	
Other 24-Hour Care				
Column Total, Duplicated		38,965	35,965	
Total Unduplicated Count Across Services	144			1,636

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

they provide critical support services for people with mental illnesses. It is a daunting task to try to gather housing data at the state level because the information is spread across multiple grantees funded by HUD. However, housing data may be derived more easily from two sources—either HUD’s new Supportive Housing Program (SHP) or all other Federal and state housing programs. One state identified HUD’s new Homeless Management Information System (MIS) as a potential source of housing assistance data for people with mental illnesses, but this system was not used in the OSA Project. In the future, this new system will enable states to access state data at the Federal level.

Only three of the nine states reported housing data. Two states reported data from

the SHP, and one reported data from non-SHP programs. Some states reported that the requested data were not available, while in other states, the director of the housing agency did not wish to participate in the OSA Project.

3.1.7.1 Expenditures on Mental Health and Related Support Services by Housing Agencies

Reported housing expenditures ranged from \$1 million to \$8 million (see Table 21).

3.1.7.2 Sources of Mental Health Revenue for Housing Agencies

All three states reported “other Federal funds” as their sole source of funding for mental health support services (see Table 22).

Table 21. Expenditures on Mental Health and Related Support Services by Housing Agencies

Agency/Services	State 2	State 7	State 9
Housing			
SHP Housing Structure	\$1,072,400	\$8,481,384	
Non-SHP Housing Structure			\$3,169,504
Total	\$1,072,400	\$8,481,384	\$3,169,504

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

Table 22. Sources of Mental Health Revenue for Housing Agencies

Agency/Sources of Funds	State 2	State 7	State 9
Housing			
Other Federal Funds	\$1,072,400	\$8,481,384	\$3,169,504

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

Table 23. Number of Mental Health Consumers Served by Housing Agencies

Agency/Services	State 2	State 7	State 9
Housing			
SHP Housing Structure	331	1,528	
Non-SHP Housing Structure			802
Total Duplicated			802
Total Unduplicated Count	331	1,528	

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

Table 24. Expenditures on Mental Health and Related Support Services by Juvenile Justice Agencies

Agency/Services	State 3	State 6	State 7	State 9
Juvenile Justice				
Inpatient Hospital		\$59,012		\$938,586
Less than 24-Hour Care		\$1,511,611	\$1,884,442	\$4,978,515
Other 24-Hour Care		\$4,184,038	\$9,094,001	\$1,871,161
Other	\$2,655,152	\$262,866		\$221,220
Column Total	\$2,655,152	\$6,017,527	\$10,978,443	\$8,009,482

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

3.1.7.3 Mental Health Consumers Served by Housing Agencies

All three states reported the number of consumers served (see Table 23).

3.1.8 Juvenile Justice Agencies

3.1.8.1 Expenditures on Mental Health and Related Support Services by Juvenile Justice Agencies

Four states reported data on mental health and related support expenditures provided by their juvenile justice agency. Total expenditures ranged from less than \$3 million to almost \$11 million. As shown in Table 24, expenditures were distributed across four types of services. Two of the states spent the majority of their funds providing “other 24-hour care,” while one state provided more services in the “less than 24-hour care” category.

In cases where a child was served by both the child welfare agency and the juvenile justice agency at the same time, some of the juvenile justice expenditures might have been listed under the child welfare agencies. There was no reported algorithm for splitting the expenditures. This approach may understate the expenditures of an OSA.

3.1.8.2 Sources of Mental Health Revenue for Juvenile Justice Agencies

Only three of the four reporting states were able to report their sources of mental health funding, and as Table 25 shows, the only sources they reported were “Medicaid” and “other state funds.” One state reported possible underreporting of expenditures because mental health services funded via sources other than these two categories were not included. In another state,

Table 25. Sources of Mental Health Revenue for Juvenile Justice Agencies

Agency/Sources	State 6	State 7	State 9
Juvenile Justice			
Other State Funds	\$328,431	\$4,102,424	\$3,145,569
Medicaid	\$5,689,096	\$4,991,576	\$4,863,913
Column Total	\$6,017,527	\$9,094,000	\$8,009,482

Note: Blank spaces indicate the state(s) did not report data for this category to the USA Project.

Table 26. Number of Mental Health Consumers Served by Juvenile Justice Agencies, by Type of Service

Agency/Services	State 6	State 7	State 9
Juvenile Justice			
Inpatient Hospital	16		
Less than 24-Hour Care	4,136		583
Other 24-Hour Care	466	677	629
Other	243		
Column Total, Duplicated Across Services	4,861	677	1,212
Total Unduplicated Count Across Services	4,341		

Note: Blank spaces indicate the state(s) did not report data for this category to the USA Project.

underreporting of expenditures was likely because the files of its juvenile justice agency contained mental health data only on consumers who received either psychotropic medications or services from mental health professionals.

3.1.8.3 Mental Health Consumers Served by Juvenile Justice Agencies

The capacity to provide consumer count by service types differed across states. One state reported that the absence of a unique mental health identifier in the juvenile justice database meant they had to rely on program-level data. Although expenditure data were reported for a particular service type, the count of consumers receiving such service was not provided in some cases (see Table 26).

3.1.9 Early Intervention Agencies or Programs

Early intervention programs provide mental health services to children aged 0 to 3, or in some states, 0 to 5 years old. The programs are usually located in either the state department of health or the state department of education. Three of the nine participating states reported data on their early intervention programs.

The three states used different approaches to identifying expenditures and consumers served. For example, one state used data from its Medicaid files. Another state used the CMHC databases. This procedure limited the reporting of expenditures and consumers to existing mental health consumers in the CMHC databases and

Table 27. Expenditures on Mental Health and Related Support Services by Early Intervention Agencies or Programs

Agency/Services	State 5	State 6	State 9
Early Intervention			
Less than 24-Hour Care	\$61,420	\$84,411	
Other	\$1,960,047		\$1,086,997
Column Total	\$2,021,467	\$84,411	\$1,086,997

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

excluded consumers receiving services from other early intervention sources. These approaches mean that both states probably spent more and served more consumers than they were able to report.

3.1.9.1 Expenditures on Mental Health and Related Support Services by Early Intervention Agencies or Programs

Expenditures across the three reporting states ranged from \$84,000 to \$2 million. One state did not have the ability to provide a service breakdown, while the other two states reported only two service types: “less than 24-hour care” and “other” (see Table 27).

3.1.9.2 Sources of Mental Health Revenue for Early Intervention Programs

Only two of the three states reported sources of funds. One state reported

Table 28. Sources of Mental Health Revenue for Early Intervention Programs

Agency/Sources	State 6	State 9
Early Intervention		
Other State Funds		\$1,086,997
Medicaid	\$84,411	
Column Total	\$84,411	\$1,086,997

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

“Medicaid” as the source of its early intervention mental health funds, while the other state said that “other state funds” was its source of revenue (see Table 28).

3.1.9.3 Mental Health Consumers Served by Early Intervention Agencies or Programs

Two of the three states were able to report unduplicated consumer counts (see Table 29).

3.1.10 Substance Abuse Agencies/Offices

Only two states reported data on mental health and related support services provided by state substance abuse agencies/offices. Of the procedures and protocols developed for the OSA Project, those designed for the substance abuse agencies/offices proved to be among the most challenging during implementation. The focus of the OSA Project was to identify expenditures and consumers served by state agencies other than the SMHA. However, five of the nine participating states have integrated their mental health and substance abuse services into a single agency. Since these states did not have separate substance abuse agencies from which to gather data, the procedures and protocol developed for the OSA Project were not appropriate. Program developers said that substantial revision of the procedures and protocol was needed to help states determine how much they were

Table 29. Number of Mental Health Consumers Served by Early Intervention Programs

Agency/Services	State 5	State 6	State 9
Early Intervention			
Less than 24-Hour Care		186	
Other			400
No Breakdown	853		
Column Total, Duplicated	853		400
Total Unduplicated Count	304	186	

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

spending on services for people with both mental illnesses and substance use disorders and what types of services they were providing.

3.1.10.1 Expenditures on Mental Health and Related Support Services by Substance Abuse Agencies/Offices

The two states that were able to report substance abuse data used their funds on two types of services: “pharmacy” and “less than 24-hour care” (see Table 30).

3.1.10.2 Sources of Mental Health Revenue for Substance Abuse Agencies/Offices

The source of funds in both states was “other state funds” (see Table 31).

Table 30. Expenditures on Mental Health and Related Support Services by Substance Abuse Agencies/Offices, by Type of Service

Agency/Services	State 5	State 9
Substance Abuse		
Less than 24-Hour Care		\$75,000
Pharmacy	\$141,283	
Total	\$141,283	\$75,000

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

3.1.10.3 Mental Health Consumers Served by Substance Abuse Agencies/Offices

The consumers of interest to the substance abuse agencies/offices werethose who have co-occurring mental health and substance use disorders. Only one of the two reporting states was able to identify the count of consumers with co-occurring disorders by type of service they received (see Table 32).

Table 31. Sources of Mental Health Revenue for Substance Abuse Agencies/Offices

Agency/Sources	State 9
Substance Abuse	
Other State Funds	\$75,000

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

Table 32. Number of Mental Health Consumers Served by Substance Abuse Agencies/Offices

Agency/Services	State 5	State 9
Substance Abuse		
Less than 24-Hour Care		
Pharmacy	103	
Total Unduplicated Count	103	7,486

Note: Blank spaces indicate the state(s) did not report data for this category to the OSA Project.

3.2 Limitations of the OSA Data

Caution should be used in interpreting the data from the OSA Project because of the limitations described below.

3.2.1 Possible Underreporting of Data

In some agencies, the existing data systems lacked information necessary to identify all mental health consumers. If an OSA did not have an identifier that indicated a person received mental health services, the state had to match the OSA client records with the SMHA client database and thereby determine the number of SMHA clients who were also served by the OSA. Consumers who received mental health services from the OSA who were not also served by the SMHA would not be identified, and the total consumer count would underestimate the actual total number of people served. Interestingly, in a few cases, the lack of mental health identifiers might actually have led to overreporting if clients who actually had a developmental or other disability were counted as “consumers.” Furthermore, differences in service accounting definitions and categories were possible sources of underreporting.

3.2.2 Possible Overreporting of Medicaid Funding

Medicaid was found to be a major funding source for many of the OSAs such as child welfare and juvenile justice. In these cases, if an analyst added up total expenditures of OSAs, Medicaid could be counted multiple times (both in the Medicaid expenditures and in the other OSA expenditures). Some states found it difficult to identify unique individuals who were included in both Medicaid and the OSA data file. If the OSA data system lacked unique consumer

identifiers, the state was not able to identify mental health services if they were not funded by Medicaid. Most states simply did not have the time and technical resources necessary to unduplicate these data.

3.2.3 Variability in OSA Capacity to Track Mental Health and Related Support Services

The capacity of each OSA to report mental health and related support service expenditures varied greatly. If the OSA had provisions for these services built into its budget, it was better able to track its expenditures. Medicaid was the OSA that most closely resembled the SMHAs’ method of tracking mental health expenditures and consumers, and all nine states were able to report data for Medicaid.

- Other OSAs, particularly those such as early intervention and education that serve a broad population, may not track people according to specific disabilities such as “mental illness.” Rather, they may include people with mental illnesses under a broader category of “special needs” or “disability.” When this is the case, it is impossible to know from state databases what the actual funding is for mental health and related support services.
- Differences in reported expenditures across states may therefore be attributed to variation in OSA capacity to track and report mental health expenditures and not necessarily to actual differences in expenditures. All states agreed there is a continuing need for interagency alignment of technology as well as definitions of services and consumers.

3.2.4 Incomplete Reporting

Only three states were able to report data from all nine of their OSAs, and some states were not able to provide expenditure data categorized by service type. Some OSAs were not able to report revenue sources.

3.2.5 Difficulty Collecting Unduplicated Counts of Mental Health Consumers

The technical difficulty and time required to determine unduplicated counts of consumers across service setting and service types posed an extremely difficult challenge to several states. They varied in their ability to conduct unduplicated counts of consumers both within and across state agencies (see Table 33).

Column 2 of Table 33 shows the number of states that were able to report unduplicated counts of consumers within a single OSA. For example, for Medicaid, six states were able to develop an unduplicated count of the number of consumers who received Medicaid-funded mental health services.

3.2.6 Difficulty Determining Mental Health Consumer Overlap

Determining the magnitude of overlap between persons served by the OSAs and the SMHA required considerable time, staff expertise, and advanced technical skills, and only five states were able to report these data. Two states reported the overlap between the SMHA and Medicaid, and one state reported the overlap between the SMHA and vocational rehabilitation. The remaining two states reported the overlap between the SMHA and six OSAs. The consumer overlap in these two states is illustrated in Figure 2.

Table 33. Number of States Reporting Unduplicated Counts of Consumers Across Service Types Within OSA

Agency	Number of States Reporting Unduplicated Counts of Mental Health Consumers Across Service Types Within OSA
Criminal justice	3
Medicaid	6
Vocational Rehabilitation	4
Housing	1
Education	2
Child Welfare	2
Juvenile Justice	1
Substance Abuse	1
Early Intervention	2
SCHIP	2

The two states used different approaches to determine consumer overlap. One state used probabilistic matching within the Medicaid consumer database, while the other state used direct consumer file matching between the SMHA and the OSA. (See Appendix C for details of these two different approaches.)

With the use of advanced technology, a state data warehouse that included data from various state agencies enabled one state to determine consumers receiving services across service systems. Table 34 portrays the data generated by this particular state.

3.3 Chapter Summary

The data presented in this chapter provide insight into the role of participating OSAs in the delivery of mental health and related support services and the number of consumers currently being served by OSAs. The intrinsic value of the OSA Project is not so much the data that were identified per se.

Figure 2. Determining Mental Health Consumer Overlap (i.e., Common Consumers) Between the SMHA and an OSA

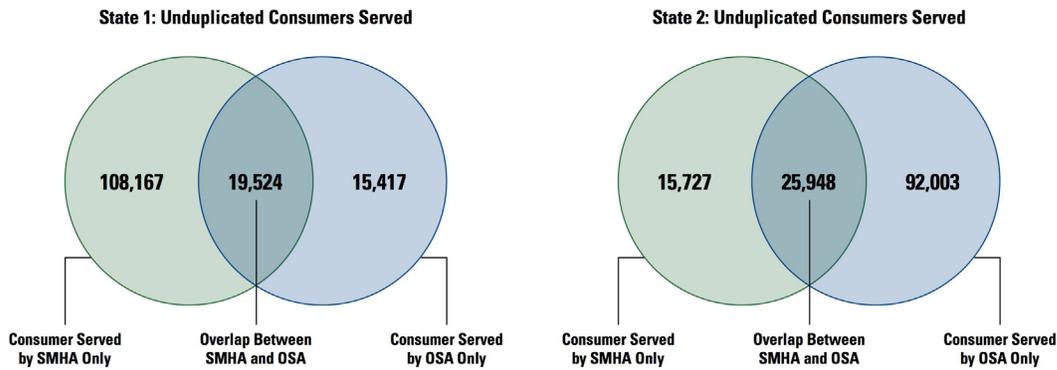


Table 34. Determining Mental Health Consumer Overlap Using a State Data Warehouse

Overlap	SMHA	Corrections	Medicaid	Child Welfare	Juvenile Justice	Education	Vocational Rehab	TANF	One Agency Only
SMHA	41,675		16,116	366	2,825	80	1,394	5,167	24,761
Corrections	NA	NA	NA	NA	NA	NA	NA	NA	NA
Medicaid			104,767	3,958	4,265	1,636	1,326	51,915	40,072
Child Welfare				3,984	70	78	22	3,685	26
Juvenile Justice					4,341	17	182	1,531	71
Education						1,636	10	1,128	-
Vocational Rehabilitation							5,478	371	3,351
TANF								51,915	-
One Agency Only									68,281

Note: This table shows, for example, that the total number of consumers who received mental health services from Medicaid was 104,767. It further shows that consumers received Medicaid-funded mental health services through various government agencies. That is, 16,116 consumers are receiving Medicaid-funded services from the SMHA; 3,958 are receiving such services in child welfare; 4,265 in juvenile justice; 1,636 in education; and 1,326 in vocational rehabilitation. The last column shows that 40,072 consumers are served by Medicaid alone (i.e., they do not receive Medicaid-funded services from other agencies).

Rather, the OSA Project constitutes a significant first step in helping states pinpoint where their limited resources can be best directed to improve data collection across state agencies to develop a more rational plan for the provision of services to mental health consumers and their families.

IV. Conclusions

The OSA Project was the first cooperative, multistate project to use standard procedures and protocols to identify OSA mental health expenditures and resources and the number of mental health consumers served. In the course of the project, two messages came through clearly: Agencies other than SMHAs are providing a substantial amount of mental health and related support services, and the type of information generated by the project could be of considerable benefit to policymakers as they allocate statewide resources to serve mental health consumers and their families more effectively. Key conclusions that may be drawn from the project follow.

- The OSA Project demonstrated it is feasible to share data across state agencies that serve mental health consumers. The value of the completed OSA Project is not so much the data identified by the different states. Rather, the project is valuable as an important first step in developing a more consistent means of charting where people receive mental health services and supports, where the funds for these services come from, and where they are being spent. The report opens a window into the types of services provided and the populations treated.
- Participating states reported significant benefits from the project, and they indicated these benefits outweighed the multiple difficult challenges of the project. The states indicated that knowing what agencies other than their SMHAs are spending on mental health and related support services and how many consumers the agencies are serving could eventually help policymakers improve the development and implementation of comprehensive SMHPs and enable them to use their limited state funds more efficiently and effectively. Moreover, dialogue between the SMHAs and OSAs continues in many of the states, and some have begun new collaborative projects as a result of this initiative.
- Participating states found that current OSA accounting practices and data systems often did not lend themselves to an easy and straightforward identification of mental health and related support services or the number

of consumers OSAs served. Determining unduplicated counts of consumers and the magnitude of overlap among consumers served by the OSAs and the SMHAs required considerable time, staff expertise, and advanced technical skills.

- States with data warehouses that routinely combined client and service data from multiple state agencies found them to be extremely useful. The warehouses enabled them to generate and analyze complex data for policymakers and generate cross-agency reports that provided a broad overview of state-funded programs. The states indicated that warehouses would have been even more useful if they had an official interpretation of the Health Insurance Portability and Accountability Act (HIPAA) that all OSAs could have adopted. A standard interpretation would facilitate the execution of data sharing agreements across agencies and thereby facilitate data exchanges.
- The role of Medicaid in the funding of mental health services cannot be overestimated. As both a direct funder of mental health services and a funding source for OSAs, Medicaid is the state governments' major mental health resource. During the time frame of this project, Medicaid paid for over half of the participating SMHAs' mental health and related support services in some states and for an even greater share in some OSAs such as child welfare.
- Medicaid's dual positions as a direct funder of services and a resource for

OSAs made it difficult to distinguish between which services Medicaid funded directly and which services it funded through OSAs. Moreover, the services Medicaid covers vary from one state to the next, which further complicated data analysis. This situation was alleviated somewhat because an earlier SAMHSA/CMHS-funded analysis of Medicaid data facilitated the identification of mental health services within Medicaid (Whalen, Pepitone, Graver, & Busch, 2000), and Medicaid-paid claims and pharmacy data are becoming increasingly available to SMHAs to analyze and link with their consumer data. Each state in the project developed its own unique method of analyzing and matching Medicaid data to SMHA data.

- Criminal justice/corrections agencies in this project served the largest number of consumers of any of the OSAs except Medicaid. As a result of the rules in the protocol that focused on counting only mental health service expenditures for these individuals (and excluding costs of incarceration such as meals, uniforms, housing, etc.), the identified expenditures for these persons appeared relatively low. If the costs of incarceration were included, the mental health impact on the criminal justice system would be much larger. In most states, the substantial expenditures for mental health services in local jails and detention centers were excluded because they are paid for by city and county governments rather than by state governments. Several participating states recommended expansion of

future OSA projects to include city and county government expenditures for criminal justice/corrections and education.

- For future projects, participating states recommended that several additional OSAs and Federal agencies be included such as developmental disabilities agencies and Veterans Affairs and National Guard agencies. If the latter agencies collaborated with the U.S. Department of Veterans Affairs and the U.S. Department of Defense around mental health services, they could provide a more comprehensive view of how the mental health needs of veterans and active duty military personnel are being met across multiple systems.
- Participating states said that future OSA projects might use Federal data systems to analyze and link SMHA and OSA data. The systems might include, but not be limited to, vocational rehabilitation data sets (RSA 911) maintained by the Department of Education, housing data sets maintained by HUD, and data on mental health services provided by the

Department of Veterans Affairs and the Department of Defense.

- Participants further thought it would be helpful if data standards and definitions were made more uniform across Federal, state, and local agencies
- Finally, states indicated that linking OSA data to consumer outcomes was beyond the scope of this project, but participating states could begin to move toward this important goal.

In sum, all participating states believed the OSA Project was an essential first step toward using their limited resources more efficiently and creating truly comprehensive mental health systems. They indicated the data would help policymakers pinpoint where funds could be best directed to develop more rational SMHPs that increase cooperation and interagency planning and decrease fragmentation. The states also found the experience of working collaboratively, though not always easy, was ultimately valuable, and in some cases, it paved the way for future collaborative projects. All the participating states found they made substantial progress toward a more rational approach to the coordination and financing of comprehensive services and supports for mental health consumers and family members.

Glossary

ACT	Assertive Community Treatment
CMHC	Community Mental Health Center
CMHS	Center for Mental Health Services
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedure Coding System
HIPPA	Health Insurance Portability and Accountability Act
HUD	Department of Housing and Urban Development
IEP	Individual Education Plan
MHT SIG	Mental Health Transformation State Incentive Grant
MIS	Management Information System(s)
NRI	National Association of State Mental Health Program Directors Research Institute, Inc.
OSA	Other State Agency (Project)
PPE	Probabilistic Population Estimation
SCHIP	State Children's Health Insurance Program
SED	Serious Emotional Disturbance
SHP	Supportive Housing Program
SMHA	State Mental Health Agency
SMHP	State Mental Health Plan
SMI	Serious Mental Illness
SRO	Single Room Occupancy (dwelling)
TSP	Technical Support Panel
VR	Vocational Rehabilitation

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Appendix A

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Appendix C

Determining Duplicated Versus Unduplicated Counts of Consumers Served and Overlap of Consumers Served by Different Agencies

To the extent possible, it is important for OSA projects to address the overlap in services, expenditures, and persons between the SMHA and the OSA. Given the often fragmented system of providing mental health services in America, it is highly likely that many of the persons who receive mental health service or supports from an OSA also receive services from the SMHA (and possibly from other OSAs).

If states do not address the duplication in persons served across agencies, any count of persons served by multiple OSAs will be an overcount of the number of individuals in states who actually received mental health services. If there is much overlap between agencies, the overestimate of the number of persons served could be substantial.

At a minimum, it is recommended to look at the overlap between the SMHA and other OSAs. This could potentially identify SMHA consumers who also receive mental health services from an OSA. The other category includes individuals who received mental health services from an OSA but did not

receive services from the SMHA. Where possible, the project should distinguish between individuals and services in these two categories. The relative number of individuals, services, and dollars in these two categories would provide important information about the functioning of systems of care.

When determining the overlap, or “unduplicating” consumers across agencies, it is important to investigate whether the consumer received uniquely different services from each agency or the overlap resulted from inefficient duplication of the same services to each consumer. With regard to services, OSA services in one category could be seen as supplemental to SMHA services. OSA services in the other category could be seen as providing an alternative to SMHA services. With regard to service system characteristics, one may be seen as an indication of service system integration; the other could be seen as an indication of a “silo” approach.

For standard databases such as Medicaid Management Information Systems (MMIS) files, many SMHAs routinely receive copies of paid claims data from Medicaid and use common unique identifiers to link to the SMHA's consumer data files. With this approach, the SMHA usually uses either a match-merge approach to link data files based on common keys (identical variables) such as Social Security Number, name, date of birth, or they use a "deterministic or probabilistic" approach to link individual consumer records between the two databases. Once the databases are linked at a consumer level, estimates of overlap in services can be calculated between systems.

In addition to linking SMHA files with Medicaid data files, several other states have been building state-level data warehouses that use various techniques to link consumer data files from multiple OSAs. For example, the State of Washington has built, within its Department of Social and Health Services, a data warehouse of consumer-level data from all the major divisions contained within the department (including mental health, substance abuse, Medicaid, employment and vocational rehabilitation, social services, and others). States that have developed such multiple OSA databases can use them to estimate the overlap in services between the SMHA and multiple OSAs.

An alternative approach to linking datasets that does not require individual consumer-level identifiers is Probabilistic Population Estimation (PPE). PPE is a statistical procedure that provides unduplicated counts of the number of persons represented in more than one data set without reference to personally identifying information (Banks & Pandiani, 2001). The method of PPE has been used

extensively in the measurement of treatment outcomes for adult mental health programs. Rates of hospitalization subsequent to community mental health treatment, for instance, have been determined using PPE to measure the amount of overlap between community program caseload during one year, and inpatient population during subsequent years (Pandiani, Banks, Schacht, & Gauvin, 1999). PPE has also been used to evaluate systems of care for children and adolescents. The degree to which child-serving agencies share responsibility for children and adolescents has been recognized as an important measure of service system performance for several years. A child-focused measure of this shared responsibility is provided by the caseload segregation/integration ratio. Caseload segregation/integration has been measured using anonymous records from children's mental health, child protection, and special education programs on a statewide basis (Banks, Pandiani, & Schacht, 1999).

PPE has three important advantages. First, the personal privacy of individuals and the confidentiality of medical records are assured because PPE does not depend on information that identifies specific individuals. Second, because the methodology relies on existing databases, it does not require the commitment of substantial amounts of staff time or financial resources. Finally, PPE can support retrospective evaluation of changes in systems of care that have occurred in the past, and provide longitudinal baseline data for evaluating current or anticipated changes in systems of care wherever basic consumer information resides in electronic databases. The PPE approach estimates the overlap of consumers between datasets, but since it does not link individual consumer records

between the data sets, the estimation of costs associated with the overlap will require further analytic steps.

Proposed PPE Method to Estimate Costs

When unique personal identifiers are not shared by service systems that share consumers, PPE can be used to estimate total cross-sector costs for categories of individuals without direct record linkage or reference to personally identifying information. This is accomplished by a multistep analysis of data sets from the two service systems. First, individuals in each data set are divided into three categories: low-cost consumers (lowest one-third), high-cost consumers (highest one-third), and mid-cost consumers (middle one-third), and the average cost for each category is calculated. Second, PPE is used to determine the number of individuals represented in each of the nine combinations of categories from the two data sets (low-low, low-middle, low-high, middle-low, middle-middle, middle-high, high-low, high-middle, high-high).

The total cross-sector cost of services for individuals in each cell is obtained by a three-step process. First, the number of people in each cell is multiplied by the average cost of mental health service for that

group. Second, the number of people in each cell is multiplied by the average cost of other sector services for that group. Third, the two costs are summed. (For individuals “not in other sector,” there are no “other sector” costs.) The total cross-sector cost for all individuals is the sum of the costs of all sectors. This approach to measuring the cost of cross-sector service utilization is efficient and does not threaten the personal privacy of individuals or the confidentiality of medical records.

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Appendix D

Sample Letter Soliciting Participation of Other State Agencies

Dear: _____

In line with the recommendations of the President's New Freedom Commission to transform mental health care in America, the [state name of SMHA] is currently undertaking an initiative to reduce fragmentation in the mental health system. An initial step towards this goal is to have a comprehensive understanding of what mental health services are funded and delivered in the state and how well we can all work together to improve the efficiency and quality of services provided to children and adults with mental illnesses. Our collaborative work on this project may benefit our state by helping all of us to:

- Identify the full range of mental health services and related expenditures being provided across state government
- Identify opportunities to coordinate and to reduce barriers to services
- Identify the overlap between consumers served by our and your agency (i.e., how many consumers are being served by both our agencies?)
- Enable us to develop a better picture of unmet need for mental health services by providing a more complete picture of services provided and not provided by state agencies
- Enable your agency to actively participate in the development of comprehensive mental health system plans
- Identify opportunities to maximize resources and redirect resources to improve services

Your participation in this important project will be highly appreciated. I am enclosing information about this project for your perusal. I have delegated [name of SMHA contact person] from my office who will follow up with your office about this unique project. You may reach [name of contact person] at [telephone number] or [e-mail address] with the name of your agency contact person for this project.

I appreciate the opportunity to work with you in transforming our state's mental health system. Please feel free to contact me at [telephone number of commissioner/director] or at [commissioner's/director's e-mail address] for any questions you may have.

Sincerely,

(Commissioner/Director)

Appendix E

Sample Data Sharing Agreement

Data Use Agreement/Memorandum of Understanding Between the [state] Department of [_____] and the [state] Department of [_____].

BACKGROUND

1. This [agency] is a covered entity pursuant to the Health Insurance Portability and Accountability Act (HIPAA) and therefore must comply with Federal and state laws and regulations pertaining to the confidentiality, use or disclosure, and security of certain health care related information.
2. This [agency] is not a covered entity for the purposes of HIPAA [with the exception ____].
3. This agreement, in addition to outlining the terms by which [____] and [____] will share data, also provides the terms under which the parties shall maintain the confidentiality and security of the data to be shared.
4. [Agency] will share consumer information according to Federal regulations (34 CFR 361.38(d)) for research purposes: “Personal information may be released to an organization, agency, or individual engaged in audit, evaluation, or research only for purposes directly connected with the administration of the [agency] program or for purposes that would significantly improve the quality of life for applicants and eligible individuals and only if the organization, agency, or individual assures that: (1) the information will be used only for the purposes for which it is being provided; (2) the information will be released only to persons officially connected with the audit, evaluation, or research; (3) the information will be not be released to the involved individual; (4) the information will be managed in a manner to safeguard confidentiality; and (5) the final product will not reveal any personal identifying information without the informed written consent of the involved individual or the individual’s representative.”

A. PURPOSE

In the initial cycle of the OSA study (2004–2005), the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI), developed under contract with CMHS a protocol for identifying major mental health services delivered by many of the major state government agencies other than the state mental health agency. NRI worked with nine states to document the numbers of persons receiving mental health services from these other state agencies. The study also described the services provided, estimated the overlap between

services provided by OSAs and the state mental health agency system, and documented the expenditures of OSAs for mental health services. The nine states were generally successful in identifying significant resources being expended by OSAs for mental health services, and this work led to increased collaboration between agencies.

Important objectives of the first cycle of the OSA study were to document which agencies the SMHAs worked with, how they worked together, the programs and services for which data could be compiled, their ability to integrate data, and the amount of services and expenditures of these agencies devoted to mental health. Information gained has allowed the NRI to refine the guide created to help other SMHAs work with their state agencies for the second cycle of the OSA study. The protocol to be utilized is incorporated by reference to this Data Use Agreement.

This Agreement is being made to share identifiable information on persons who have received services from both departments. Once data have been linked, deidentified data sets will be returned to each agency. Both parties acknowledge that all information furnished pursuant to this Agreement, irrespective of the manner, form, or mode, shall be used solely to determine the extent of persons being served by both departments and potentially to evaluate performance and outcomes regarding mental health and substance abuse treatment for those consumers who received publicly funded services.

B. EFFECTIVE DATES OF AGREEMENT

- I. This Agreement is in effect beginning [date] through [date]. Further, it is intended that upon the expiration of the original contract period, both parties may exercise the option to renew said contract annually.
- II. In the event either party fails to comply with the terms and conditions of this Agreement, the other party may, upon written notice of such noncompliance, cancel the Agreement effective upon actual receipt of notice. Such cancellation shall be in addition to any other rights and remedies provided by law. This Agreement may be terminated without cause by either party upon five (5) days' written notice to the other party, or in accordance with the provisions set forth herein.

C. CONFIDENTIALITY

- I. [Agency] agrees that all the data received are confidential pursuant to [add relevant laws, regulations], as well as any other specific [state] or Federal confidentiality requirements not specifically cited but incorporated by reference in general.

[Agency] agrees that all the data received are confidential pursuant to [add relevant laws, regulations]. [Agency] agrees to abide by the general common law confidentiality requirements and agrees to abide by more specific confidentiality requirements as expressed in [add relevant laws, regulations], as well as any other specific [state] or

Federal confidentiality requirements not specifically cited but incorporated by reference in general.

- II. All information furnished pursuant to this Agreement, regardless of the manner, form or mode of transmission, shall be used solely to determine the extent of persons being served by both departments and potentially to evaluate performance and outcomes regarding mental health treatment for those consumers who received publicly funded services. Any reports, summaries, compilations, or statistical abstracts produced from the use of this information will be prepared in such a manner as to comply with all applicable confidentiality requirements that govern both parties to this Agreement. Both parties agree that the information furnished pursuant to this Agreement will not be used to identify or contact any individual.
- III. Both parties will take all appropriate steps to protect from unauthorized disclosure of the information obtained pursuant to this Agreement and to return the information or destroy it by appropriate means when no longer needed. Both parties shall follow state requirements as to any preference for destruction of the information consistent with specifications herein. Neither party will use or further disclose the data other than as permitted by this Data Use Agreement or as otherwise required by law. Should such disclosure occur, both parties agree that the disclosing party will notify the other party immediately.
- IV. Both parties shall make their internal practices, books, and records relating to the use and disclosure of protected health information received from, or created by the other on behalf of the other, available to the Secretary for purposes of determining compliance with the law.
- V. [Agency] shall ensure that any agents, including a subcontractor, to whom it provides the limited data set, agrees to the same restrictions and conditions that apply to the limited data set that apply to [agency] in this agreement, with respect to such information.
- VI. Both parties shall make protected health information available in accordance with [add relevant laws, regulations].
- VII. Both parties shall make protected health information available for amendment and incorporate any amendments to protected health information in accordance with [add relevant laws, regulations].
- VIII. Both parties shall make available the information required to provide an accounting of disclosures in accordance with [add relevant laws, regulations].

D. TRANSFER OF DATA BETWEEN AGENCIES

- I. Both parties agree to furnish a list of names and official titles of all personnel designated by the [agencies] to request and/or receive information. Additions to and deletions from the list shall be furnished as necessary. Each person with access to the data will submit a signed Acknowledgment of Requirements of Data Use Agreement.

-
- II. Access to the shared data shall be limited to the authorized staff. All information pursuant to this Agreement shall be maintained in a location secure from access by unauthorized persons. Both parties shall take all appropriate steps necessary to protect shared information from unauthorized disclosure and access.
 - III. Both parties shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits.

E. MODIFICATION OR AMENDMENT OF AGREEMENT

This Agreement may be modified or terminated at the discretion of the Director/Chief Operating Officer [agency] due to changes in Federal or state statutes or regulations, or whenever in the administration of state and Federal law, either party deems such action appropriate.

In the event that the Parties mutually agree to amend this Agreement, a written amendment shall be issued to reflect such modifications, and such amendment shall be signed by authorized officials on behalf of each party.

IT IS SO AGREED.

Name, Title _____
Department _____
Signed ____ day of ____ 20 ____

Name, Title _____
Department _____
Signed ____ day of ____ 20 ____

ACKNOWLEDGMENT OF REQUIREMENTS OF INFORMATION SHARING AGREEMENT

I, _____, as an employee of the [state] Department of [_____], hereby acknowledge that I shall be a recipient of confidential information from the [state] Department of [_____]. I further acknowledge that as a recipient of this information. I will abide by all requirements set forth in the Data Use Agreement entered into by the [state department] and the [state department]. I further acknowledge that any information I receive pursuant to that Agreement will be kept confidential and disclosed only as provided for in the Agreement, and all information will be destroyed or returned when no longer needed.

I agree to report any infraction of the requirements of the above described Agreement to the General Counsel of the [state department]. I understand that if I misuse this information or divulge it to an inappropriate party, I may be held civilly and/or criminally liable for the unlawful use or release of the information.

Signature: _____ Date: _____
Title: _____

Appendix F

Customized Instructions and Data Reporting Templates for Individual “Other State Agencies”

In initiating an OSA project, it is strongly recommended states customize these templates/guidelines based on the states’ needs and objectives. States should not be limited by the reporting categories presented on each template and are strongly encouraged to work with the OSA in customizing the reporting template. For example, for Medicaid, if your state has its own specific eligibility categories that are different from those presented in the reporting template, it is advisable to customize the template based on your eligibility categories. The complete data reporting templates and Project Protocol for Gathering and Reporting Data on Mental Health Services used for the NRI’s OSA Project may be accessed via NRI’s website: <http://www.nri-inc.org/projects/OSA/protocol.cfm>.

Corrections/Criminal Justice

Possible Data Sources

- Consumer file
 - Claims file
 - State agency’s year-end financial/expenditure report
 - State agency’s budgets
 - Intergovernmental Agreements/contracts/grants
1. Data are stratified by major divisions of the state criminal justice system: prisons, jails, community corrections, parole, and others. Community corrections include court-ordered probation, specialized outpatient or residential treatment programs, and special community sentencing programs. For “Others,” look more broadly and consider expenditures on mental health and related services covered under existing diversion programs, mental health court order, and other similar expenditures provided by the OSA (not by the SMHA).
 2. Identify and itemize various types of mental health treatments provided to inmates, probationers, and parolees.

-
3. Include expenditures for specialized psychiatric inpatient/acute care facilities or units. Do not include specialized facilities or services for substance abuse or developmental disabilities unless they are intended for persons with co-occurring mental illness. However, include specialized facilities expenditures and services for sexual offenders diagnosed with mental illness. Do not include mental health screening activities that are applied to the general corrections/criminal justice population.
 4. Watch for organizational issues related to jails and prisons. Report and document any fund transfers by the state department of corrections to local jails. Determine if any local jails are actually “state” facilities and what mental health service expenditures are incurred.
 5. Review with your contract/finance staff any existing Intergovernmental Agreements (IGAs), interagency contracts, grants, gifts, and so on, that may be relevant to this project. Report and document your findings as appropriate. Note if an IGA between the department of corrections and the state mental health agency (SMHA) exists. This may involve dollars that are expended by the department of corrections from the SMHA or dollars expended by the SMHA from the department of corrections to finance mental health services for probationers. This will help to identify points of overlap where the same expenditures might be documented for both OSAs and SMHAs.
 6. Identify revenue sources of mental health service expenditures. In addition to the IGAs and contracts, it is also recommended to review the agency year-end financial report, agency budget, and program allocation documents. Note that the revenue source table should correspond to the expenditure table.
 7. Identify individuals receiving mental health services.
 8. Determine unduplicated count of individuals who received mental health services.
 9. Determine overlap with SMHA past and/or currently enrolled consumers.
 10. Describe your state’s criminal justice system for providing mental health services. Do not assume other state systems are similar to your state system. For example, what criminal justice consumers are served under the umbrella of your department of corrections? Are community corrections consumers served within agencies separate from prisons? Are your jails state-funded, county-funded, city-funded, or a combination of the above?
 11. Document all information that is essential to appropriately interpret the reported data. This includes possible under/overreporting of data and reasons for such, methods used in collecting data, and other relevant facts.

Corrections/Criminal Justice

State: _____ Reporting Period: _____ From: _____ To: _____

	Expenditures					Total
	Inpatient Hospital/ Acute Care Unit	Less Than 24-Hour Care	Professional Personnel	Pharmacy	Other	
Prisons						\$0
Jails						\$0
Parole						\$0
Community Corrections*						\$0
Other						\$0
Total	\$0	\$0	\$0	\$0	\$0	\$0
Contracted to SMHA**	\$0	\$0	\$0	\$0	\$0	\$0

	Selected Revenue Sources				Total
	SMHA	Other State Funds	Federal Funds	Local/ County Funds	
					\$0
					\$0
					\$0
					\$0
Total	\$0	\$0	\$0	\$0	\$0

	Number of Persons Served					Other
	<input type="checkbox"/> Unduplicated		<input type="checkbox"/> Duplicated			
	Inpatient Hospital/ Acute Care Unit	Less Than 24-Hour Care	Professional Personnel	Pharmacy	Other	
Prisons						
Jails						
Parole						
Community Corrections*						
Other						
Total (Duplicated)	\$0	\$0	\$0	\$0	\$0	\$0
Total (Unduplicated)	\$0	\$0	\$0	\$0	\$0	\$0

	Number of Unique (Unduplicated) Persons Served		
	Unduplicated Across Services (1)	Unduplicated Overlap with SMHA (2)	Unduplicated Served Only by OSA: (1) minus (2)
Total	\$0	\$0	\$0

*See narrative text for explanation.

**Check box if amount reported for "contracted to SMHA" is already covered in the preceding total.

Medicaid

Possible Data Sources

- Medicaid Eligibility Files
 - Medicaid Paid Claims
 - Medicaid agency year-end financial/expenditure report
 - Medicaid agency budget
1. Data are stratified by eligibility program and by age. The eligibility categories include:
 - Disabled
 - Temporary Assistance for Needy Families (TANF)
 - Dually Eligible for Medicaid and Medicare
 - Foster Care and Adoption Assistance
 - Other (e.g., medically needy, refugees)
 2. Compile Medicaid data from paid claims files that have been linked with eligibility files. The paid claims file and consumer eligibility files are used together to generate reports of Medicaid expenditures by consumer characteristics.
 3. Identify individuals who receive mental health services via “Diagnosis,” “Provider type,” “Procedure code,” and/or pharmacy list.
 4. For this study, do not try to gather data on the “general medical” cost of mental health consumers or to account for “disproportionate share.”
 5. Determine unduplicated count of individuals who received mental health services.
 6. Determine overlap with SMHA-enrolled consumers. Use existing procedures your state may already have for counting/estimating overlap between Medicaid and SMHA systems. Measuring overlap is important to be able to discuss the duplication between these two systems.
 7. Separate out services paid by SCHIP from those paid by Medicaid, but use same protocol.
 8. Describe your state’s Medicaid system for providing both mental health services and general health care (i.e., waiver, fee for service, HMO for general health and carve-out for mental health, etc.).
 9. Document all information that is essential to appropriately interpret the reported data. This includes possible under/overreporting of data and reasons for such, methods used in collecting data, and other relevant facts.

Medicaid

State: _____ Reporting Period: _____ From: _____ To: _____

	Expenditures				Total
	Inpatient Hospital	Other 24-Hour Care	Less Than 24-Hour Care	Pharmacy	
Medicaid Eligibility Category Disabled (SSI)					
< 18					\$0
18-64					\$0
≥ 65					\$0
TANF					
< 18					\$0
18-64					\$0
≥ 65					\$0
Dually Eligible for Medicaid and Medicare					
< 18					\$0
18-64					\$0
≥ 65					\$0
Foster Care and Adoption Assistance					
< 18					\$0
18-21					\$0
Other (e.g. Medically Needy, Refugees)					
< 18					\$0
18-64					\$0
≥ 65					\$0
Total	\$0	\$0	\$0	\$0	\$0
Contracted to SMHA **	\$0	\$0	\$0	\$0	\$0

SCHIP	\$0	\$0	\$0	\$0
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(Continued on next page)

Vocational Rehabilitation

Possible Data Sources

- Consumer file
- Case Service Report (RSA- 911)
- State agency year-end financial/expenditure report
- State agency budget
- Intergovernmental Agreement/contracts/grants

There are two possible sources of data, both of which are recommended to be used. One is using the state vocational rehabilitation agency consumer database to obtain a total of all cases (active and closed) and the other is analyzing the Case Service Report submitted by state vocational rehabilitation agency to the U.S. Department of Education.

1. Data are stratified by two main divisions: those eligible for vocational rehabilitation with psychiatric disability and those without psychiatric eligibility. Data are further subdivided by age group; that is, less than 18 and 18 and older.
2. Gather information on both active and closed cases. For closed cases, you may use the state file for RSA-911 forms, which are completed by the state vocational rehabilitation agency and submitted to the U.S. Department of Education.
3. Vocational rehabilitation reports by the Federal Government show that 20 percent of all vocational rehabilitation consumers are diagnosed with mental illness. Diagnoses are contained in the Rehabilitation Services Administration database. When identifying individuals who received mental health services from the vocational rehabilitation agency, it is recommended that, at a minimum, the following “Codes for Impairments” be used:

RSA – 911 Mental Impairment Codes

17 Cognitive Impairments (impairments involving learning, thinking, processing information and concentration)

18 Psychosocial Impairments (interpersonal and behavioral impairments, difficulty coping)

19 Other Mental Impairments

Codes for Causes/Sources of Impairments:

04 Anxiety Disorders

07 Attention-Deficit Hyperactivity Disorder (ADHD)

15 Depressive and other Mood Disorders

18 Eating Disorders (e.g., anorexia, bulimia, compulsive overeating)

23 Mental Illness (not listed elsewhere)

29 Personality Disorders

33 Schizophrenia and other Psychotic Disorders

-
5. Services are broken down as follows: supported employment, vocational rehabilitation/training, less than 24-hour care and others
 6. Using the most recent available RSA-911 data file, NRI will prepare reports for each SMHA regarding the number of persons receiving mental health services in vocational rehabilitation agencies, the expenditures for these services, the types of services received, and the reported outcomes (e.g., changes in education, employment status and income) at the end of treatment. This analysis is intended to corroborate the findings from data derived by states from the state vocational rehabilitation agency. (Note: RSA- 911 is submitted to the Federal Government after a consumer completes services and hence does not include current consumers). RSA files made available by the U. S. Department of Education to NRI are usually a year later than what one may get from the state vocational rehabilitation agency.
 7. Review with your contract/finance staff any existing Intergovernmental Agreements (IGAs), interagency contracts, grants, gifts, and so on, that may be relevant to this project. Report and document your findings as appropriate. Note if an IGA between the vocational rehabilitation agency and the state mental health agency exists. This will help to identify points of overlap where the same expenditures might be documented for both OSA and SMHA.
 8. Identify revenue sources of the vocational rehabilitation services provided by the OSA. In addition to the IGAs and contracts, it is also recommended to review the agency year-end financial report, agency budget, and program allocation documents. Note that the revenue source table should correspond to the expenditure table.
 9. Determine unduplicated count of individuals who received a vocational rehabilitation service.
 10. Determine overlap with SMHA enrolled consumers.
 11. Describe your state's vocational rehabilitation system for providing vocational rehabilitation services to persons with mental illness.
 12. Document all information that is essential to appropriately interpret the reported data. This includes any possible under/overreporting of data and reasons for such, methods used in collecting data, and other relevant facts.

State Housing Authority

Possible Data Sources

- Consumer file
 - State agency year-end financial/expenditures report
 - State housing agency budget
 - Intergovernmental Agreement/contracts/grants
1. Data are divided into two distinct housing programs: (a) the Housing and Urban Development (HUD) Supportive Housing Program and (b) other housing program (i.e., the non-HUD Supportive Housing Program). Under each type of housing program, expenditures are further differentiated between housing structure expenses (includes direct acquisition cost or maintenance cost of the housing structure) and expenses for (mental health/supportive) services.
 2. There are two possible state agencies that work with SMHA in providing housing for persons with mental illness. These are the state housing agency and in some cases, the Office of Housing under the Office of the Governor. The major housing programs that might be used to track housing expenditures include:
 - HUD Shelter Plus Care
 - HUD Community Development Block Grant
 - HUD Emergency Shelter Grants
 - HUD Housing Choice Vouchers
 - Section 8: Vouchers for People with Disabilities
 - HUD Section 811: Supportive Housing for Persons with Disabilities
 - HUD Homeless Grants
 - HUD Home Investment Partnerships Program, and
 - The Single Room Occupancy Program
 3. Determine whether an expenditure falls under the HUD housing program or the non-HUD housing program. The latter basically includes all other state housing programs not funded under the Federal Supportive Housing Program.
 4. Classify housing expenditures by type: structural expense versus service expense.
 5. Explore the methods in identifying persons with mental illness who received housing support from the OSA.
 6. Determine unduplicated count of persons with mental illness who received housing support.
 7. Determine overlap with SMHA enrolled consumers.
 8. Describe your state's housing program for persons with mental illness.

-
9. Document all information that is essential to appropriately interpret the reported data. This includes possible under/overreporting of data and reasons for such, methods used in collecting data, and other relevant facts.

Housing

State: _____ Reporting Period: _____ From: _____ To: _____

	Expenditures				Total
	SHIP		Other Housing Programs (Non-SHP)		
	Housing Structure Expenses	Mental Health and Other Support	Housing Structure Expenses	Mental Health Services	
Total	\$0	\$0	\$0	\$0	\$0
Contracted to SMHA**	\$0	\$0	\$0	\$0	\$0

Selected Revenue Sources					
SMHA	Other State Funds	Federal Funds	Other Federal Funds	Local/County Funds	Total
\$0	\$0	\$0	\$0	\$0	\$0
\$0	\$0	\$0	\$0	\$0	\$0

	Number of Persons Served			
	<input type="checkbox"/> Unduplicated		<input type="checkbox"/> Duplicated	
	Housing Structure Expenses	Mental Health and Other Support	Housing Structure Expenses	Mental Health Services
Total (Duplicated)	\$0	\$0	\$0	\$0
Total (Unduplicated)	\$0	\$0	\$0	\$0

Number of Unique (Unduplicated) Persons Served		
Unduplicated Across Services (1)	Unduplicated Overlap with SMHA (2)	Unduplicated Served Only by OSA: (1) minus (2)
\$0	\$0	\$0

*Check box if amount reported for "contracted to SMHA" is already covered in the preceding total.

Substance Abuse

1. The focus within the OSA population is consumers with co-occurring mental health and substance abuse disorders. At the minimum, persons with co-occurring disorders may be identified by linking consumer files of the substance abuse agency and the state mental health agency
2. Determine the mental health services provided by substance abuse agency to these individuals. Caution should be taken when identifying types of services. State mental health and substance abuse agencies may use the same nomenclature for services. Make sure that expenditures reported are related to addressing the individual's mental illness. Do not report expenditures on substance abuse services for persons with co-occurring mental health and substance abuse disorders. Only mental health services provided by the substance abuse agency to persons with co-occurring disorders should be reported.
3. Review with your contract/finance staff any existing IGAs, interagency contracts, grants, gifts, and so on, that may be relevant to this project. Report and document your findings as appropriate. Note if an IGA between the substance abuse agency and mental health agency exists. This will help to identify points of overlap where the same expenditures might be documented for both OSA and SMHA.
4. Identify revenue sources of mental health service expenditures. In addition to the IGAs and contracts, it is also recommended to review the agency year-end financial report, agency budget, and program allocation documents. Note that the revenue source table should correspond to the expenditure table.
5. In cases where a state's substance abuse agency has a distinct integrated substance abuse and mental health program, report the program's total service expenditures. It is assumed that persons referred to this program have symptoms of dual diagnosis although they may not be outright supported by a diagnosis. If this is a statewide "catchall" program for persons with co-occurring disorders, then the program data are sufficient. However, if this is not a statewide program and there are persons with co-occurring disorders who are not members of the program, mental health expenditures for this group should also be captured and reported.
6. Determine unduplicated count of individuals who received mental health services and overlap with SMHA-enrolled consumers.
7. Document your state's substance abuse agency system for providing mental health services.
8. Document all information that is essential to appropriately interpret the reported data. This includes possible under/overreporting of data and reasons for such, methods used in collecting data, methods used in identifying persons with co-occurring disorders, and other relevant facts.

Substance Abuse

State: _____ Reporting Period: _____ From: _____ To: _____

Expenditures				
Inpatient Hospital	Other 24-Hour Care	Less Than 24-Hour Care	Pharmacy	Total
\$0	\$0	\$0	\$0	\$0
Contracted to SMHA**	\$0	\$0	\$0	\$0
Total				\$0

Selected Revenue Sources					
SMHA	Other State Funds	Medicaid	Other Federal Funds	Local/County Funds	Total
\$0	\$0	\$0	\$0	\$0	\$0
Total					\$0

Number of Persons Served			
<input type="checkbox"/> Unduplicated	<input type="checkbox"/> Duplicated	Less Than 24-Hour Care	Pharmacy
Inpatient Hospital			
Other 24-Hour Care			
Total (Duplicated)			
Total (Unduplicated)			

Number of Unique (Unduplicated) Persons Served			
Unduplicated Across Services (1)	Unduplicated Overlap with SMHA (2)	Unduplicated Served Only by OSA: (1) minus (2)	Total
0	0	0	0

**Check box if amount reported for "contracted to SMHA" is already covered in the preceding total.

Education

Types of data include number of children served and expenditures for the following:

- Mental health-related services delivered as part of Individual Education Plans (IEPs); could include residential treatment, psychoeducation/day treatment, out-patient therapy, or counseling, behavioral aides
- Other non-IEP school-based mental health services provided in schools (e.g., counselors/psychologists in schools)
- School-based mental health centers
- Possible agencies/sources of data
- Special education roster of students
- Special education expenditure reports
- State department of education budget or program
- Intergovernmental Agreements/Interagency contracts/grants
- Personnel costs for mental health professionals

Early Intervention

Types of data include number of children served and expenditures for the following:

- Mental health-related services covered under Individuals with Disabilities Education Act (IDEA), Part C
- Other state-operated and/or state-funded early intervention programs that purchase or provide mental health services for infants and toddlers
- Possible agencies/sources of data
- Consumer file
- State department of education and/or health (for lead agency in your state, see <http://www.nectac.org/partc/ptclead.asp>)
- State coordinator for early intervention programs under IDEA (for coordinator in your state see <http://www.nectac.org/contact/ptccoord.asp>)
- Reports of mental health expenditures under IDEA, Part C
- State expenditures for SAMHSA-funded system of care or other grants that focus on early intervention
- Other possible data sources: Governor's Office of Children and Youth; Office of Children with Special Health Care Needs

Juvenile Justice

Types of data include number of children served and expenditures for the following:

- Mental health services delivered in juvenile justice facilities
- Mental health services delivered through courts, diversion programs, probation, and parole
- Psychiatric in-patient hospitalization
- Possible agencies/sources of data
- Consumer file
- State department of juvenile justice (facilitates and community-based)
- Contracts for mental health services (i.e., residential treatment or community mental health services)
- Personnel costs for mental health professionals
- Agency annual reports
- Services and financial management information systems (MIS)

Child Welfare

Types of data include number of children served and expenditures for the following:

- Psychiatric in-patient hospitalization
- Residential treatment
- Therapeutic foster care
- In-home family intervention
- Crisis intervention
- Mental health out-patient services
- Possible agencies/sources of data
- Consumer file
- State department of human services, family services, or child welfare
- Contracts for mental health services (i.e., residential treatment or community mental health services)
- Personnel costs for mental health professionals
- Agency annual reports
- Services and financial MIS

-
1. Expenditure data are broken down by type of service. Report actual expenditures.
 2. Review with your contract/finance staff any existing Intergovernmental Agreements (IGA), interagency contracts, grants, gifts, and so on, that may be relevant to this project. Report and document your findings as appropriate. Note if an IGA between the OSA and mental health agency exists. This will help to identify points of overlap where the same expenditures might be documented for both OSA and SMHA.
 3. Identify revenue sources of mental health service expenditures. In addition to the IGAs and contracts, it is also recommended to review the agency year-end financial report, agency budget, and program allocation documents. Note that the revenue source table should correspond to the expenditure table.
 4. Explore with OSA the recommended methods in identifying children/adolescents who receive mental health and related support services from the OSA.
 5. In children's services, be alert for interagency "money pots" (e.g., interagency collaboratives designed specifically for multiagency children where there might be central intake, pooled funding, etc.) The number of children served and expenditures for children served by these multiagency collaboratives can be put in any of the following tables for children's OSAs that best fits. Please include a note of the name of the interagency collaborative (e.g., Governor's Office for Children with Emotional Disturbances).
 6. Note and include any collaborative projects between the SMHA and one or more OSA with special fund appropriations for providing mental health services and other related support services.
 7. Determine overlap with SMHA-enrolled consumers using the recommended methodology.
 8. Document your state's children and adolescents service system for providing mental health services.
 9. Document all information that is essential to appropriately interpret the reported data. This includes possible under/overreporting of data and reasons for such, methods used in collecting data, and other relevant facts.

Education

State: _____ Reporting Period: _____ From: _____ To: _____

	Expenditures			Total
	24-Hour Care	Less Than 24-Hour Care	Other	
Total	\$0	\$0	\$0	\$0
Contracted to SMHA**	\$0	\$0	\$0	\$0

Selected Revenue Sources					
SMHA	Other State Funds	Medicaid	Other Federal Funds	Local/County Funds	Total
\$0	\$0	\$0	\$0	\$0	\$0

	Number of Persons Served		
	<input type="checkbox"/> Unduplicated	<input type="checkbox"/> Duplicated	Other
Total (Duplicated)	\$0	\$0	\$0
Total (Unduplicated)	\$0	\$0	\$0

Number of Unique (Unduplicated) Persons Served		
Unduplicated Across Services (1)	Unduplicated Overlap with SMHA (2)	Unduplicated Served Only by OSA: (1) minus (2)
\$0	\$0	\$0

*Check box if amount reported for "contracted to SMHA" is already covered in the preceding total.

Early Intervention

State: _____

Reporting Period: _____

From: _____

To: _____

Expenditures				
	24-Hour Care	Less Than 24-Hour Care	Other	Total
Total	\$0	\$0	\$0	\$0
Contracted to SMHA**	\$0	\$0	\$0	\$0

Selected Revenue Sources					
SMHA	Other State Funds	Medicaid	Other Federal Funds	Local/County Funds	Total
\$0	\$0	\$0	\$0	\$0	\$0

Number of Persons Served				
	<input type="checkbox"/> Unduplicated	<input type="checkbox"/> Duplicated	Total	
	24-Hour Care	Less Than 24-Hour Care	Other	Total
Total (Duplicated)	\$0	\$0	\$0	\$0
Total (Unduplicated)	\$0	\$0	\$0	\$0

Number of Unique (Unduplicated) Persons Served		
Unduplicated Across Services (1)	Unduplicated Overlap with SMHA (2)	Unduplicated Served Only by OSA: (1) minus (2)
\$0	\$0	\$0

*Check box if amount reported for "contracted to SMHA" is already covered in the preceding total.

Juvenile Justice

State: _____

Reporting Period: _____

From: _____

To: _____

	Expenditures			Total
	Inpatient Hospital	Other 24-Hour Care	Less Than 24-Hour Care	
Total	\$0	\$0	\$0	\$0
Contracted to SMHA**	\$0	\$0	\$0	\$0

Selected Revenue Sources				
SMHA	Other State Funds	Medicaid	Other Federal Funds	Local/County Funds
\$0	\$0	\$0	\$0	\$0
				Total
				\$0

	Number of Persons Served			Total
	<input type="checkbox"/> Unduplicated	<input type="checkbox"/> Duplicated	Other	
Inpatient Hospital				
Other 24-Hour Care				
Less Than 24-Hour Care				
Total (Duplicated)	\$0	\$0	\$0	\$0
Total (Unduplicated)	\$0	\$0	\$0	\$0

Number of Unique (Unduplicated) Persons Served		
Unduplicated Across Services (1)	Unduplicated Overlap with SMHA (2)	Unduplicated Served Only by OSA: (1) minus (2)
\$0	\$0	\$0

*Check box if amount reported for "contracted to SMHA" is already covered in the preceding total.

Child Welfare

State: _____ Reporting Period: _____ From: _____ To: _____

Expenditures					
	Inpatient Hospital	Other 24-Hour Care	Less Than 24-Hour Care	Other	Total
Total	\$0	\$0	\$0	\$0	\$0
Contracted to SMHA**	\$0	\$0		\$0	\$0

Selected Revenue Sources						
	SMHA	Other State Funds	Medicaid	Other Federal Funds	Local/County Funds	Total
	\$0	\$0	\$0	\$0	\$0	\$0

Number of Persons Served				
	<input type="checkbox"/> Unduplicated	<input type="checkbox"/> Duplicated		
	Inpatient Hospital	Other 24-Hour Care	Less Than 24-Hour Care	Other
Total (Duplicated)	\$0	\$0	\$0	\$0
Total (Unduplicated)	\$0	\$0	\$0	\$0

Number of Unique (Unduplicated) Persons Served			
	Unduplicated Across Services (1)	Unduplicated Overlap with SMHA (2)	Unduplicated Served Only by OSA (1) minus (2)
	\$0	\$0	\$0

*Check box if amount reported for "contracted to SMHA" is already covered in the preceding total.

Appendix G

Forms for Collecting Contextual Information at the Beginning and End of the Project

OTHER STATE AGENCY (OSA) PROJECT Initial Contextual Report

State of _____
Report Written by _____
Phone _____ E-mail Address _____

INTRODUCTION

Provide a brief narrative of your state's expectations of the project. Cite why you think it's worthwhile to participate. Based on your expectations, please describe how the state plans to use the output of this project.

SMHA PROJECT STRUCTURE

The succeeding questions will document how the project is managed within the state mental health agency (SMHA). This information is critical in understanding the resources that were committed to successfully launch this project.

1. Which division in the SMHA has the lead in implementing this project?

- Budget/Finance
- Evaluation/Research
- Information Technology (IT)
- Planning
- Quality Improvement
- Others, specify: _____

2. Which divisions within the SMHA participated or were consulted in launching this project?

Please check all that apply.

- Budget/Finance
- Clinical/Program Staff
- Commissioner's Office
- Contracts/Procurement
- Evaluation/Research
- Grants Office
- Information Technology
- Planning
- Quality Improvement
- Others, specify: _____

ESTABLISHING THE INITIAL CONTACT

The succeeding questions document how an initial contact with the Other State Agencies (OSAs) was established. This is critical in understanding the approaches and strategies to get OSAs engaged in this project.

1. Did you secure your Governor's Office approval or endorsement of the project?

- Yes
- No

2. What medium of communication was used to introduce the project to the OSAs? Check all that apply.

- Letter using the Commissioner's letterhead*
- Letter using the Governor's letterhead*
- Phone call to OSA by the Commissioner
- Phone call to OSA by the SMHA lead person
- Presentation at any interagency meeting
- Others; specify: _____

*Please provide a copy of the letter(s) sent to OSAs if this medium was used.

3. What is the rank of your initial point of contact (i.e., to whom was the letter addressed, or who did the Commissioner call, or who were the attendees in the meeting at which the presentation was made)? Check all that apply.

- Head of agency
- Office of Program Director/Manager
- Chief Financial Officer
- IT administrator
- Program staff
- Others; specify: _____

2. Which of the following techniques did you use to orient the OSAs about the project? Please check all applicable techniques.

a. Orientation meeting

- Held an orientation meeting attended by all OSAs
- Held an orientation meeting with each OSA
- Both

b. Dissemination of project protocol

- Provided complete copy of protocol issued by NRI
- Provided complete copy of protocol customized to the state
- Provided copy of protocol customized by state to the OSA

b. Other techniques used; specify _____

ENGAGING THE OSAs

The succeeding questions document the “marketing” strategies that were used to engage the OSAs and the features of the project in which they are most interested. This is to understand how to keep them engaged and ensure that the project remains beneficial to all parties.

1. What factors facilitated or helped you promote the project to the OSAs? Check all that apply.

- Long-term relationships
- Financial assistance
- Quid pro quo for an existing, past, or future project
- Mandate (from the Governor, Legislature, Department Secretary, etc.)
- Upholding the same ideology of collaboration, transparency, efficiency
- Others; specify: _____

2. Based on your discussions with the OSAs, which of the following project features did the OSAs explicitly cite as areas of interest (i.e., what got them excited)? Check all applicable items.

- Identifying overlaps in clients
- Determining the total number of clients receiving mental helpful services
- Better understanding of revenues and expenditures allocated to clients
- Improving allocation of resources to clients
- Others, specify: _____

OSA PARTICIPATION

The succeeding questions will document the status of your outreach to the OSAs. By knowing the OSAs that you have successfully engaged and those that still remain in the pipeline, this information will give NRI insights into the technical assistance that states may still need in launching the project.

1. Please check the agencies you have approached:

<input type="checkbox"/> Corrections	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Early Intervention
<input type="checkbox"/> Housing	<input type="checkbox"/> Vocational Rehabilitation	<input type="checkbox"/> Juvenile Justice
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Education	<input type="checkbox"/> Child Welfare
<input type="checkbox"/> Others; specify		

2. Of the agencies cited in #1 above, please check which ones agreed to participate.

<input type="checkbox"/> Corrections	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Early Intervention
<input type="checkbox"/> Housing	<input type="checkbox"/> Vocational Rehabilitation	<input type="checkbox"/> Juvenile Justice
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Education	<input type="checkbox"/> Child Welfare
<input type="checkbox"/> Others; specify: _____		

3. Of the agencies cited in #1 above, please check which ones declined to participate:

<input type="checkbox"/> Corrections	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Early Intervention
<input type="checkbox"/> Housing	<input type="checkbox"/> Vocational Rehabilitation	<input type="checkbox"/> Juvenile Justice
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Education	<input type="checkbox"/> Child Welfare
<input type="checkbox"/> Others; specify: _____		

Please check all applicable reasons cited by OSAs for declining to participate:

- Cannot allocate existing agency resources to the project
- Doesn't think their agency fits within the scope of project
- Doesn't believe project is relevant
- Believes that project is a duplication of an ongoing initiative
- No reason cited (we gave up!); OSA didn't respond to SMHA letters or calls
- Additional reasons; specify: _____

4. Please cite all divisions within the OSAs you have started to work with that were represented in your discussions about the project

Corrections:

<input type="checkbox"/> Budget/Finance staff	<input type="checkbox"/> Evaluation/Research staff
<input type="checkbox"/> Clinical Program staff	<input type="checkbox"/> IT staff
<input type="checkbox"/> Contracts/Procurement/Grants staff	<input type="checkbox"/> Planning staff
<input type="checkbox"/> Director's Office	<input type="checkbox"/> Other; specify _____

Housing:

<input type="checkbox"/> Budget/Finance Staff	<input type="checkbox"/> Evaluation/Research Staff
<input type="checkbox"/> Clinical Program staff	<input type="checkbox"/> IT Staff
<input type="checkbox"/> Contracts/Procurement/Grants Staff	<input type="checkbox"/> Planning Staff
<input type="checkbox"/> Director's Office	<input type="checkbox"/> Others; specify _____

Medicaid:

<input type="checkbox"/> Budget/Finance staff	<input type="checkbox"/> Evaluation/Research staff
<input type="checkbox"/> Clinical Program staff	<input type="checkbox"/> IT staff
<input type="checkbox"/> Contracts/Procurement/Grants staff	<input type="checkbox"/> Planning staff
<input type="checkbox"/> Director's Office	<input type="checkbox"/> Other, specify _____

Substance Abuse:

<input type="checkbox"/> Budget/Finance staff	<input type="checkbox"/> Evaluation/Research staff
<input type="checkbox"/> Clinical Program staff	<input type="checkbox"/> IT staff
<input type="checkbox"/> Contracts/Procurement/Grants staff	<input type="checkbox"/> Planning staff
<input type="checkbox"/> Director's Office	<input type="checkbox"/> Others; specify

Vocational Rehabilitation:

<input type="checkbox"/> Budget/Finance staff	<input type="checkbox"/> Evaluation/Research staff
<input type="checkbox"/> Clinical Program staff	<input type="checkbox"/> IT staff
<input type="checkbox"/> Contracts/Procurement/Grants staff	<input type="checkbox"/> Planning staff
<input type="checkbox"/> Director's Office	<input type="checkbox"/> Others; specify

Early Intervention:

<input type="checkbox"/> Budget/Finance staff	<input type="checkbox"/> Evaluation/Research staff
<input type="checkbox"/> Clinical Program staff	<input type="checkbox"/> IT staff
<input type="checkbox"/> Contracts/Procurement/Grants staff	<input type="checkbox"/> Planning staff
<input type="checkbox"/> Director's Office	<input type="checkbox"/> Others; specify

Education:

<input type="checkbox"/> Budget/Finance staff	<input type="checkbox"/> Evaluation/Research staff
<input type="checkbox"/> Clinical Program staff	<input type="checkbox"/> IT staff
<input type="checkbox"/> Contracts/Procurement/Grants staff	<input type="checkbox"/> Planning staff
<input type="checkbox"/> Director's Office	<input type="checkbox"/> Others; specify

Juvenile Justice:

<input type="checkbox"/> Budget/Finance staff	<input type="checkbox"/> Evaluation/Research staff
<input type="checkbox"/> Clinical Program staff	<input type="checkbox"/> IT staff
<input type="checkbox"/> Contracts/Procurement/Grants staff	<input type="checkbox"/> Planning staff
<input type="checkbox"/> Director's Office	<input type="checkbox"/> Others; specify

Child Welfare:

<input type="checkbox"/> Budget/Finance staff	<input type="checkbox"/> Evaluation/Research staff
<input type="checkbox"/> Clinical Program staff	<input type="checkbox"/> IT staff
<input type="checkbox"/> Contracts/Procurement/Grants staff	<input type="checkbox"/> Planning staff
<input type="checkbox"/> Director's Office	<input type="checkbox"/> Others; specify

5. Please estimate the average time involved in establishing "partnership" with OSAs. Calculate time from when you made the initial to the OSA (i.e., when you made the initial call or sent out the letter) up until you received a response from them (i.e., received acknowledgement of your letter and OSA provided a contact person to initiate the process).

OTHER INFORMATION

Please use the remaining space or add a separate page, if needed, to describe other pertinent information not covered above such as barriers, issues, or problems you encountered and how you addressed them. You may also use the space to elaborate on some of your responses. Your responses can be a narrative or bullet points highlighting implementation factors you considered or did not consider (but in hindsight you think should have been useful) to successfully launch this project. Please share some “food for thought” from your experience in project implementation and tools you used that were beneficial to the process.

**OTHER STATE AGENCY PILOT PROJECT
FINAL CONTEXTUAL REPORT**

State of _____

This report documents your state's experience with compiling the Other State Agency (OSA) data. This includes, among others, methods used, special considerations on the data, exceptions made, known limitations of the data, crosswalk issues, problems or barriers in the collaborative process, and agency relationships that have a bearing on the accurate interpretation of the data. This report has two sections. Section I contains questions on the process used in implementing the project, and Section II contains the technical notes on the completed OSA data table. States are strongly encouraged to consult with the OSA when completing Part II of this report.

SECTION I, PROCESS:

1. Of the agencies you approached to participate in the project, please check which OSA declined to participate/was not able to engage in the project:

<input type="checkbox"/> Corrections	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Early Intervention
<input type="checkbox"/> Housing	<input type="checkbox"/> Vocational Rehabilitation	<input type="checkbox"/> Juvenile Justice
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Education	<input type="checkbox"/> Child Welfare
<input type="checkbox"/> Others; specify:		

2. Please check all applicable reasons cited by the OSA that prevented it from participating in the project:

Reasons	Corrections	Housing	Medicaid	SA	Voc Rehab	Educ	EI	JJ	CW	Other (specify)*
1 Agency cannot allocate resources for the project										
2 Agency doesn't feel it fits within the project scope										
3 Agency doesn't believe project is relevant										
4 Agency believes that the project is a duplication of an ongoing initiative										
5 Agency did not provide response; no reason cited; did not return calls										
6 Agency data not available, not accessible, IT issues, etc.										
7 Other reasons (specify)										
a										
b										
c										

*To report more "other" agencies, please use the template found on the last page of this report.

-
3. Describe the approach(es) used to collect the data from the other state agencies. Please include all approaches used to engage the OSAs to participate in the project, and specify if each was effective, and if not, state what you could have done otherwise.

4. Based on your experience, what changes would you recommend in the following areas that would have enabled you to be more successful with this project?

a. Protocol

- No changes recommended
 Recommendations

b. Questions and Answers Forum

- No changes recommended
 Recommendations

c. Listserv and Web page

- No changes recommended
 Recommendations

d. Monthly conference call

- No changes recommended
 Recommendations

e. Financial assistance (state transfers)

- No changes recommended
 Recommendations

f. Others suggestions or comments that would be helpful in the successful implementation of the project.

5. Please describe and approximate the state mental health agency resources used in working with the OSA to extract, report, and analyze the requested data

Staff time (total staff hours worked on the project): _____

Programming time: _____ hours

Equipment and software (specify): _____

Other (specify): _____

6. Please briefly describe how Medicaid is structured in your state.

7. What do you find as the most challenging part of the project?

SECTION II, DATA NOTES: *States are encouraged to consult with the OSA when completing this section of the report. Please replicate this section of the report for each OSA table that is completed.*

Check the OSA for which this section is completed:

<input type="checkbox"/> Corrections	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Early Intervention
<input type="checkbox"/> Housing	<input type="checkbox"/> Vocational Rehabilitation	<input type="checkbox"/> Juvenile Justice
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Education	<input type="checkbox"/> Child Welfare
<input type="checkbox"/> Others; specify:		

1. Please describe data sources (e.g., client database, claims, financial statements) and methods used to compile the data reported for this project.

2. Please provide any supplemental notes/comments to explain the reported data on the tables. If you used a crosswalk of state categories (e.g., Medicaid eligibility categories) or services to fit into the prescribed categories on the reporting tables, please include it in your response.

3. Service Category Descriptions. What services are included in each category? If different from the protocol, please state how these services are defined in your state and how they were classified or reclassified to fit the reporting tables.

4. Identification of persons who received services, unduplication, and overlap. What method was used to identify/account for persons who received services? Were you able to unduplicate the number of persons served across service types and across data strata? What method did you use to unduplicate the number of persons? If you were able to calculate the client overlap with the state mental health agency, what method did you use?

5. Please describe and approximate the resources used by the OSA in compiling, extracting, and reporting the requested data

Staff time (total staff hours worked on the project): _____

Programming time: _____ hours

Equipment and software (specify): _____

Others (specify): _____

To report more “other” agencies (Part 1, question 2 continuation):

	Reasons	Other (specify)	Other (specify)	Other (specify)
1	Agency cannot allocate resources for the project			
2	Agency doesn't feel it fits within the project scope			
3	Agency doesn't believe project is relevant			
4	Agency believes the project is a duplication of an ongoing initiative			
5	Agency did not provide response; no reason cited; did not return calls			
6	Agency data not available, not accessible, IT issues, etc.			
7	Other reasons (specify)			
	a			
	b			
	c			

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