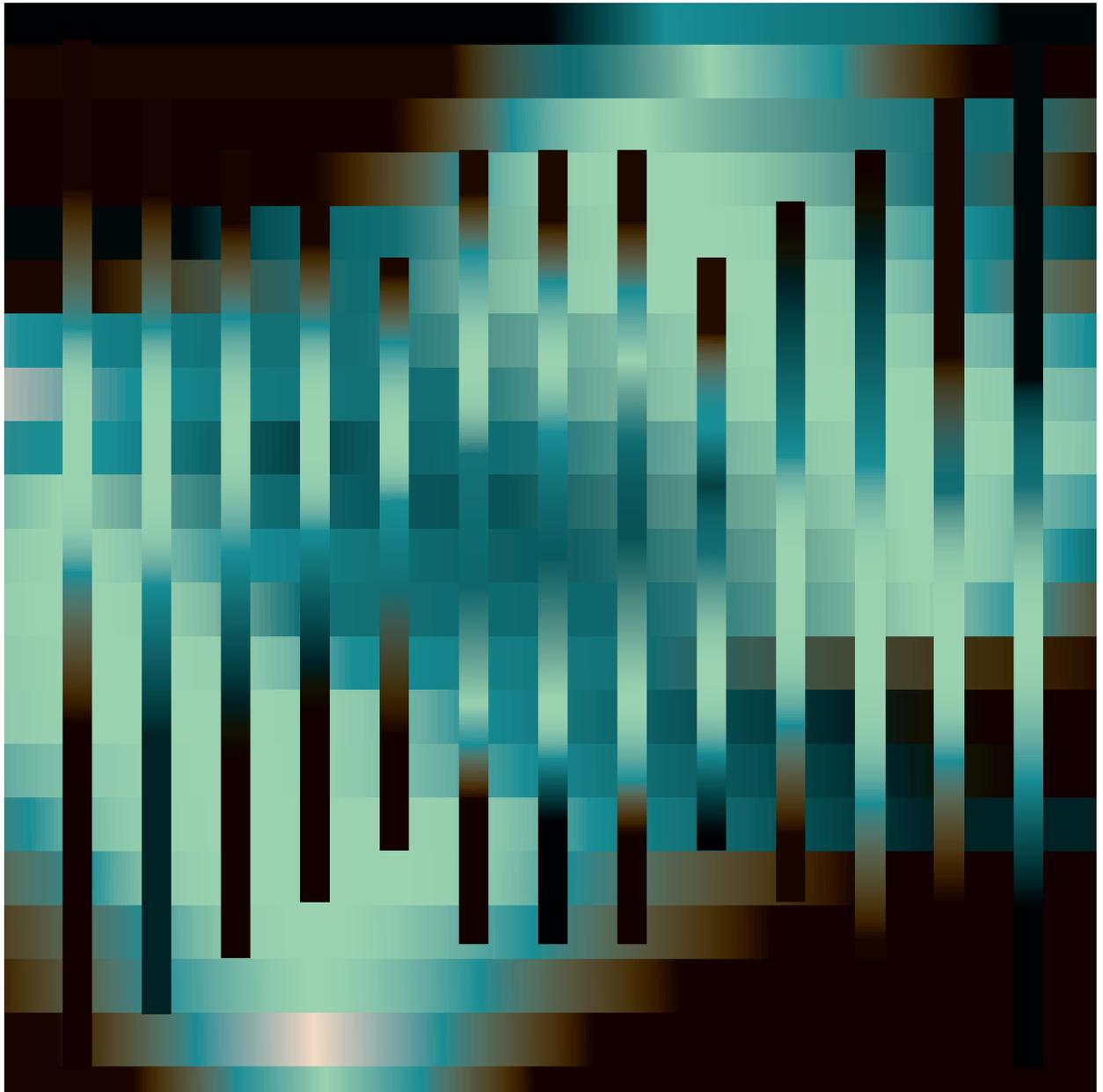


Independent Evaluation of the Community Mental Health Services Block Grant



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
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EXECUTIVE SUMMARY

This report presents the findings of an independent evaluation of the Community Mental Health Services Block Grant program (Block Grant). The evaluation used qualitative and quantitative data gathered from FY 2006 State applications and implementation reports, the Uniform Reporting System (URS), and interviews and surveys with State and Federal representatives.

The Block Grant is the principal Federal discretionary program supporting community-based mental health services for adults with serious mental illnesses and children with serious emotional disturbances. To receive a Block Grant award, States must submit an application prepared in accordance with the law for the fiscal year for which the State is seeking funds. The funds awarded are to be used to carry out the State Plan contained in the application; to evaluate programs and services set in place under the Plan; and to conduct planning, administration, and educational activities related to the provision of services under the Plan.

The purpose of the evaluation was to determine whether the Block Grant is effective in encouraging and facilitating development of effective community-based mental health service systems that promote Federal priorities and support recovery and resiliency for adults with serious mental illnesses and children with serious emotional disturbances.

By design, the Block Grant is a flexible source of funding that States can use to meet the unique needs of their community-based mental health systems. In most cases, Block Grant funds are blended with other Federal or State funds or are allocated directly to community-based provider agencies (termed “subrecipients”), where they are combined with other resources. As a result, it is often difficult to draw a direct line from Block Grant funding to a specific outcome. The evaluators sought to capture a combination of quantitative data on outcomes likely affected by Block Grant funding, plus qualitative input from those on the front lines of mental health services in the States who can speak to the impact of the Block Grant from firsthand experience.

This report presents considerable information on the Block Grant, the role it plays in driving change, and the way it fits into the larger context of mental health transformation.

The broad lessons, stakeholder recommendations, activities, and specific examples herein may prove useful not only for policymakers and program administrators, but also for the mental health system’s other key stakeholders (e.g., service providers, consumers, family members, advocates, etc.).

State and Federal representatives interviewed in the course of the evaluation offered a number of suggestions for improving the Block Grant. Across all recommendations, State and Federal interviewees stressed the importance of involving States and subrecipients to support implementation and ensure that any adjustments are shaped in part by contributions from these important stakeholders.

Following is an overview of the highlights of this independent evaluation of the Block Grant. Taken together, these findings demonstrate that the Block Grant is meeting the requirements of its congressional mandate and has proven effective in helping develop a stronger mental health system both in individual States and nationwide.

QUESTION 1 – Is the Block Grant being implemented according to congressional intent?

The evaluation indicates that the Block Grant is being implemented according to congressional intent. State and Federal stakeholders reported a high level of collaboration and information exchange that result in the development of effective State Plans serving adults and children with the most serious disorders.

Selected outcomes

- Nearly 6 million adults and children accessed mental health services through state mental health agencies (SMHAs) in FY 2006. An average of 73 percent of adults and 76 percent of children met the criteria for serious mental illnesses and serious emotional disturbances, respectively. Twenty-three percent of adults and 6 percent of children receiving services had co-occurring mental and substance use disorders.
- All States have State Mental Health Planning and Advisory Councils (Planning Councils). Many Planning Councils played significant roles in statewide planning, advocacy, and outreach efforts that exceed what is required in the Block Grant’s authorizing legislation.

- The Block Grant application and guidance encourage States to create comprehensive State Plans that cover the full range of system needs and services for adults and children.
- The regional review process offers an opportunity for States to exchange information, hear about innovative programs or strategies, and learn from the experiences of other States.
- Monitoring site visits allow Federal staff to see Block Grant-funded programs in context and identify opportunities to provide targeted training and technical assistance (TA).
- Training and TA provided to States through the Block Grant expose SMHA staff to promising practices and efficient implementation methods.
- URS data collection and reporting activities have increased the extent to which States are able to comprehensively describe program outcomes and client services, and to identify service gaps.

QUESTION 2 – Is the Block Grant achieving the results it was created to achieve?

The Block Grant, through both its funding design and the application of its legislative requirements, empowers SMHAs to better address the needs of adults and children with serious mental illnesses and serious emotional disturbances. Stakeholders believe that increased funding would provide valuable support for implementation of evidence-based mental health practices, data infrastructure, and TA.

Selected outcomes

- From 2004 to 2006, the vast majority of consumers of public mental health services said that they were satisfied with adult (84-86 percent) and child (76-79 percent) services.
- Representatives from more than two-thirds of States interviewed credited the Block Grant with contributing to

an increase in consumer involvement and use of community-based treatment services, including evidence-based practices; they also credited the Block Grant with decreasing unmet need.

- Eighty-two percent of States reported implementing at least one evidence-based practice in FY 2006. Supported Housing, Supported Employment, and Assertive Community Treatment were the practices most commonly received by adults; Therapeutic Foster Care was the practice most commonly received by children.
- Representatives from more than 50 percent of States interviewed reported leveraging the Block Grant funds to achieve an impact greater than the size of individual State grants would suggest. States also used the Block Grant's Maintenance of Effort (MOE) requirement to protect critical mental health funding from other sources.

QUESTION 3 – Does the Block Grant promote innovation?

By using Block Grant funds as seed or startup monies, States can demonstrate effectiveness of new or expanded programs, which in turn makes them more effective in seeking additional financial resources such as Medicaid reimbursement or other government funds.

Selected outcomes

- States have used Block Grant funds to initiate or supplement such promising practices as peer support, jail diversion, suicide prevention, information technology (including telemedicine), self-directed care, and disaster response.
- States have also used Block Grant funds to help build programs around outreach and education, reduction in bias and discrimination, and evaluation and consumer satisfaction, as well as to support programs directed toward rural, transitional, and veteran populations.

I. INTRODUCTION

In 2003, the Office of Management and Budget (OMB) conducted an assessment of the Community Mental Health Services Block Grant (Block Grant) using the Program Assessment Rating Tool (PART). OMB's assessment rated the Block Grant as "adequate," placing it within the top 25 percent of Federal Government programs rated at that time. OMB also recommended to the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), and the U.S. Department of Health and Human Services (HHS) that the Block Grant undergo a full, independent evaluation. This document is CMHS's report of the resulting independent evaluation of the Block Grant as it existed in FY 2006.

Because of the program's intentionally flexible design, specific Block Grant dollars generally cannot be traced directly to individual outcomes, making program evaluation

inherently challenging. States use Block Grant monies to meet the unique needs of their mental health systems, and in most cases, Block Grant funds are blended with other Federal or State funds or are allocated directly to community-based provider agencies (termed "subrecipients"), where they are combined with other resources.

Nonetheless, the qualitative and quantitative results of this evaluation demonstrate that the Block Grant plays a role in achieving SAMHSA's mental health transformation goals. The flexible nature of Block Grant funding allows States to explore new initiatives and strategies; target identified needs with special programs; pay for services not covered by public/private insurance (e.g., peer support programs, distance learning) that are recovery focused and consumer centered; and create the administrative, organizational, and service delivery linkages that foster a community-based, transformed system of mental health services.

II. METHODOLOGY AND LIMITATIONS

To provide context for this evaluation, CMHS identified three core objectives (Table 1) that characterize the purpose of the Block Grant: to encourage and facilitate the development of effective community-based mental health service systems that promote Federal priorities and support recovery and resiliency for adults with serious mental illnesses and children with serious emotional disturbances.

An Evaluation Advisory Workgroup (EAW) made up of consumers, representatives from advocacy organizations, Planning Council members, and State mental health agency (SMHA) staff advised on the review’s design and implementation, dissemination of findings, and use of the findings to improve the Block Grant. The EAW convened consistently throughout the evaluation, with an annual in-person meeting and multiple conference calls each year. A roster of EAW members appears in Appendix E.

The Evaluation Team developed a set of secondary questions designed to address each objective as directly as possible (Table 1). They also crafted a logic model to capture the components of the Block Grant at the State and Federal levels (Figure 1). The logic model is based on the statute that established the Block Grant, as well as input from the Federal staff who currently administer the program.

Evaluation methodology

This retrospective evaluation of the Block Grant used a multi-level, cross-sectional approach, collecting four key types of data (Table 2): quantitative data reported by SMHAs to the Uniform Reporting System (URS); qualitative data derived from FY 2006 Block Grant applications and implementation reports from the 59 States and territories; Web-based survey responses from regional reviewers, site visit monitors, and Planning Council members; and in-person interviews with CMHS staff and representatives from 19 States (Table 3). Through these approaches, the Evaluation Team obtained both subjective perspectives and objective evidence about the ways in which the Block Grant affected the States in FY 2006.

In-person interviews. The Evaluation Team conducted semi-structured interviews with Federal staff who administer the Block Grant and State staff who implement it. Team

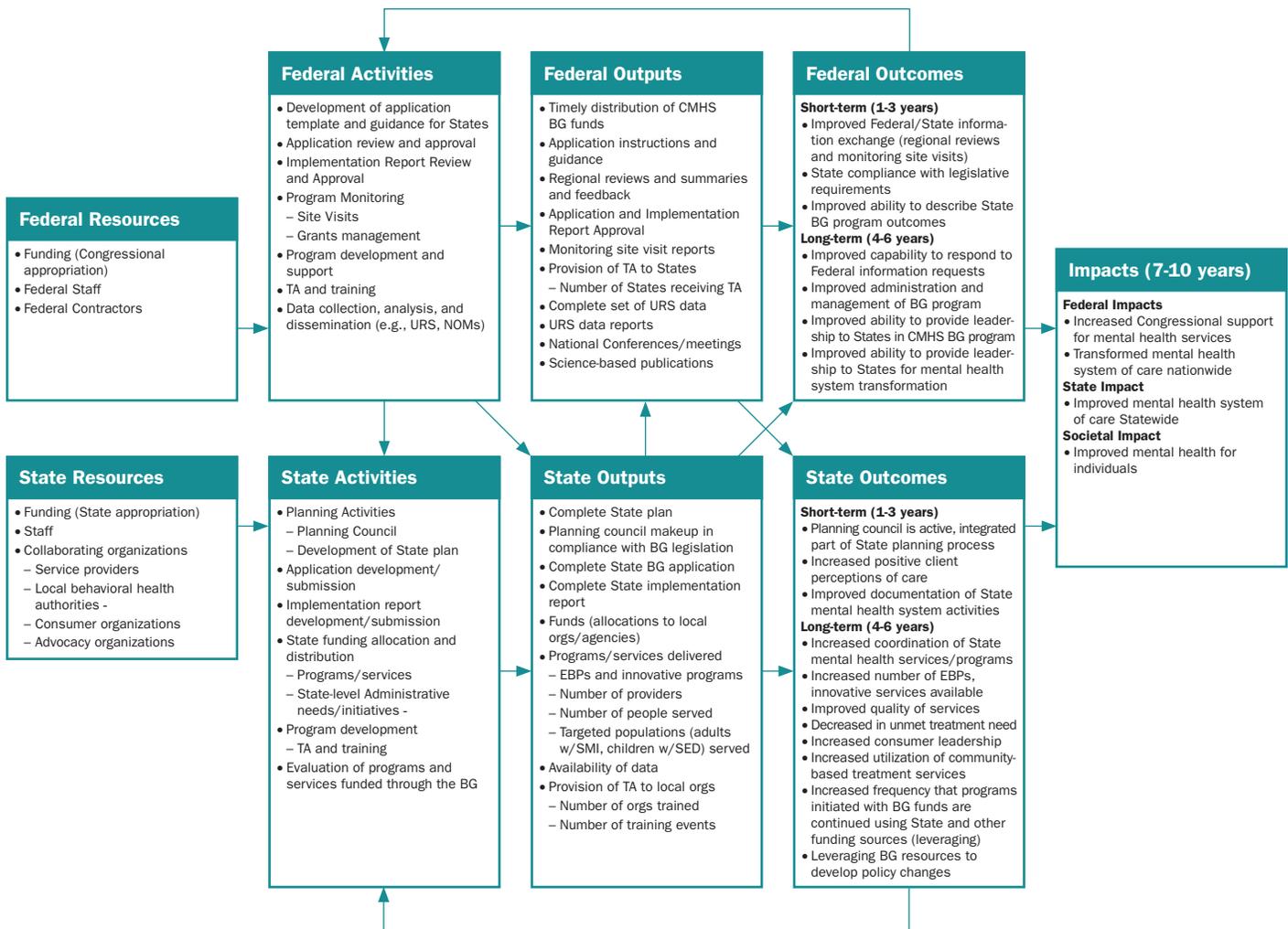
members trained in both general and protocol-specific interviewing performed the in-person interviews.

Evaluators administered the 57-item Federal interview protocol (Appendix B) to 22 Federal staff within CMHS and SAMHSA. The sample included Federal Project Officers (FPOs) from the Division of State and Community Systems Development, which administers the Block Grant; the CMHS Director and Deputy Director; and staff from SAMHSA’s Office of Policy, Planning, and Budget. Federal interviews lasted approximately 90 minutes and were designed to elicit responses from a wide range of Federal officials with strong knowledge of and involvement in the program.

Table 1. Objectives of the Independent Block Grant Evaluation

Primary Objective	Secondary Questions
Evaluate the extent to which the Block Grant is implemented according to congressional intent by examining State Mental Health Planning and Advisory Council involvement, application and implementation report development, the regional review process, the monitoring site visit process, and Block Grant technical assistance.	<ul style="list-style-type: none"> Is the Block Grant being implemented according to congressional intent? <ul style="list-style-type: none"> Do States submit applications? Are Planning Councils involved? How does CMHS ensure compliance?
Examine the extent to which States leverage Block Grant funds to spur policy changes, infrastructure supports, and system building to promote Federal policy goals and initiatives in support of SAMHSA’s Mental Health System Transformation Agenda.	<ul style="list-style-type: none"> Is the Block Grant achieving the results it was created to achieve? <ul style="list-style-type: none"> Are community mental health systems stronger as a result of the Block Grant? Do States use the Block Grant in a way that is consistent with Federal priorities?
Document innovative ways in which States use Block Grant funds to build community-based systems of mental health services.	<ul style="list-style-type: none"> Does the Block Grant promote or facilitate innovation among the States and their community-based systems of mental health services? <ul style="list-style-type: none"> What are examples of such innovation?

Figure 1. Logic model for the independent evaluation of the Community Mental Health Services Block Grant. -



To maximize the quality, depth, and accuracy of the data collected, evaluators conducted site visits with a sample of States selected using the following criteria:

- At least one large State with a metropolitan area;
- At least one rural State with a relatively small population;
- At least one State with an ethnically/racially diverse population;
- At least one State where Block Grant funds comprise a larger percentage of the State’s budget for mental health services;
- At least one State where Block Grant funds comprise a smaller percentage of the State’s budget for mental health services;
- States representing diverse service systems (e.g., State as provider, combined mental health-substance abuse departments, etc.); and

- States from each of the five Block Grant regions.

Because of the high time and cost burden required for travel outside the continental United States, only the lower 48 States were considered for onsite, in-person interviews. Evaluators asked State Mental Health Commissioner/ Directors to help select State staff members for participation, to include at a minimum the State Planner, State Data Analyst, and State Mental Health Commissioner/Director.

Evaluators pilot tested the 105-item State protocol on 6 States before administering it to 19 States in total (Table 4). Interviews lasted approximately 3.5 hours, to allow adequate time to explore the Block Grant activities that take place at the State level.

Web-based surveys. Evaluators distributed Web-based surveys to a variety of stakeholders within the 59 states and

territories, including Planning Council members, State Planners, State Data Analysts, and State Mental Health Commissioner/Directors. After extensive discussion with the EAW, the Evaluation Team selected the Web-based mode of survey administration in large part because of the following advantages:

- Responses to the electronic survey instrument are captured automatically and coded in a SQL database for later analysis;
- The system is designed to produce evaluation reports based on administrator-determined criteria;
- Surveys can be self-administered by multiple respondents simultaneously at no additional cost;
- The Web-based system allows respondents to access the survey multiple times and complete and save parts of it each time, increasing the likelihood that participants will complete the full survey; and
- Flexible scheduling and convenience make the Web-based system less burdensome to respondents compared with other modes.

The Evaluation Team tailored a Section 508-compliant off-the-shelf survey administration software package to the specific surveys (Appendix B). Table 4 describes the population and response rate for the stakeholder groups. Because of the challenges inherent in administering surveys via the Web (discussed in greater detail in the “Limitations” portion of this section), the Evaluation Team sent the survey to the entire population of each stakeholder group to maximize the

number of respondents. Although these challenges are not unique to this evaluation, they may have contributed to the relatively low response rate. No data were available to determine differences between those who completed the survey and those who did not.

The Evaluation Team contacted stakeholders via email describing the survey and inviting them to participate and allowing 8 weeks for survey participation; addresses were collected from CMHS staff and the National Association of Mental Health Planning and Advisory Councils (NAMHPAC). Each email message contained a direct Web link to the survey, as well as contact names, phone numbers, and email addresses for those who preferred to complete the survey in hard copy or via structured telephone interview. The Evaluation Team sent automated reminder emails every 3 weeks thereafter during the 8-week period the survey was available for completion.

Quantitative data abstraction. The Evaluation Team obtained URS data for FY 2004-2006 from the contractor who manages the system and used selected data for descriptive analyses and in support of the evaluation framework. Data include demographic characteristics of the persons served, use of evidence-based practices (including number funded, number of States funding them, and number of clients receiving them), client assessment of care, insurance status, and SMHA expenditures. All percentages are rounded to the nearest tenth.

Table 2. Data Collection and Analysis Methods

Collection Method	Source	Instrument	Analysis Method
In-person interviews	22 CMHS staff 19 representatives from State mental health agencies	Interview protocols for Federal and State staff (Appendix B)	EContent analysis (NVivo v.7)
Web-based surveys	192 Planning Council members 11 regional reviewers 7 monitoring site visitors	Stakeholder surveys (Appendix B)	Content analysis (NVivo v.7)
Quantitative data analysis	Uniform Reporting System 2004-2006	N/A	Descriptive statistics (i.e., central tendency, rates); Kruskal-Wallis test (Stata 9)
Qualitative data abstraction and analysis	FY 2006 Block Grant application and implementation reports	Data abstraction form (Appendix B)	Content analysis (NVivo v.7)

NOTE: All data collection instruments were approved through the Office of Management and Budget. NVivo v.7, QSR International (Doncaster, Victoria, Australia). Stata 9, StataCorp LP (College Station, TX).

Table 3. States Participating in In-Person Interviews

Region	State	Rationale
Midwest	Illinois	Large, diverse, high spending per capita
	Iowa	Small, rural plains State, services provided by counties
	Michigan	Large, diverse
	Wisconsin	Rural and urban areas, Northern plains State
Northeast	Delaware	Small, urban, diverse, high spending per capita, but smaller percentage of revenue from Block Grant compared to other States. Evaluation of incentive-based contracting system to be published in an upcoming issue of Health Policy. State provides services as well as contracts for services
	Massachusetts	Urban and rural areas, diverse, high spending per capita, regional service system with State- and managed care vendor-operated programs
	New York	Large, diverse, high spending per capita. State provides services as well as contracts out services
	Vermont	Small, rural population in northern New England. Not funded well compared to other States including Block Grant allocation. Piloting an integrated service structure for co-occurring disorders
Southeast	Florida	Large, diverse, high spending per capita in total, but with low percentage of Block Grant contribution compared to other States
	Georgia	Small, rural, larger percentage of Block Grant funding compared to other States. Regional service system with State- and vendor-operated programs
	North Carolina	Large, diverse, larger percentage of Block Grant funding compared to other States. Combined mental health and substance abuse State system
	West Virginia	Small, rural State, not funded well overall
Southwest	Arkansas	Small, mostly rural, not funded well but with larger Block Grant percentage compared to other States, integrated mental health and substance use department
	Colorado	Large, urban and rural areas. State contracts treatment services to local provider programs
	New Mexico	Geographically large, rural areas, diverse, not funded well overall but with larger Block Grant percentage compared to other States
	Texas	Large, diverse, urban and rural, large geographic area, high spending per capita. State contracts with local mental health agencies
West	California	Large, diverse, high spending per capita with low Block Grant percentage compared to other States. State provides services as well as contracts with counties for provision of treatment
	Washington	Urban and rural areas, high spending per capita. Regional treatment network comprising counties and public and private treatment programs
	Wyoming	Small, rural, frontier State, not funded well, with low Block Grant percentage compared to other States. Combined mental health and substance abuse State system

NOTE: The Midwest region comprises States with similar percentages of Block Grant funds compared to total monies dedicated to mental health, so this criterion was not used for that region.

To minimize the effects of skewed distributions and extreme outliers, this report describes continuous data in terms of medians, interquartile ranges (IQRs), and ranges instead of means and standard deviations. The Evaluation Team applied the Kruskal-Wallis test to assess for the significance of

differences in medians across 2004-2006¹ and used Stata 9 (StataCorp LP, College Station, TX) to perform all quantitative analyses.

Qualitative data abstraction. States are required to apply for Block Grant funds each year. In these annual

¹The Kruskal-Wallis test determines whether at least one of the year values is different from the other year values. Subsequent use of pairwise comparisons (Dunn procedure) identifies the particular year values that are different.

applications, States describe their mental health system of care in detail, including children’s services; data infrastructure; and services for rural, homeless, and elderly adults. States also submit implementation reports describing their accomplishments of the preceding year. The FY 2006 documents represented the most recent set of fully completed applications and implementation reports submitted as of the start of this evaluation and were the source of the qualitative data the evaluators abstracted and analyzed.

Applications describe funds set aside for children’s mental health services, report on activities of Planning Councils, provide an overview of the State service system, and summarize the intended plan for providing services throughout the State. In the implementation report, States identify areas they recognize as needing improvement, describe the previous year’s most significant events affecting the State mental health system and the clients it serves, and list sub-recipients, or those agencies to which the State distributed Block Grant funds.

To conduct data abstraction, the Evaluation Team identified questions and developed an abstraction form for secondary data reviews based on the evaluation framework. The evaluators trained a team of research analysts on evaluation-specific methods and provided access to the Web Block Grant Application System (WebBGAS) electronic portal. Once the research analysts finished abstracting the data, a team of senior analysts conducted a content analysis of each question from the abstraction form for every State. They identified and grouped key themes and commonalities across States and conducted further analysis to identify higher-order themes that emerged from the groupings.

They then stored and cleaned all data, including interview responses and abstracted program information, in

Microsoft Word and subsequently imported it into NVivo v.7 (QSR International, Doncaster, Victoria, Australia) for content analysis. Specific examples of Federal and State accomplishments and Block Grant outcomes were also stored in NVivo.

Limitations of the evaluation

As with all evaluations, the independent review of the Block Grant reported herein has a number of limitations. In particular, the time and resources available for this evaluation, combined with the sheer volume of documentation from the 59 Block Grant recipients, limited the scope of document analysis and review to 1 year, FY 2006. This evaluation design did not allow for examination of how the quality and/or usefulness of program documents may have changed over time. Although the Evaluation Team analyzed URS data for the period 2004-2006, readers should consider findings from other data sources only in the context of how the Federal Government administered the 2006 Block Grant.

The retrospective nature of the evaluation also carries inherent challenges. Data used in this evaluation of the Block Grant come from multiple sources with varying degrees of quality and objectivity. Data from interviews and surveys reflect the perceptions, opinions, and experiences of individual participants, who have differing goals, timelines, and methods of collecting, interpreting, and reporting data about their own State’s Block Grant activities. Social desirability may have affected responses, particularly during State staff group interviews in which State staff may have replied in a manner that would be viewed favorably by others. Block Grant applications and implementation reports may have been prepared with a view toward presenting the

Table 4. Stakeholder Survey Population and Response

Stakeholder Group	Total Population	Number of Respondents	Response Rate (%)
Planning Council members and chairs	2,078	192*	9.24
Regional reviewers	34	11	32.35
Monitoring site visitors	25	7	28.0
Total	2,137	210	9.83

* 200 email survey invitations were returned undelivered due to faulty email addresses.

States' programs in the best possible light and minimizing program challenges, the discussion of which may have affected the findings of this evaluation. Finally, the extent to which States have a systematic process in place to assess the quality of data reported by subrecipients is not known.

To this end, it is important to note that the information used in the qualitative analyses was reported by States for the purpose of completing their FY 2006 Block Grant applications and implementation reports and not with the intent of responding to the evaluation questions identified. There is natural variability in the extent to which States reported certain information. Consequently, not every State is represented in every element of the full qualitative or quantitative analysis presented in this report. Where relevant, the text indicates the number of States reporting on a particular finding.

At this time, there is no large-scale source of quantitative data exclusively from the Block Grant. The URS, from which a large proportion of data were extracted for this evaluation, describes the entire public mental health system at the State level, not just the Block Grant. Because of the numerous agencies and programs reporting to the URS and the flexibility of Block Grant funds to be used where they are most needed in each State, the Block Grant cannot be definitely credited with improvements or other changes any more than can any other State funding source.

The same is true of the National Outcome Measures (NOMs), which are populated with URS data. At URS's inception in 2001, States were also asked to report on NOMs. SAMHSA uses the NOMs to measure whether the Agency's vision is being achieved. In collaboration with the States and jurisdictions, each of the 10 NOMs domains is associated with desired program outcomes and specific performance measures for mental health, prevention, and treatment. As of December 1, 2007, 85 percent of States were able to report on 8 of the 10 NOMs. Because of the small number of client data points and the cultural and infrastructure differences between the Pacific jurisdictions and the 48 contiguous States, Alaska, Hawaii, and the District of Columbia, data from only the lower 48 states data were included in the quantitative analysis.

Additionally, the URS was in only its fifth year during FY 2006, and States were focused at that time on reaching

full reporting of the required data. As such, these data vary greatly in quality and completeness. For example, although CMHS requires States to report on client perceptions of care, some States surveyed such a small client population that any possible conclusions based on those data are severely limited.

As noted briefly above, the response to the Web-based Planning Council survey was relatively low. This low response rate may limit the generalizability of the resulting data. Such challenges are common in administering online surveys, and this evaluation was no exception. Challenges encountered in conducting this survey included the following:

- Some Planning Council members did not have easy access to the Internet.
- Some Planning Council members did not have valid email addresses.
- Some Planning Council members were extremely uncomfortable with or mistrustful of submitting information over the Internet.

Also of note is that several characteristics of the Block Grant itself make it difficult to attribute specific outcomes to the program. For instance, the broad variation in needs and systems from State to State made use of a comparison group a virtual impossibility for this evaluation. Although the Evaluation Team developed criteria specifically to ensure a diverse and representative sample for in-person interviews, the considerable diversity across States in combination with the program's flexibility means that no subset of States is representative of all States. With SMHAs choosing vastly different ways of using Block Grant funds, there is no way to ensure that the findings of the onsite interviews are comparable across all States.

Finally, the small proportion of State community mental health spending made up of Block Grant funds, combined with the intentional flexibility States have in allocating funds to subrecipients, pose another challenge. In some cases, States can identify particular initiatives or activities funded exclusively with Block Grant dollars. But in most cases, Block Grant funds are blended with other sources of revenue to leverage existing resources and/or support services. This makes it extremely difficult to track exactly which behavioral health outcomes are direct results of Block Grant funding in any particular State.

III. BACKGROUND

History of the Community Mental Health Services Block Grant

The Block Grant evolved out of a 45-year history of support by the Federal Government for the development of community-based services for people with mental illnesses. In 1963, the Community Mental Health Centers (CMHC) Act was adopted to support the development of comprehensive mental health services in local communities. In 1981, support provided under the CMHC Act was converted into a Block Grant administered by the National Institute of Mental Health. Subsequent legislation in 1986 and 1990 further encouraged States to develop and enhance community-based systems of care. In 1992, Congress passed legislation moving responsibility for administration of the Block Grant to CMHS, part of the newly formed SAMHSA within the U.S. Department of Health and Human Services (HHS). In FY 2006, the Block Grant budget was \$428 million.²

The Block Grant is the principal Federal discretionary program supporting community-based mental health services for adults with serious mental illnesses and children with serious emotional disturbances. To receive a Block Grant award, States must submit an application prepared in accordance with the law for the fiscal year for which the State is seeking funds. The funds awarded are to be used to carry out the State Plan contained in the application; to evaluate programs and services set in place under the Plan; and to conduct planning, administration, and educational activities related to the provision of services under the Plan.

A grant may be made only if the application includes a State Plan that meets five specific criteria articulated in the statute and is approved by the Secretary of HHS.³ The State Plan must:

- Provide for the establishment and implementation of an organized, community-based system of care for individuals with serious mental illnesses;

- Estimate the incidence and prevalence of serious mental illnesses (adults) and serious emotional disturbances (children) within the State;
- Provide for a system of integrated services appropriate for the multiple needs of children;
- Provide for outreach to and targeted services for rural and homeless populations; and
- Describe the financial and other resources necessary to implement the Plan and describe how the Block Grant funds are to be spent.

The State must provide any data required by the Secretary pursuant to the statute and cooperate with the Secretary in the development of uniform data collection criteria.⁴ A State applying for Block Grant funds must also create a State Mental Health Planning and Advisory Council (Planning Council); maintain a specific level of expenditures for children's services and for overall community mental health services; and demonstrate that it has implemented its State Plan for the previous funding year.

The Block Grant represents only a small amount of most States' *community* mental health funding. In 2005, Block Grant funds accounted for 2 percent of State mental health agency (SMHA) community mental health expenditures (\$20.5 billion) and less than 2 percent of *all* SMHA expenditures (\$29.4 billion). If Medicaid and other funding sources outside the control of SMHAs were included in the figure, in FY 2005 the Block Grant constituted only a fraction of 1 percent of public mental health spending (National Association of State Mental Health Program Directors Research Institute, Inc., 2007).

Despite the limited size of the Block Grant, many States report that the flexibility and stability of Block Grant funding make it an important component of their public mental health system. Funding can be used to support new services and programs, enhance existing programs, expand access, and leverage additional State and community dollars. Some States allocate Block Grant dollars to counties or regional mental health agencies using a formula or other grant

²FY2006 funding information is cited here because the data abstracted and analyzed for this evaluation was from the States' FY 2006 Block Grant applications.

³Section 1912(a)-(b) of the PHS Act.

⁴Section 1943(a)(3) of the PHS Act.

process. Other States use Block Grant dollars to support specific services or initiatives. This may include the State providing funding directly to providers, advocates, consumers, or family members to support State needs or priorities. Block Grant dollars can be pooled with other resources to support larger projects or multiagency initiatives. The Block Grant statute includes only a few specific prohibitions on the use of funding; for example, States may not use Block Grant funding to support inpatient services.

The Block Grant's historical emphasis on transforming mental health systems to emphasize community-based care was supported in 2003 with the release of the President's New Freedom Commission on Mental Health report *Achieving the Promise: Transforming Mental Health Care in America*. That report called for a complete transformation of the mental health system to accomplish six specific goals designed to achieve "a future when everyone with a mental illness at any stage of life has access to effective treatment and supports—essentials for living, working, learning, and participating fully in the community."

The report followed and reinforced a landmark 1999 U.S. Supreme Court decision in *Olmstead v. L.C. and E.W.*, which required States to provide services to people with disabilities in the most integrated setting appropriate for their needs. Both the New Freedom Commission report and the *Olmstead* decision were supported by HHS through policy and supports designed to encourage States to implement mental health transformation and community integration.

The flexibility of the Block Grant makes it an effective vehicle through which CMHS supports States in these efforts. Its primary purpose—to support the development of effective community-based systems of care—is consistent with the core principles of the *Olmstead* decision. In addition, Block Grant funding can be used to support a broad range of initiatives to promote recovery, resiliency, and other goals of mental health transformation. Beginning in FY 2009, States were asked to report the amount of Block Grant funding used to support mental health transformation activities.

Components of Block Grant implementation

State Mental Health Planning and Advisory Councils

Federal statute articulates three discrete purposes for Planning Councils: (1) to review the State Mental Health

Plan and make recommendations to the State; (2) to monitor, review, and evaluate State mental health services; and (3) to serve as advocates for adults with serious mental illnesses and children with serious emotional disturbances.

The Planning Councils represent a diverse array of State mental health stakeholders. The legislation specifies that each Council must include staff representing the State agencies responsible for mental health, housing, criminal justice, social services, and vocational rehabilitation, and Medicaid. It must also include adult consumers with serious mental illnesses; family members of either adult consumers or children with serious emotional disturbances; and representatives from public or private organizations involved in the provision, planning, funding, or use of mental health services and supports. To ensure adequate consumer and family participation, the legislation also requires that at least 50 percent of the Council's membership be individuals who are not State employees or mental health service providers.

State Plans, applications, and implementation reports

The five criteria of the State Plan, discussed in the section "History of the Community Mental Health Services Block Grant," form the basis of the applications for Block Grant funds that States submit to CMHS each year. The Plan itself outlines the framework for the State's mental health system, including comprehensive, community-based mental health service systems; mental health system epidemiology data; children's services; targeted services to rural and homeless populations and to older adults; and management systems.

By statute, States submit applications to CMHS annually on September 1 with detailed descriptions of their current systems of care and their plans for implementing the systems of care in the coming year. States must also submit an implementation report on December 1 of each year detailing their activities and achievements for the preceding fiscal year. Most States submit their applications and implementation reports through the Web Block Grant Application System (WebBGAS) electronic portal.

Regional reviews

CMHS conducts an annual consultative regional review of every State's Block Grant application (based on the State

Plan) and implementation report for compliance with the requirements of the statute. Each review is performed by a Regional Review Panel of peers, which includes State mental health staff, current or former Planning Council members, mental health consumers, advocates, family members, and mental health service providers. The Chair for each region is an experienced reviewer and generally has held that role for multiple years. Similarly, the majority of the reviewers on each panel have served as reviewers previously, with one to two new reviewers per panel each year.

Reviews are divided across five regions—Northeast, Southeast, Midwest, Southwest, and West—and reviewers typically are selected from a State in the region under review. Each reviewer brings direct experience in developing or reviewing a State Plan or application for the Block Grant program and is thus familiar with its content and requirements, as well as with the level of work required to prepare the document. CMHS conducts a reviewer training session each year and gives reviewers access to the Block Grant plans and applications several weeks before the review.

Federal Project Officers (FPOs) for the States being reviewed attend as technical experts. The FPOs represent a consistent Federal response across the Regional Review Panel to questions regarding statutory and technical compliance, modifications or requests for information, and technical assistance (TA).

To the extent possible, concerns regarding State compliance with requirements that arise before the regional review are transmitted to the State and FPO for resolution before the face-to-face meetings, thus reducing the need to address technical compliance details during the review. Reviewers and FPOs meet 1 day before the full regional review to compare notes and discuss any concerns regarding State compliance.

Questions regarding compliance with Block Grant application requirements that cannot be resolved in advance are addressed to State representatives during the course of the review. If the questions cannot be answered or clarified during this discussion, the State submits a modification to meet the requirement (e.g., by providing missing data, clarifying text, etc.) within 30 days. Once compliance issues have been addressed, regional reviewers routinely ask for further information regarding State initiatives, strengths, challenges,

and strategies described in the State Plan or application, or mentioned by the State representatives or Planning Council Chair.

Monitoring site visits

The purpose of a monitoring site visit is to verify a State's compliance with the requirements of the Block Grant and to assess the public mental health system's progress toward the Block Grant goal of establishing a comprehensive, community-based system of care that meets the needs of adults with serious mental illnesses and children with serious emotional disturbances. Site visits last 3 days and occur every 3-5 years for each State. During this onsite monitoring, the Block Grant Monitoring Team observe and learn about Block Grant-supported programs and the State mental health system. The Block Grant Monitoring Team also provides guidance to the State on specific programs and challenges.

The organization and execution of each site visit is supported by a contractor who facilitates previsit conference calls and sharing of materials for State and Federal participants. Those involved in each visit receive information materials provided by the State in advance of the visit (either on compact discs or via the contractor's Web site). Conference calls between the monitors and CMHS staff, facilitated by the site visit contractor, provide FPOs the opportunity to discuss the status of State systems and highlight issues important to the State that would be addressed by the monitors on the visit.

One month before the visit, States receive a CMHS packet detailing expectations for the site visit and protocol organized by adult, child, and fiscal categories (the monitoring prompts outline the parameters of the visit and facilitate the purpose of the visit) and information on the final report. A template for the agenda outlines the information to be covered by the monitoring prompts, requesting that the State insert the names of staff that would be responsive to each section.

The programs visited and the information presented at each site visit varies based on how each State is structured and how the State uses Block Grant funds. Each site visit follows the same protocol with regard to compliance with the Block Grant statute and the program's organization to provide a comprehensive, community-based system of care. These activities include a State presentation,

interviews and exchanges between State staff and the Block Grant Monitoring Team, and a visit to a local program. The Block Grant Monitoring Team may make recommendations for TA and/or the States may request TA; such recommendations and requests are referred to the TA contractor.

Following each visit, the Block Grant Monitoring Team develops a report summarizing findings, recommendations, the site visit process, and the State system. Each member of the Block Grant Monitoring Team reports on areas that fall within his or her expertise (e.g., adult services, child services, fiscal management, etc.), with one monitor assigned as the team leader. The FPO reviews the draft, followed by the State. Once any factual revisions or other edits are complete, the CMHS Director approves and signs off on the final report.

Training and TA

Five percent of Block Grant funding is set aside for CMHS to provide TA and consultation to SMHAs, State Mental Health Planning and Advisory Councils, consumers, and families to help ensure that the best practices and most up-to-date knowledge in mental health and related fields are translated into action at the State and local levels. Currently, much of the TA provided by CMHS is designed to help States and communities transform their mental health systems to be evidence based, recovery focused, and consumer centered.

CMHS has also used this 5 percent set-aside to fund activities that promote community integration of individuals with serious mental illnesses in line with the Supreme Court's 1999 decision in *Olmstead v. L.C. and E.W.* In addition, CMHS conducts national and regional TA meetings to help States develop their annual applications (known as State Plans), enhance their existing systems of community mental health services, and report on a set of national mental health objectives.

Also as part of the Block Grant TA set-aside, States have access to regulated, customized, on-site training and TA for SMHAs, Planning Councils, consumers, families, and community-based organizations on a variety of issues, including co-occurring disorders, disaster mental health planning and response, and the reduction and elimination of seclusion and restraint, among other topics. Community mental health centers can receive

such assistance if they are a stakeholder in the particular training topic that a State's Mental Health Commissioner/Director requests.

States determine the type of TA they require based on their assessment of emerging and ongoing public mental health system needs. CMHS works to help States define their priorities but does not direct the spending of Block Grant funds for TA activities. CMHS makes training and TA available to States through a TA contractor, the FPO, training conferences, and requests. States can request TA in the grant application, during the review process, and through a formal request at other times.

In addition to training and TA made available directly from CMHS, States may use Block Grant funds to support training and TA and development for their staff and subrecipients (i.e., those to whom States allocate Block Grant funds, such as providers, regional behavioral health agencies, and counties).

Data collection

Federal grantees are increasingly required to demonstrate accountability, in part by submitting data on performance measurement. These data enable stakeholders to track progress toward program goals and objectives. States report such data as client demographics, outcomes of care, quality of care, and expenditures. These data provide "snapshots" of the mental health system at specific points in time. URS data are gathered, reported, and analyzed by an independent contractor who identifies and reports on trends, mortality rates, and other information to describe how the Block Grant serves specific populations. CMHS also conducts limited in-house analyses of URS data to determine the extent to which States are accomplishing their goals.

To meet Block Grant reporting requirements, States often need to collect required data from their subrecipients (i.e., those agencies to which they allocate Block Grant funds). To accomplish this, many States use Web-based forms and document collection systems and hard-copy narratives submitted by subrecipients. Types of subrecipient data include services provided and client demographic data (e.g., populations served, special services provided); admissions; length of stay; involuntary commitments; drug use; age distribution; modality of treatment; cost of services; and administrative functions (e.g., financial resources,

projected budget by income source, expense categories, program and personnel resources).

Among the data States submit to the URS are information about their use of evidence-based practices. As identified by the 2006 URS Guidelines for Reporting Evidence-Based Practices (DIG Coordinating Center 2006), evidence-based practices of interest include:

- Assertive Community Treatment (ACT)
- Supported Employment
- Supported Housing
- Family Psychoeducation
- Integrated Treatment for Dual Disorders
- Illness Management/Recovery
- Medication Management
- Multisystemic Therapy (MST)
- Therapeutic Foster Care
- Functional Family Therapy (FFT)

CMHS also requires States to collect and report several measures of client satisfaction with State mental health care in such areas as access, quality and appropriateness (for adult consumers) or cultural sensitivity of staff (for child/adolescent consumers), outcomes, and, optionally, consumer participation in treatment planning and general satisfaction. The Mental Health Statistics Improvement Program (MHSIP) Survey is the preferred instrument for collecting adult consumer satisfaction data. CMHS recommends that States use the MHSIP Youth Services Survey for Families (YSS-F) to collect information on satisfaction with children’s services. States report the results of these surveys via the URS system. Data on client characteristics in this report came from the URS.

Characteristics of persons served

According to Uniform Reporting System (URS) data, nearly 6 million adults and children accessed mental health services through SMHAs in FY 2006 (Figure 2), the period of focus for this evaluation. These consumers included men, women, and children of diverse racial/ethnic and clinical populations; 63 percent were white and 20 percent were African American. Most minority groups were consistently served at a higher rate than the white population from 2003 to 2006 (Table 5).

The clinical and cultural complexity this broad population brings to mental health systems of care underscores the challenges States face in providing coordinated, high-quality

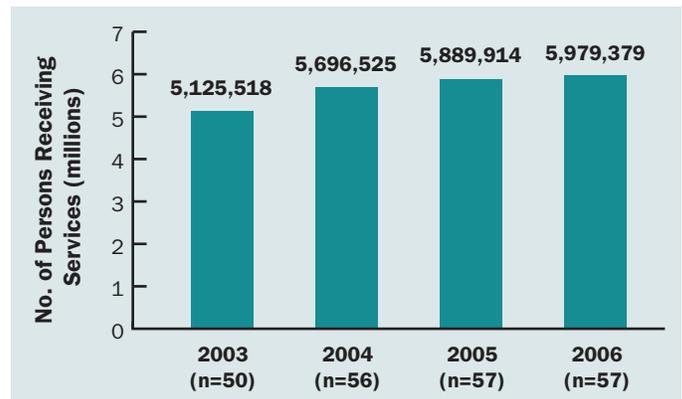


Figure 2. Number of persons receiving mental health services funded by State mental health agencies (N=59), 2003-2006. Data from the Uniform Reporting System, SAMHSA.

practices, including evidence-based practices, which emphasize consumer-driven recovery.

During this time period, the URS reporting elements, discussed in further detail in the “Data collection” section of this report, were further refined and common measures were implemented by the States. As a result, the number of States reporting on the URS tables and the level of detail provided has increased annually.

In 2006, an average of 73 percent of adults served through 55 SMHAs met the Federal definition for serious mental illnesses (Figure 3A). In 45 States, 23 percent of adults

Table 5. Demographics of Persons Served by SMHAs in FY 2006

Race/Ethnicity	Penetration (per 1,000 population)	No. of States Reporting
American Indian/Alaska Native	25.7	53
Asian	6.3	56
Black/African American	32.3	56
Native Hawaiian/Pacific Islander	20.9	44
White	15.9	57
Hispanic	14.5	13
Multiracial	19.8	43
TOTAL	19.9	57

served had co-occurring mental and substance use disorders (Figure 3B).

An average of 76 percent of children served through 54 SMHAs met the Federal definition for serious emotional disturbances (Figure 4A). In 41 States, 6 percent of those children had co-occurring disorders (Figure 4B).

From 2003 to 2006, the number of persons reportedly served by community mental health programs increased 12 percent, to a total of 5.26 million (Figure 5). Adult admissions to community programs increased 34 percent from 2003 to 2006.

The number of admissions to children’s residential treatment programs increased 132 percent, from 10,046 in 2003 to 23,269 in 2006, compared to a 29 percent increase in admissions to community programs during the same period. The evaluation did not determine the extent to which the increase is due to an increase in the number

of States reporting, or the extent to which the increase in children’s residential admissions is affected by children’s systems other than mental health (e.g., juvenile justice and child protection).

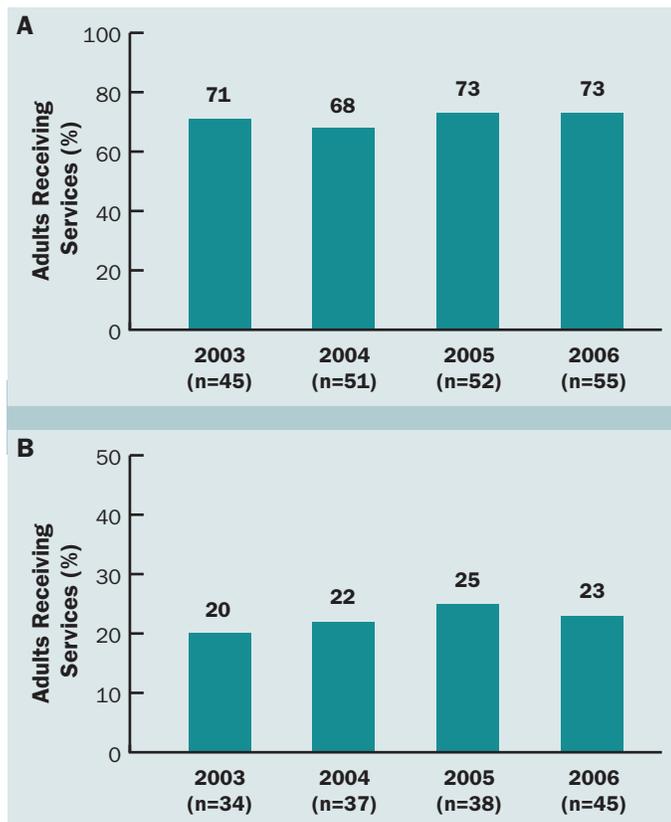


Figure 3. Average percentage of adults with (A) serious mental illnesses and (B) serious mental illnesses and co-occurring substance use disorders served by State mental health agencies (N=59), 2003-2006. Data from the Uniform Reporting System, SAMHSA.

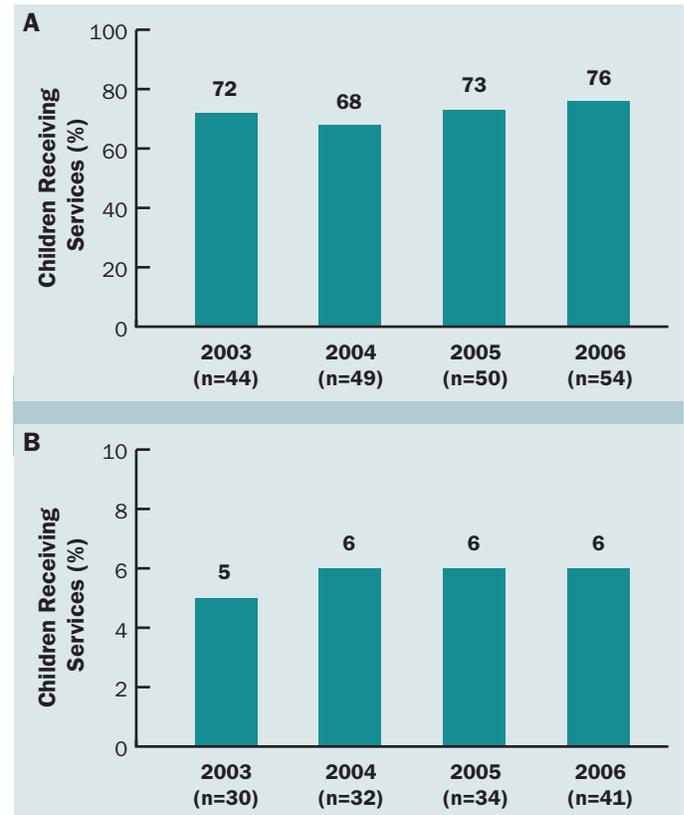


Figure 4. Average percentage of children served by State mental health agencies (N=59) who had (A) serious emotional disturbances and (B) serious emotional disturbances with co-occurring substance use disorders, 2003-2006. Data from the Uniform Reporting System, SAMHSA.

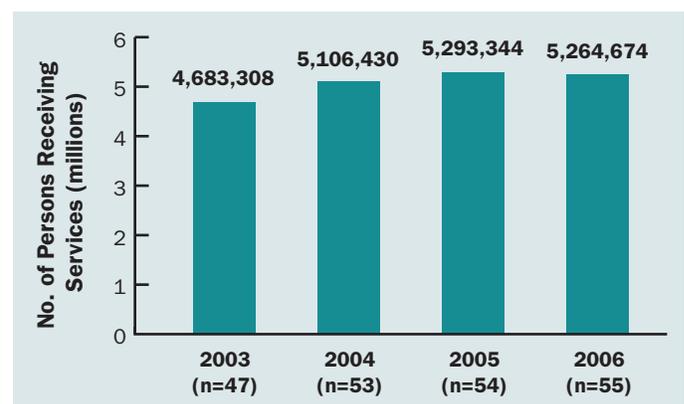


Figure 5. Number of persons receiving mental health services through community mental health programs (N=59), 2003-2006. Data from the Uniform Reporting System, SAMHSA.

IV. FINDINGS OF THE EVALUATION

QUESTION 1 – Is the Block Grant being implemented according to congressional intent?

Careful examination of the Block Grant reveals that the program has been and continues to be implemented according to congressional intent. Following is an in-depth discussion of the strengths and challenges in Planning Councils, the Block Grant application process, regional reviews, site monitoring visits, training and technical assistance (T.A.), and data collection.

Highlights of implementation outcomes:

- **Nearly 6 million adults and children access mental health services annually through State mental health agencies (SMHAs).** An average of 73 percent of adults and 76 percent of children receiving services meet Federal criteria for serious mental illnesses and serious emotional disturbances, respectively. In 2006, 23 percent of adults and 6 percent of children receiving services had co-occurring mental and substance use disorders.
- **All States have Planning Councils that serve as mechanisms for consumers, family members, and other advocates to influence decisions.** In many States, Planning Councils have played significant roles in statewide planning, advocacy, and outreach efforts, and their activities are not restricted to the Block Grant. Planning Council members also engage in legislative advocacy, training, and leadership, among other initiatives.
- **URS data collection and reporting requirements have increased the extent to which States are able to identify service gaps and comprehensively describe the outcomes of the programs and client services in their systems of care.** The number of States reporting client and utilization data has continued to increase since these requirements took effect, and there exist opportunities to build consensus among uniform and meaningful measures that would be useful to the full range of stakeholders.
- **Processes are in place to monitor compliance with Block Grant requirements and support States in developing their systems of care.** Application and implementation reports, regional reviews, and monitoring site visits provide opportunities for State-to-Federal, Federal-to-State, and State-to-State communication and exchange.

Summary of stakeholders' recommendations for improvement in implementation:

- **Make better use of Planning Councils** by incorporating their input from the beginning of the State Plan development process, providing training and support to Planning Council members, and empowering States to appoint members to fill gaps in knowledge and skills.
- **Reduce the burden of the Block Grant application process** by combining the application and implementation into a single, tightly focused document that is due no less than 3-4 months from receipt of final guidance, and by shortening the OMB review process to allow more time for States to develop and submit applications during revision years.
- **Increase efficiency and value of the regional review process** by streamlining the review format and taking advantage of video and Web conference technology, supporting reviewers to better understand State needs by giving them more informal time to interact, incorporating formal Planning Council presentations, and sharing highlights and exemplary practices among all States.
- **Streamline monitoring site visits and increase their impact** by reducing previsit information collection burden, facilitating use of electronic document review and video/teleconferencing so the Block Grant Monitoring Team can get the maximum efficiency from their onsite time, and revising the monitoring report to make it a reader-friendly tool that States can use as a resource for action.
- **Make training and TA more readily available and diverse** by consolidating resources into a single, centralized repository accessible by all grantees; taking advantage of Web conferences and tutorials; establishing a repository for training and TA results; and assessing training and TA on an ongoing basis.
- **Clarify and simplify the process of data collection and interpretation** by supporting infrastructure development and maintenance to reduce manual collection burden, actively soliciting input from States and subrecipients, supporting States to meet reporting requirements and quality standards, and training reviewers to avoid misinterpreting data or making inappropriate data comparisons.

State Mental Health Planning and Advisory Councils

The Planning Council is expected to represent a diverse array of stakeholders. A total of 65.6 percent (126 of 192) of respondents to the Web-based survey for Planning Council members were neither State employees nor mental health service providers, which is consistent with the statutory requirement that no more than 50 percent of the Planning Council membership be State employees or mental health providers. Respondents included:

- Staff representing State agencies responsible for mental health, housing, criminal justice, social services, vocational rehabilitation, and Medicaid (63 of 192; 32.8 percent);
- Adult consumers with serious mental illnesses (34 of 192; 17.7 percent);
- Family members of either adult consumers or children with serious emotional disturbances (20 of 192; 10.4 percent); and
- Representatives from public or private organizations involved in the provision, planning, funding, or use of mental health services and supports: advocacy organization representatives (21 of 192; 10.9 percent), mental health providers (21 of 192; 10.9 percent), health-related professionals (1 of 192; < 1 percent), and “other” (21 of 192; 10.9 percent). Eighty-five percent (163 of 192) of Planning Council respondents reported reviewing the FY 2006 State Plan.

Strengths Identified by Stakeholders

The Planning Council:

- **Offers diversity of opinion** appreciated by States for the value “fresh eyes” bring to identifying the State system’s strengths and weaknesses;
- **Gives voice to consumers, family members, and other advocates** to contribute to the development, evolution, and growth of the State system;
- **Exerts strong impact on the mental health system** by giving Planning Council members a platform for advocacy, leadership, and increased visibility of key issues; and
- **Benefits from a strong collegial working relationship** among members that promotes sharing of ideas, productive discourse, and valuable recommendations.

Representatives from 16 (84.2 percent) of 19 States reported engaging in many activities outside of their Block Grant or statutory responsibilities. In fact, when asked to describe their State’s Planning Council, representatives spoke almost exclusively about these non-Block Grant-specific activities.

Representatives from 6 (31.6 percent) of 19 States reported that their Planning Councils have subcommittees with well-defined and distinct roles and responsibilities. Most of these States have committees for Children and Families, Adults, Youth, and Legislation and Policy. Other committees of note include Budget, Recovery, Quality Improvement, and Employment. With many subcommittees and a range of responsibilities, it is not surprising that many State representatives reported that their Planning Councils meet regularly throughout the year. Meeting frequency ranges from monthly to quarterly. This information is consistent with responses to the Web-based Planning Council survey. Approximately 56.8 percent (109 of 192) of Planning Council respondents reported that they meet 5 or more times in a typical year, whereas nearly 35 percent (67 of 192) meet 3-4 times each year.

Overall, Planning Council respondents believe that they influence State-level policy with their various activities. The 192 respondents to the Web-based survey cited the following activities as meaningful in influencing policy:

- Advocating within the Planning Council for a specific issue or population (165 of 192; 85.9 percent);
- Collaborating with other agencies or groups (153 of 192; 80 percent);
- Disseminating planning-related information (103 of 192; 53.7 percent);
- Developing special reports (99 of 192; 51.6 percent);
- Providing testimony (98 of 192; 51 percent);
- Sponsoring public meetings or hearings (74 of 192; 38.5 percent); and
- Other (listed as needs assessments, reviewing requests for proposal, specific programmatic areas such as suicide prevention, and consumer-operated services; (17 of 192; 8.9 percent).

Sixteen (84.2 percent) of the 19 States interviewed cited Planning Councils’ ability to look at the State system with another “set of eyes” as their main strength. State representatives value input from Planning Councils because it allows consumers, family members, and other advocates a voice in

the State system. Planning Councils provide an opportunity for members to react to the effects of decisions at the State level. Said one State representative, “While we don’t always want to hear what they are saying, it’s good to hear it.” It would be difficult to obtain the input of many different communities and constituencies without the structure of the Planning Council. The diversity of the Planning Council members affords State representatives access to a wide range of experiences and knowledge related to the State mental health system and, in turn, allows Planning Council members to educate their communities.

One hundred forty (72.9 percent) of 192 Planning Council respondents strongly or somewhat agreed with the statement “The [State mental health agency] staff solicits the opinion of the [Community Mental Health Services Block Grant] Planning Council beyond what is legislatively required.” Of those who vocalized opinions toward their Planning Council’s activities, all but two report positive attitudes (190 of 192; 99 percent). Overall, State representatives reported listening to the Planning Councils and taking their recommendations seriously.

Reviewing and revising the State Plan. All Planning Councils review the State Plan, but the level of detail at which this review is conducted varies. On one end of the spectrum, several States report that their Planning Councils are mostly concerned with whether the State is moving in the right direction in terms of service provision. They approach the review by examining the system as a whole. On the other end of the spectrum, a few States report that their Planning Councils review their draft State Plans “page by page” and “in minute detail.” According to the State representatives interviewed, Planning Councils typically only review the draft State Plan, although in some States they also review State Plans from previous years as well as corresponding performance data.

According to State representatives, the Planning Council’s recommendations, comments, and concerns are typically documented in a letter to the SMHA. In most States, the Planning Council also authors a letter to the governor or the SAMHSA that documents their review and support for the final State Plan. For some States, the meeting to provide feedback on the State Plan is a formal process in which Planning Council members cast votes to approve the State Plan.

States reported that they consider all recommendations made by their Planning Councils. Recommendations deemed appropriate and feasible are promptly incorporated into the State Plan. However, only approximately half of States were able to give an example of a Planning Council recommendation they incorporated. Of the examples provided, many conveyed varying degrees of Planning Council influence. Representatives from one State said that the State “really listens” to the Planning Council and their comments have significant influence over the State’s mental health system. Another State’s representative said that their Planning Council encouraged them to more directly articulate a recovery model for the system, which led State staff to rewrite significant portions of the State Plan. Representatives from another State, however, remarked that the Planning Council review comments are mostly editorial in nature. Seven (36.8 percent) of 19 States reported that their Planning Councils do not make substantive recommendations to the State Plan.

Most States said that they typically give the Planning Council 2-4 weeks to review the State Plan. Planning Council members largely concurred: 26.6 percent (51 of 192) reported having more than a month to review; 21.9 percent (42 of 192) reported more than 2-4 weeks; 17.7 percent (34 of 192) 1-2 weeks; and 12 percent (23 of 192) more than 1 week. Approximately 20 percent (38 of 192) of the Planning Council respondents “strongly” or “somewhat” disagreed that the timeframe to review the State Plan is adequate. Approximately 33 percent (63 of 192) of State representatives did not specify how much time they give their Planning Councils. One State reported not finishing its draft until the middle of August, so the Planning Council was not able to fully review the final draft before its September 1 submission.

More than half of State representatives (10 of 19; 52.6 percent) describe a highly structured, minimally interactive forum for the Planning Council review of the State Plan. Of those 10 States, 8 provide a draft State Plan for the Planning Council to review followed by either a face-to-face meeting or conference call during which Planning Council members give oral or written feedback. Slightly less than half of the State representatives (8 of 19; 42.1 percent) describe an interactive, ongoing review process with their Planning Councils. These States frequently describe holding a series of meetings in which the State officials and the Planning Council come together to discuss the State Plan.

The most common way Planning Councils provide feedback, according to 37 percent (71 of 192) of the Planning Council respondents, is in meetings with the SMHA and, in some cases, other State agencies. This includes both regular Planning Council meetings and specific hearings to discuss the State Plan, depending on the State's relationship with the Planning Council.

Some Planning Councils reportedly convene working meetings to discuss the State Plan with the SMHA. The effectiveness of these meetings varies. One Planning Council respondent characterizes them as having "minimal explanation," but another said that "interactive dialogue is the norm." In many cases, the SMHA sends a representative to Planning Council meetings to receive feedback in person and on an ongoing basis. "We have State people regularly attending our meetings and, in fact, the [Federal Block Grant] State rep works directly with our Council on almost a monthly basis," said one respondent. Other ways of providing feedback include letters, emails, reports, and meeting minutes, which are submitted to the SMHA directly at a meeting, via telephone, and through a Web site created for this purpose.

Advocacy. One of the Planning Council's most important roles is as an advocate for adults with serious mental illnesses and children with serious emotional disturbances. The Planning Council can advocate for mental health before the State legislature and, in the words of one State representative, "can write letters that we're not allowed to write." Planning Councils can focus on specific issues; develop leadership at State and local levels, especially among consumers and family members; and reduce discrimination and boost visibility for persons affected by mental illness. Increased visibility may affect State systems in various ways.

Nearly 20 percent (38 of 192) of Planning Council respondents focus on the Planning Councils' ability to advocate for inclusion of unmet needs in the State mental health system on issues such as services in rural areas, children's needs, recovery-oriented services, consumer-driven services, suicide prevention, mental health courts, and services for the under- or uninsured and people who are homeless. The majority of State representatives reported that one of the Planning Council's main responsibilities is advocacy for increased mental health funding and specific policy issues and population-directed services.

Planning Councils are not only involved with legislative advocacy. Three (15.8 percent) of 19 States reported that Planning

Council members are actively engaged in other mental health-related working groups. For example, one State has a Governor-appointed Task Force with Planning Council member participation focusing on mental health issues across the State. This Task Force is separate from any SMHA-created working groups and demonstrates involvement of Planning Councils beyond what is required by the Block Grant legislation.

Needs assessment and policy analysis. Representatives from 5 (26.3 percent) of 19 States reported that their Planning Councils conduct studies to assess need and/or analyze policies. Most commonly, Planning Councils are involved in determining areas of unmet need, identifying innovative local programs throughout the State, and reviewing State-funded projects. For example, one Planning Council assesses the overall effectiveness of State-funded mental health programs annually. Planning Councils in two other States spend much of the year identifying areas of unmet need, which they then use as the basis for writing position papers.

Data collection. In addition to conducting data assessments of their own, 21.1 percent (4 of 19) of State representatives reported Planning Council involvement with optimizing the CMHS performance data collection. In one State, the Planning Council approves performance measures. In the other States, Planning Councils are involved in developing new performance measures and optimizing current ones.

Planning Council challenges identified by stakeholders:

- **Utilization in the State planning process.** Planning Council members said they have limited influence on the State planning process. Difficulties they identified include a lack of follow-through on the part of the SMHA, lack of SMHA support, and one-way dialogue at Planning Council meetings.
- **Training and education.** State representatives said that Planning Council members often do not have the education and objectivity necessary to fulfill their role, and Planning Council members agreed. One hundred twenty (62.5 percent) of 192 Planning Council respondents could not recall having received training and TA in 2006. Although 40 (20.8 percent) did receive training, only 25 (13.0 percent) perceived that their Council changed as a result.
- **Balance in the Planning Council's role.** Representatives from some States complained that their Planning

Councils are unable to give much input on the State Plan, whereas other State representatives expressed frustration because their Planning Councils are becoming involved in just about every State program.

Stakeholders' recommendations to improve Planning Councils:

- Establish and maintain clear channels for frequent two-way communication between the SMHA and the Planning Council.
- Involve the Planning Council from the beginning of the State Plan development process and have the Planning Council review the Plan more frequently.
- Train and orient Planning Council members to ensure that they have the knowledge and skills to carry out their mandated functions. Although Planning Council Chairs receive annual training as part of the Annual National Grantee Conference on the Mental Health Block Grant and Data, there has been no clear way of determining whether this information is transferred to the other members of the Planning Council.
- Provide training and experiences to strengthen members' participation and leadership skills.
- Issue guidelines for Planning Council activities, including location of Planning Council offices, responsibility for the State Plan, and setting a certain percentage of funding that can be spent on administrative activities.
- Detail the level of support and integration the Planning Council should have with the State mental health system to increase consistency throughout the Block Grant program and ensure that Planning Council resources are being used as effectively and efficiently as possible.

Application/implementation report development

Federal (n=22) and State (n=19) representatives largely concluded that the Block Grant application template and guidance, State Plan, and implementation report meet their basic purpose and objectives. Application and implementation report development facilitates regular communication between Federal staff and State stakeholders. The application guidance and template successfully communicate the parameters of the Block Grant application, as evidenced by few if any questions that Federal Project Officers (FPOs) reported receiving from State Planners about the guidance. The application guidance and instructions provide clear, consistent aid to States to ensure

Strengths Identified by Stakeholders

The process of developing the Block Grant application and implementation report:

- **Facilitates communication between Federal and State** staff by providing States with clear guidance and instructions from CMHS and incorporating their feedback into the final application and report parameters;
- **Encourages States to work with stakeholders** within a structure and with a common goal;
- **Enables States to create comprehensive State Plans** that cover the full range of adult and child services and system needs and issues;
- **Serves as a quality assurance and accountability mechanism** by requiring States to review and analyze their progress and goals annually; and
- **Demonstrates that priorities chosen by the State are informed by data** through requirements to assess epidemiologic and utilization data and subrecipient activities.

that applications are submitted in a timely manner and the requirements are consistent across States. However, interviewees also described several challenges and areas for improvement for the documents and the process used to develop them.

The State planning process begins with the development of the application guidance and instructions, which occurs every 3 years and is led by the FPO who facilitates CMHS's consultative regional peer reviews. A number of Federal staff members review the guidance, including SAMHSA's executive staff, the Grants Management Office, the Chief of the State Planning

State Plan Development Process at a Glance

Although States vary in the specific process for developing the State Plan each year, these steps are common to the 19 States interviewed in the Block Grant review.

1. Review the previous year's State Plan and performance measures.
2. Begin drafting the new Plan and develop a complete first draft.
3. Solicit and implement input from the Planning Council and other stakeholders.
4. Conduct a final review.
5. Finalize and submit the new State Plan.

and Systems Development Branch, and FPOs. CMHS solicits input from State Mental Health Commissioner/Directors, State Planners, and Planning Councils before submitting the draft application guidance to the Federal Register for 60- and 30-day review and public comment periods to allow the States and the public to request changes. State officials can also provide feedback at the Annual National Grantee Conference on the Mental Health Block Grant and Data.

Ultimately, OMB reviews and approves the guidance and instructions. During the most recent review period for application guidance and instructions, comments resulted in changes to a table in the guidance requesting States to identify and report data on mental health transformation activities.

Even though the Block Grant funds constitute a small proportion of State mental health budgets, some Federal interviewees (7 of 22; 31.8 percent) said they believe the Block Grant is effective in helping States develop comprehensive and well-rounded State mental health systems. The guidance requires States to describe the entire State Plan, including the five elements identified in the Background section of Section III of this report as mandatory criteria, a description of the Planning Council, and plans for data collection. State representatives and Planning Council respondents agreed that the application process allows the State to focus on what has been done and identify what remains to be done.

State representatives also agreed that the application process is a tool for the States to track and act on the Block Grant performance measures. The implementation report in particular is a tool for the States to report on the extent to which the previous year's goals were attained and to ensure that the States fulfill their responsibilities to adults with serious mental illnesses and children with serious emotional disturbances. The implementation report serves as a mechanism for ensuring that the State is accountable for the use of Block Grant monies. Additionally, the process of completing the implementation report requires the State staff to review epidemiologic and utilization data and to keep abreast of subrecipient activities. Many State representatives (15 of 19; 79 percent) said that the implementation report is useful as a mechanism for assembling data and describing the experience of service providers.

State Block Grant application development process. Typically, the SMHA develops a plan, sets timelines, meets with the Planning Council to exchange information,

and starts the writing and updating process for the application and State Plan. The State Planner (or planning group) has primary responsibility for the Block Grant application process, although various State staff are responsible for completing different sections of the document. Reported timelines vary: 2 (10.5 percent) of 19 States report that the process takes approximately 8 months (September-April) with the development process beginning soon after submission of the previous year's application, whereas a majority of States (11 of 19; 57.9 percent) report that the entire process takes approximately 3.5 months.

Representatives from 7 (36.8 percent) of 19 States reported that the application “forces us to get together and think about these elements in a structured way.” The application process provides an opportunity for the staff and the Planning Council to come together and make commitments for the coming year. Slightly less than 58 percent (111 of 192) of the Planning Council members cited diversity of their input as important in developing the State Plan.

State Plan development process. The process for developing State Plans varies widely across States. Representatives from 89.5 percent (17 of 19) of States interviewed reported having 1-year plans; the remaining States reported having 2- or 3-year plans. Plan development can take as little as several weeks or as long as 1 year. Most States (13 of 19; 68.4 percent) reported a 2- to 4-month period. The two States reporting a year-long process also described a formal and lengthy process for soliciting input.

All of the 19 States interviewed said that they typically begin the process of developing the State Plan by reviewing the previous year's State Plan, and some States also review performance measures. In reviewing the previous year's State Plan, States look for areas affected by changes in SAMHSA requirements and mental health service areas that need to be strengthened. After completing the review, States begin drafting the new State Plan.

Most States (13 of 19; 68.4 percent) reported that they designate one or two individuals to lead writing and submission of the new State Plan—usually the State Planner or Block Grant Coordinator. In some States (3 of 19; 15.8 percent) only a few individuals write the State Plan: either the State Planner or two Directors or Deputy Directors (one representing child mental health services and one representing mental health services for adults). Other States (2 of

19; 10.5 percent) reported using a large team of writers and dividing the State Plan into sections with a writer for each.

All State representatives reported that they actively solicit input from their Planning Councils (see the section on Planning Councils for additional details). “The strengths are [that] there are many players at the table. The families that are served and other providers or collaborators [are] at the table to help develop policies and plans to meet the needs of our common clients,” said a Planning Council member. The performance data staff is another critical and near-universal group that contributes to the State Plan.

A majority of States (11 of 19; 57.9 percent) solicit input from only a few stakeholders, but 31.6 percent (6 of 19) of States solicit input from dozens of program staff, providers, and the community. States sometimes include stakeholders such as representatives from the State budget office, the State Medicaid agency, the Governor’s Advisory Council, and an internal Block Grant committee. After States incorporate stakeholder input, they hold a final draft review. In most States (15 of 19; 79 percent), only a few individuals participate in the final review, although several States (3 of 19; 15.8 percent) use multiple reviewers. States implement final review comments and finalize the State Plan.

Implementation report development process.

Although each State is unique in the specific staff and resources used to complete the implementation report, representatives from the 19 States interviewed described similar approaches to report preparation. For the majority of States (16 of 19; 84.2 percent), the implementation report process mirrors the application development process.

All 19 of the States interviewed reported receiving instructions for the implementation report with receipt of the Block Grant award. Work on the implementation report starts immediately after submission of the State Plan and takes an average of 2 months. State representatives tend to use the same chain of review used for the application because the reports so closely mirror one another. The majority of State representatives (15 of 19; 79 percent) reported that the information required for the implementation report duplicates information previously submitted with the application itself.

States work with their programmatic staff—including experts in one or more of the areas addressed in the implementation report, epidemiologists, data analysts, consultants, and administrative staff—to assign specific areas for

comment, input, or completion. Most of the implementation report review occurs within the department. State representatives involve their Planning Council in the review at different stages in the process, approximately half before submission to CMHS and the remaining States after incorporating input from their FPOs. If the Planning Council approves the report, they submit a letter of support to CMHS.

Application/implementation report development challenges identified by stakeholders:

- **OMB clearance.** According to interviewees, the clearance process for the revised Block Grant application guidance takes at least 6 months, with the Federal Register notice requiring 60 days. In addition, the document goes through a lengthy review and approval process at SAMHSA before submission to OMB. As a result, every 3 years when approval is required, States have relatively little time to write and submit their Block Grant applications.
- **Notification of application changes.** A majority of State representatives are frustrated that a draft of the application guidance is the only document available for reference until “almost” the September 1 application deadline. CMHS interviewees question States’ capability to respond to revisions within a short timeframe. Last-minute adjustments are burdensome for States.
- **Reporting burden.** State and Federal representatives agreed that completion of the application and implementation report requires considerable resources and may detract from programmatic activities. Redundant sections, especially between the adult and child sections, add to this burden. Planning Council members also said that it is a “long and arduous process every year” that takes up too much of their time. They consider the implementation report to have little use or impact.
- **Relevance and timeliness of application sections.** State and Federal interviewees and Planning Council respondents believe that the application guidance is outdated and does not reflect current mental health treatment and prevention practices and knowledge. The application does not take into account differences between services for children and adults and asks equivalent questions for the two populations. A number of Planning Council respondents contend that the five required elements of the Block Grant application are not adequate to describe the diversity of the State system.

Stakeholders' recommendations to improve application/implementation report development:

- Institute an expedited review within SAMHSA to shorten the review and approval process for the guidance.
- Give States a lead time of 3-4 months between receipt of final guidance and the application deadline.
- Increase State involvement in the creation of application guidance; by bringing States into the process early, CMHS can improve State buy-in and create consensus.
- Change the application to cover a 2- or 3-year period, with annual implementation reviews, allowing for a planning horizon longer than 12 months and elevating the implementation report to become a more useful document.
- Eliminate redundancy between the child and adult sections.
- Combine the Block Grant application and implementation report into one deliverable due on December 1 (but only if it does not jeopardize the timing of the Block Grant funding award), and streamline both reports into one cohesive document rather than simply adding them together.
- Fit the five required elements under an overarching framework of recovery orientation that reflects current thinking.
- Add or change criteria to include aging populations, veterans, and cultural competence.
- Expand the required elements of the Block Grant application to include specialized programs, innovative initiatives, local differences, children's concerns, consumer goals, information on unmet needs, and other aspects of the State mental health system.

Regional review process

Within the regional review, individual State reviews last an average of 90 minutes: 15 minutes for the State to present program highlights and activities, 45 minutes for reviewers, and 30 minutes for the State to respond to questions and discussion. One primary and two secondary reviewers review each State Plan or application following a systematic review across three major sections: Planning Council, Adult Mental Health Plan, and Child Mental Health Plan. Review of the Planning Council section includes compliance with membership requirements, Planning Council and public involvement in the Block Grant application, and evidence of Council activities to support adults with serious mental illnesses and children with serious emotional disturbances.

Reviews assess the adult and child mental health plans for compliance with the five statutory criteria of a Block Grant State Plan described previously.

The most commonly cited strength of the regional review is the opportunity it provides to exchange information and to learn about innovative programs or strategies from the experiences of other States. Almost three-quarters of States interviewed (14 of 19; 73.7 percent) and one-quarter of Planning Council respondents (48 of 192; 25 percent) specifically highlighted this feature. They used such terms as “osmosis of knowledge,” “learning process,” and “cross-pollination of ideas” to describe the value of this information sharing. Representatives from 3 (15.8 percent) of 19 States also noted the importance of informal information sharing that occurs outside the formal review during hallway conversations, over meals, or sharing transportation. In the words of one State Planner, “The programmatic exchange is a process that occurs before, during, and after the regional review.”

Another, closely related strength State representatives identified is the opportunity to network with colleagues from different States, FPOs, and members of their own State team. Representatives cited the opportunity to “learn about our accomplishments,” build relationships with reviewers, improve communication, and learn from experienced reviewers and participants. The opportunity to “put faces to names” is especially appreciated among newer review participants, as is the chance to spend one-on-one time with

Strengths Identified by Stakeholders

The regional review process:

- **Creates a process of learning and information exchange** that is widely praised by State representatives and Planning Council members;
- **Provides networking opportunities** both within and among States and Planning Councils, as well as between States and reviewers;
- **Fosters an atmosphere of dialogue and collegiality** that promotes back and forth in a consultative and supportive environment; and
- **Offers States objective feedback** that can help them identify strengths and weaknesses they may have overlooked and provide resources to improve the mental health system of care.

their own State representatives. One State staff member highlighted the value of sharing a plane ride with a new Planning Council Chair, for example. However, more experienced participants described the meeting as providing little new information.

Interviewees and survey respondents cited the collegiality of the review environment and the variety of perspectives among reviewers and State participants as a strength. They described the regional reviews as “a dialogue” and as fostering a “consultative atmosphere.” States also praised as a strength the opportunity to “defend” their applications and to highlight achievements, program outcomes, and impact of Block Grant funding. Said another representative, “CMHS has done a good job of making [the review] a collaborative environment.”

Some respondents cited as strengths the experience of the peer reviewers and their knowledge of national trends, understanding of State systems, and familiarity with State applications or plans. Planning Council respondents reported that they value reviewers’ “third-party eyes,” which allow for a more objective look at the State Plan with the chance to uncover weaknesses in the Plan that those close to the process may overlook. However, one State representative remarked on the uneven experience and input from regional reviewers, and another representative reported that reviewers have a tendency to focus on their own pet issues rather than broader areas.

Another challenge, said representatives from five States (26.3 percent), is that reviewers are “not necessarily comparing apples to apples” and may not fully understand the complex and individual features of different State systems. As a result, their critiques or recommendations may be “completely off base” or may “run counter to State law,” said representatives. Seven (3.7 percent) of 192 Planning Council members complained that reviewers and Federal participants do not appreciate State diversity and at times apply “inappropriate criteria” to rural and frontier areas, which face unique challenges.

Thirty (15.6 percent) of 192 Planning Council respondents mentioned the diversity of input from interested stakeholders (i.e., providers, consumers, family members, and State staff) as a strength. Respondents also noted the fact that States with small populations receive the same level of attention that more populous States receive. These factors contribute to the perception that regional reviews help create greater transparency in the Block Grant process,

particularly compared to other grant review processes.

Other cited strengths of the regional reviews include the focus on regional as well as State issues, and the chance to gain a national perspective on mental health issues through exchanges with other States and CMHS staff. One State representative said that the Block Grant process creates a national forum for information sharing and the development of an agenda for mental health services. Representatives from 4 (21.1 percent) of 19 States also appreciated the consistency of individuals participating in the reviews. However, two States (10.5 percent) expressed that this consistency results in a lack of new perspectives and input.

Regional review challenges identified by stakeholders:

- **Expense of in-person meetings.** Twenty-one (10.9 percent) of 192 Planning Council respondents and representatives from 5 (26.3 percent) of 19 States expressed concern that the review meeting is not time or cost effective. This was the most commonly cited weakness, with some of the Planning Council and State representatives describing the review process as tedious. Most States require 1-2 days for travel (jurisdictions outside the continental United States routinely require 2 days for travel) to attend a 90-minute review meeting, only a small portion of which is allotted to the State for presentation or discussion.

States that would like to invite more attendees find it difficult to justify the time and expense required to attend such a brief session. One commentator described feeling “shortchanged.” Participants suggested that time spent at the regional review would be better used if there were greater opportunity for information sharing and networking, or a format that allowed for more extensive feedback from and exchange with other States. One State representative noted that the informal lunch discussions are often more useful than the technical review.

- **Limited benefits.** Some respondents said the review meeting does not provide much new information, especially for seasoned review participants. Because the Block Grant represents such a small proportion of State funding for mental health services, the regional reviews have only minimal impact on State policy.

- **Role of the Planning Council.** Some respondents feel that Planning Councils lack power and have limited

involvement in the process. Some State representatives and Council members described their role as a “rubber stamp” formality with “passive pressure” from the State to “give good feedback.”

- **Reviewers’ qualifications.** Reviewers may lack understanding of the diversity and complexity of different State mental health systems, leaving States feeling that some recommendations are inappropriate or ill informed. Some participants expressed frustration at the time devoted to listening to multiple reviewers and focusing on either technical details or issues mainly of personal interest to individual reviewers.

Stakeholders’ recommendations to improve regional reviews:

- Build in more opportunities for regional networking, information sharing among States, and training, such as extending the review to include meetings addressing special topics of interest.
- Develop an ongoing, regional partnership program to promote inter-State information exchange (e.g., the Mental Health Statistics Improvement Plan (MHSIP) user groups, National Prevention Network, Data Infrastructure Grant).
- Conduct reviews via video or Web conference to reduce travel time and expense.
- Establish a format that allows for more “give and take” with reviewers and among different review participants.

- Extend the period of time allotted to States during the review to elaborate on specific activities and programs, perhaps in a summary or conclusion session or during lunch or another special meeting time designated for information exchange among the States.
- Distribute examples of high-quality Block Grant applications among States to serve as a model.
- Share summaries of State highlights and activities presented during the reviews with all States.
- Ensure that time is formally allotted for Planning Council presentations during the review.
- Hold open-microphone or information-sharing sessions for Planning Council members from multiple States.
- Build in more networking opportunities for Planning Council members, including with Federal staff.
- Allow States more time to respond to questions and/or create more opportunities for informal give and take with reviewers.

Monitoring site visit process

Representatives from the 19 States interviewed said that the overarching strength of the monitoring site visits is the onsite, consultative method in which they are conducted. Whereas the monitoring site visit is a mechanism for verifying compliance with Block Grant requirements, it also serves to strengthen the CMHS-State relationship and increase CMHS understanding of State structures, organizations, and programs. In addition, the monitoring site visit also identifies areas and programs that could benefit from TA.

States reported that the face-to-face interaction between State/Federal staff and experts in the field is extremely valuable in education and transfer of knowledge about the State’s mental health programs. The process allows States to examine themselves in terms of specific programs and provides a unique opportunity for Federal staff to play a more direct, interactive role in providing guidance, expertise, and TA.

The face-to-face nature of the monitoring site visit reinforces relationships between Federal and State staffs and provides CMHS the opportunity to evaluate Block Grant-supported programs in their natural environment. The on-site visit allows States to showcase their system of care to the Block Grant Monitoring Team. Monitors can observe the system within the larger environment of a particular State, including its organizational structure and the characteristics of its population. In addition, the in-person format of the

Strengths Identified by Stakeholders

The monitoring site visit process:

- **Benefits from the face-to-face nature of the visits,** which affords the Block Grant Monitoring Team the chance to see Block Grant-funded programs in context;
- **Identifies opportunities for targeted TA** by allowing the Block Grant Monitoring Team to observe and interact with programs and services in person;
- **Allows States to showcase their mental health systems** within the larger environment of a particular State; and
- **Promotes flexibility in the focus of the visit** by allowing the Block Grant Monitoring Team to focus on various aspects of the States public mental health system and future plans.

monitoring site visit offers a supportive environment for learning and sharing. Further, CMHS interviewees said that they are better able to identify opportunities and resources for States to use when interacting and observing programs in person. The Block Grant Monitoring Team also enjoys flexibility to focus on different aspects of a State's public mental health system and its future plans.

Monitoring site visit challenges identified by stakeholders:

- **Previsit burden.** State representatives reported feeling overwhelmed by the amount of time and resources required to prepare in advance the information required for a monitoring site visit. Additionally, the purpose of the required information is not always clear.
- **Length of the monitoring visit.** A 3-day visit can be burdensome for State staff, yet insufficient for the Block Grant Monitoring Team to travel as needed in-State.
- **Usefulness of the monitoring report.** State representatives and Federal interviewees agreed that the monitoring reports are not useful apart from serving as a historical record of a State's efforts to develop a comprehensive system of care.

Stakeholders' recommendations to improve monitoring site visits:

- Clearly delineate for States how data and information requested before the site visit may be used.
- Incorporate as much offsite monitoring of State information as possible to include electronic document review and video/teleconferencing to allow for more efficient use of onsite time.
- Revisit the purpose of the monitoring report and consider which components of the visit should be documented.
- Consider streamlining the monitoring site visit report to create a more user-friendly document that States can use for other purposes (e.g., responses to legislators).

Block Grant training and technical assistance

Representatives from 11 (57.9 percent) of 19 States said that some of the most valuable information States receive is via discussions with the FPO, ranging from brief conversations during lunch and in passing during regional reviews and site monitoring visits to lengthy telephone conversations and email exchanges. State representatives reported

the following examples of topics of training and TA received over the last several years:

- Block Grant data definitions and requirements;
- Research on peer-support models;
- Evidence-based practice training;
- Planning Council advocacy and strategic planning; and
- Therapeutic Foster Care.

Training and TA on data consistently appears on States' wish lists, but the training and TA most highly praised by State representatives for their usefulness and applicability are literature reviews and background research provided by CMHS staff.

Training and TA challenges identified by stakeholders:

- **Marketing of training and TA resources.** Representatives from several States said they have limited information about the training and TA resources available through the Block Grant. Additionally, the time between identifying training and TA needs, submitting a request, and actually receiving assistance often has an adverse effect on the benefits of the assistance.
- **Involvement of FPOs in TA negotiations and delivery.** Currently, FPOs have no direct involvement in delivery of training and TA, negotiations for which are conducted by the State and TA contractor. Greater FPO involvement would enhance accountability across the contract.
- **Availability of alternate methods of training and TA.** Several State representatives advised that methods for and content of training and TA have changed very little over the last 10 years, with limited availability of alternate methods.

Strengths Identified by Stakeholders

Block Grant training and TA:

- **Provides States with critical support,** including access to resources and hands-on training;
- **Can be valuable in multiple formats,** including when delivered even through brief conversations or phone and email exchanges; and
- **Spans the gamut from data definitions and requirements to specific trainings,** all of which support States in creating strong mental health systems of care.

- **Communication about the receipt, acceptance, and award of training and TA.** Currently, there is no system for tracking the results of training and TA provided to States. Although FPOs and contractors are responsible for following up on receipt of training and TA, there is no formal repository for States to document and share the TA they receive.

Stakeholders' recommendations to improve training and TA:

- Create and disseminate an inventory of the types of training and TA that have been provided through the Block Grant.
- Consider an approach for advertising training and TA opportunities to States that catalogs the experience of previous recipients.
- Design and disseminate training and TA packets or Web-based tutorials to States as a way to avoid long lag times between State requests and Federal responses.
- Consolidate resources and materials related to the Block Grant in one location on the Web site to increase efficiency of locating resources available from the various TA contractors.
- Revisit the scope of work for provision of training and TA to increase transparency and diversity, including FPOs and other CMHS staff in the process.
- Develop a formal mechanism for “closing the loop” on training and TA requests.

Strengths Identified by Stakeholders

The Block Grant data collection process:

- **Provides the ability to describe State systems** in a systematic and comprehensive manner;
- **Allows flexible use of data** such as by combining URS data with information from independently collected, State-specific performance measures;
- **Benefits from the Web-based nature of the URS**, which makes it easy to access data;
- **Promotes collaboration between State and Federal partners** to standardize and quantify performance measures and advocate for better, higher-impact mental health programs and services; and
- **Empowers States to leverage subrecipient accountability** with the Block Grant requirements' emphasis on data uniformity and completeness.

- Revise the training and TA system to include a mechanism (such as a monthly keyword search or literature search) that will keep the program current with the latest training and TA approaches.
- Consider different and newer methods of providing support to States, such as facilitating stakeholder groups to build consensus and delivering Web-based tutorials.
- Establish a repository for training and TA materials, including information on implementation in specific States.
- Conduct ongoing evaluations of training and TA efforts aimed at assessing the impact of training and TA activities on recipients.

Data collection process

As evidenced by Table 2 and Figures 2-5 (see the section “Characteristics of Persons Served”), the number of States submitting data to the Uniform Reporting System (URS) has increased since 2003. However, as States work toward fully meeting these reporting requirements, the completeness of reporting the required data elements varied from 2004 to 2006. In 2006, for example, 57 (96.6 percent) of the 59 states and territories reported the number of persons served, but only 41 States (69.5 percent) reported on the number of children with co-occurring disorders.

Despite challenges and limitations, Federal staff view data collection as a success. Both Federal interviewees and State representatives appreciated the Web-based URS for its ease of reporting and accessibility. Said one Federal interviewee, “We cannot underestimate the impressiveness of States’ participating [in data collection and reporting activities] at this level. There are 50 different structures, 6 million consumers, and 6,000 to 9,000 providers, and still States collaborate and volunteer. This has been a phenomenal achievement.”

The majority (16 States; 84.2 percent) of the 19 States interviewed reported that they analyze their data independent of CMHS. The most commonly cited uses of State-analyzed data are to report to stakeholders and to respond to legislative and *ad hoc* service utilization requests. Thirteen (68.4 percent) of the 19 States use Block Grant data for planning purposes, especially to ascertain service gaps, to advocate for system improvements, and as background and context for understanding their mental health systems. One State funded a Population in Need Study, which guided its allocation methodology and identified ways of addressing service gaps

and leveraging funding. Another State reported analyzing URS data to create reports for counties and subrecipients to show service penetration for local planning purposes. States also use URS data for internal review and quality improvement, as well as to monitor subrecipients.

URS is designed to help SMHAs gauge the impact and scope of client services and to allow CMHS to describe populations served in a systematic and comprehensive manner. As one State representative described it, the URS provides “a national, standardized, uniform database to provide a snapshot of what’s going on in each State’s mental health system. It gives information on who is receiving services and, more importantly, about who is not.”

Representatives from all 19 States interviewed emphasized that collaboration between SAMHSA and the States to standardize and quantify performance measures enables them to advocate for better, higher-impact mental health programs and services. Additionally, the dialogue concerning data collection and reporting has strengthened relationships and encouraged collegial decision making among State and Federal partners. Some State representatives noted that, in collaborating with their Federal partners to design and revise the URS data set, SMHAs drew upon the expertise of many mental health stakeholders. As a result, States are increasingly willing to invest in improving data systems, as evidenced by SMHAs’ reported willingness to volunteer for pilot studies and participate in data workgroups.

Some States reported that the Federal emphasis on data uniformity and completeness enabled SMHAs to respond fully to inquiries from legislators and consumers. States also praised the Block Grant requirement to report on the use of evidence-based practices, which has encouraged subrecipients to place greater value on their use. Several additional aspects of the URS were identified by States as being beneficial:

- Representatives from 2 (10.5 percent) of 19 States interviewed said that the flexibility of the URS format allows them to manipulate and analyze data in a form relevant for both Federal and State purposes. The presentation of data in the URS tables makes service gaps in State delivery systems readily apparent.
- Representatives from two other States noted that, without Block Grant funding, data on mental health programs, services, and expenditures simply would not be collected and reported in their States.

- Three (15.8 percent) of the 19 States explained that the URS enables them to gather program and client-level data from subrecipients, where data were previously not readily available.

Five (26.3 percent) of the 19 States interviewed said that URS data are useful, especially when combined with independently collected, State-specific performance measures. One SMHA reported linking URS data to Medicaid and Temporary Assistance for Needy Families information systems to gain a better understanding of how its mental health system “fits” into other State processes.

URS data are subject to analysis by both an independent contractor and, on a limited basis, within CMHS (see the subsection “Data collection” within the Background section of this report for additional detail). The majority (12 of 22; 54.6 percent) of Federal interviewees expressed concern over the limited funds available to appropriately and completely analyze Block Grant data.

Data collection challenges identified by stakeholders:

- **Burden of collection.** State representatives’ most common complaint was the considerable burden that data collection requirements place on States administrative staff, subrecipients, and providers, and they questioned whether the benefit of the Block Grant is commensurate with that burden considering the small amount of the awards. States also reported that this burden adversely affects data integrity and completeness because it elicits minimal compliance and discourages expansion or innovative use of participatory statewide reporting systems. They cited insufficient technological capacity for large-scale data collection, reporting this as a significant factor in the burden.
- **Subrecipient buy-in.** Many States reported grappling with conveying to subrecipients the importance of URS data reporting requirements. According to State representatives, there was minimal input from subrecipients on the URS design, which instead relied heavily on suggestions from FPOs. Consequently, subrecipients are often reluctant to cooperate because they believe their needs have been overlooked.
- **Capability to report federally required measures.** Some State representatives pointed out their lack of capacity to meet all reporting requirements. For instance, States frequently mention that the adult criminal justice National

Outcome Measure (NOM) is “wasteful” because a comprehensive data set describing the criminal justice system is simply inaccessible to a majority of them. Without additional funding or support, subrecipients that lack adequate resources cannot report on certain required measures.

- **Data integrity.** Although some States make efforts to monitor data quality, State representatives and Federal interviewees agree that the URS data tables do not capture data on all State programs and services. Federal interviewees report that States’ apparent inability to give unduplicated counts of clients and service units calls into question the validity and reliability of URS data. Several State representatives point to evidence-based practice data as being especially weak because States have no way of knowing whether subrecipients are reporting according to standardized definitions.
- **Use of data.** State representatives frequently expressed concern with Federal and State stakeholders’ interpretation of the URS data, saying that they are “too quick” in making causal inferences or inappropriately “read into” URS data and disregard its limitations. Further, State representatives emphasized that poor outcomes resulting from “apples to oranges” comparisons stigmatizes States. Although CMHS has agreed to avoid using URS data to make State-to-State comparisons, State representatives expressed the opinion that consumer advocates and policymakers tend to make inappropriate comparisons. Due to the variation in State programs and data systems, there is lack of uniformity in definitions, and data often are not comparable.

Stakeholders’ recommendations to improve data collection:

- Provide States with direct resources for building, maintaining, and monitoring the quality of integrated data systems, possibly through dedicated training and TA to State and Federal staff. States and subrecipients need to be able to enter and access data easily.
- Present URS data in a clear and organized format to eliminate the need for SMHAs to aggregate data manually.
- Provide more timely feedback on client demographics and clinical status to provider agencies and create a “single-source” automated system.
- Substantiate appropriate use of URS data and legitimize reliable and comparable data reporting practices to increase subrecipient participation in Federal data collection activities.

- Expand URS workgroups to include a subrecipient voice.
- Support the development of information technology and statewide reporting infrastructures, such as a Web-based tool or electronic data exchange system.
- Provide focused training and TA to SMHAs and allocate adequate resources for local entities and subrecipients to balance Federal and State reporting requirements.
- Use Federal guidelines to increase collaboration among State agencies and providers. Some agencies are reluctant to provide data without impetus from established Federal guidelines.
- Provide training and TA and resources to monitor and improve the quality of subrecipient data.
- Establish State-level “quality units” to ensure that URS data are being reported accurately. Offer incentives to subrecipients to encourage accurate and consistent reporting of data.
- Train Block Grant reviewers on the appropriate use of these data to prevent data misinterpretation during the Federal review process.
- Continue to reexamine and revise URS measures to work toward uniformity and comparability.
- Emphasize system-level as opposed to only client-level outcomes to obtain a more direct measure of the outcome and impact of the CMHS Block Grant.

QUESTION 2 – Is the Block Grant achieving the results it was created to achieve?

The Block Grant is the principal Federal discretionary program supporting community-based mental health services for adults with serious mental illnesses and children with serious emotional disturbances. The funds awarded are to be used to carry out the State Plan contained in the application; to evaluate programs and services set in place under the Plan; and to conduct planning, administration, and educational activities related to the provision of services under the Plan.

Across the 19 States interviewed, responses to specific questions about the effects of the Block Grant varied widely, which is to be expected in light of the intentional flexibility of the program and the diversity among recipients. Nonetheless, States agreed on several areas in which they perceive positive outcomes, including increased consumer involvement, use of evidence-based practices, decreased levels of unmet treatment needs, and greater utilization of community-based treatment services, among other areas.

Although States have great flexibility in their allocation of Block Grant funds, these monies support only a very small part

of States' mental health services, and State representatives believe that it may not be realistic to expect transformation to occur with such limited funds. However, despite limited financial resources, State and Federal staff working directly with the Block Grant expressed the belief that CMHS plays a strong leadership role with regard to guiding States in developing comprehensive systems of care. CMHS has provided strong guidance, support, and leadership to States through a variety of activities including Federal policy development, TA, and evaluation efforts.

States are not required to conduct fidelity monitoring of evidence-based practices and few States do so. The lack of fidelity monitoring makes it difficult to ensure that evidence-based practices are being implemented properly, successfully, or at all. Fidelity monitoring, however, is extremely expensive to conduct and Block Grant resources are limited; this may explain the difficulty many States have in conducting this kind of monitoring. Both State and Federal interviewees praised the flexibility of the Block Grant program as a valuable aspect, and perhaps its most valuable. No interviewees suggested adding any new restrictions or requirements to the program; any additional requirements could limit the critical flexibility that is at the core of so many positive outcomes of the Block Grant.

Highlights of Block Grant outcomes reported by the 19 States interviewed:

- **78.9 percent** (15 States) reported that (1) use of evidence-based practices and (2) consumer involvement in their State increased as a result of the Block Grant, specifically Planning Council activities; the result has been transformation, advocacy leadership, and consumer-focused programs.
- **73.7 percent** (14 States) credited the Block Grant program with contributing to a decrease in unmet treatment needs.
- **68.4 percent** (13 States) reported an increase in use of community-based treatment services.
- **68.4 percent** (13 States) attributed an increase in the ready availability of training and TA to the Block Grant, and agreed that it supports workforce development.
- **63.2 percent** (12 States) reported improved coordination of mental health services as a result of Block Grant activities.
- **63.2 percent** (12 States) identified programs that were initiated with Block Grant funds and were sustained by State-appropriated and other funding sources.
- **63.2 percent** (12 States) reported leveraging Block Grant funds to effect change in State policies and programs.

Summary of stakeholders' recommendations for improvement in achieving results:

- **Increase Block Grant funding.** Almost universally, States recommended increasing Block Grant funding to better support core evidence-based practices, data infrastructure, and training and TA to ensure that those who need support and treatment in the community can receive it, and to make it easier to leverage the Block Grant.
- **Provide more support for long-term sustainability.** States agreed that the Block Grant does provide funding and resources to launch small-scale pilot programs, but they need more support to foster long-term funding and sustainability. Fears about sustaining new programs have prevented some States from using Block Grant funds to develop start-up programs.
- **Increase the number and skill level of Block Grant-dedicated Federal staff.** States identified the need for more and better-trained staff at the Federal level, with increased opportunities for interaction and support with and across States. Federal interviewees also recommended allocating more resources to the Block Grant.
- **Increase coordination across SAMHSA programs.** Both State and Federal interviewees pointed to untapped opportunities for coordination across other SAMHSA programs and initiatives, and with discretionary grant programs.

States' perception of Block Grant impact

Fifteen (79 percent) of 19 States agreed that evidence-based practices and consumer involvement in their States increased as a result of the Block Grant. (The sections "Evidence-based practices" and "Question 3: Does the Block Grant Promote Innovation?" discuss evidence-based practices in more detail.) State representatives attribute an increase in consumer

Strengths Identified by Stakeholders

According to States, the Block Grant's impact:

- **Is positive overall in multiple areas**, including client perception of care, use of evidence-based practices, leveraging of Block Grant funds and requirements, and Federal leadership; and
- **Is largely the result of programmatic flexibility**, which allows States to allocate funding and resources based on individual needs to achieve positive outcomes.

involvement to Block Grant activities and primarily the Planning Council. This involvement, in turn, has contributed to transformation, advocacy leadership, and consumer-focused programs. A companion survey of Planning Council members conducted in conjunction with this evaluation found that members believe their Councils have contributed to wide-ranging changes in their mental health systems.

Representatives from 14 States (73.7 percent) agreed that the Block Grant has contributed to a decrease in unmet treatment need. Block Grant funds help pay for treatment to uninsured adults with serious mental illnesses and children with serious emotional disturbances, and contribute to supporting State public mental health system infrastructure. Nevertheless, representatives reiterated that the proportion of unmet treatment need addressed by Block Grant funds, however important, is quite small.

Thirteen (68.4 percent) of the 19 States agreed that there has been an increase in utilization of community-based treatment services resulting from Block Grant funding. Although most of them said that Block Grant funds support only a small proportion of these services, these monies are still important as States move away from a health care model based in acute care and State hospitals. Interview responses indicate that more children and adolescents with serious emotional disturbances are enrolled into intensive, community-based programs as an alternative to residential treatment centers. URS data indicate a greater increase in enrollment to children’s residential treatment programs compared to admission to community-based programs; however, this increase may be attributable to an increase in clients referred through the juvenile justice system or social services agencies and does not negate the increase perceived by States.

Twelve (63.2 percent) of 19 States said that their coordination of mental health services has improved as a result of Block Grant activities. When asked for specific examples, these representatives cited provision of direction, fostering connections with other agencies, setting priorities, refining thinking, filling service gaps, and developing new programs.

Thirteen States (68.4 percent) indicated that, as a result of the Block Grant, training and TA is more readily available to support workforce development. States often use the Block Grant’s TA set-aside to stage conferences and train State staff. They may also contract for training of direct providers. A few use these funds to work on certification issues, but 89.5 percent (17 of 19) of States interviewed said that the Block Grant has not affected the number or type of credentialed mental health workers in their State. Fewer than half (7 of 19; 36.8 percent) of States believed that the Block Grant has affected credentialing of workers, accreditation of programs, or formal connections with sister State agencies.

Client perceptions of care

Analysis of URS data shows that the proportion of positive responses to general satisfaction questions between FY 2004 and FY 2006 has been relatively constant for both child and adult services (Figure 6). General satisfaction has been high, between 84 and 86 percent for adults and 75.5 and 79 percent for children and adolescents. Responses to specific questions about access, outcomes, participation in treatment, treatment quality and appropriateness, or cultural sensitivity show no significant change across 2004, 2005, and 2006. (Appendix C contains detailed consumer survey data.)

The level of satisfaction with participation in treatment planning, treatment quality and appropriateness, and cultural sensitivity of staff are relatively high and consistent. In general, percentage of satisfaction in these areas hovers just above 80 percent for adult consumers and 65 percent for child/adolescent consumers.

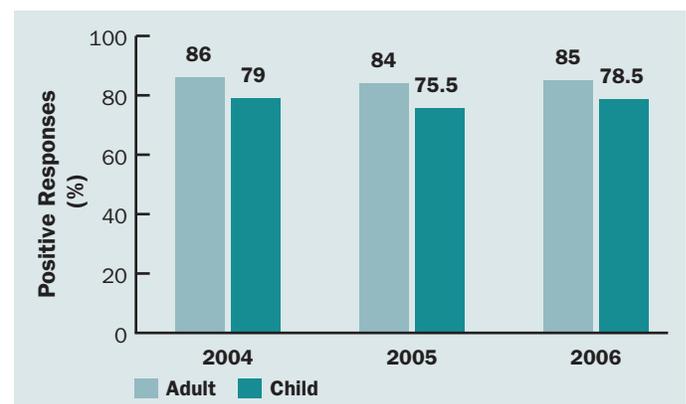


Figure 6. Percentage of positive responses to general consumer satisfaction surveys, 2004-2006 (N=59). Data from the Uniform Reporting System, SAMHSA.

Strengths Identified through Evaluators

Client perceptions of care:

- **Included relatively high levels of general satisfaction** among adults and children; and
- **Remained consistent from 2004-2006** according to URS data. -

Perception of Federal leadership

The Evaluation Team interviewed a sample of 22 CMHS staff, including FPOs who work directly with Block Grant recipients, and SMHA staff members from 19 States to obtain their opinions on how Federal leadership and guidance in conjunction with the Block Grant may or may not have affected the mental health systems of care for adults with serious mental illnesses and children with serious emotional disturbances.

Overall Federal staff responses. Seventeen (72.3 percent) of the 22 Federal interviewees agreed that CMHS provides a solid leadership function to the States through the Block Grant program. Examples of these leadership activities included fostering relationships built on mutual trust and dialogue, being aware of State issues, and providing TA and information. In addition, they cited a number of specific examples of Federal leadership, including spearheading a national dialogue on seclusion and restraint, developing a Federal Action Agenda to improve the Nation’s mental health system of care, and working with States to improve data infrastructures and measures.

A minority (5 of 22; 22.7 percent) of Federal interviewees reported that it has been challenging to provide leadership to States, although they believed there was and is potential for an expanded leadership role. Three (13.6 percent) respondents said they felt that CMHS and SAMHSA focus more energy and staffing resources on discretionary grants, at the expense of the Block Grant.

Overall State staff responses. The responses of State representatives are similar to those of their Federal partners. The majority (12 of 19 States; 63.2 percent) said that CMHS provides leadership to States through the Block Grant program. When asked for specific examples of leadership, State

representatives mentioned regional reviews, site visits, application guidance, presentations at meetings, and ongoing communications via email and telephone. State representatives expressed that the National Grantee Conference on the Mental Health Block Grant and Data provides a forum for information sharing across States. Representatives from 10 (52.6 percent) of 19 States emphasized the positive Federal-State partnership in moving policy forward and in guiding States toward improving their comprehensive mental health systems of care.

Mental health system transformation. Most State representatives agreed that CMHS has played a leadership role in system transformation. Representatives from 10 (52.6 percent) of 19 States believed that CMHS demonstrated leadership by keeping transformation in the forefront of discussions and in its overall direction through dissemination of best practices during conferences and workshops and aggregation of State-level information to present a national picture of transformation. They agreed with their Federal counterparts that the statutory flexibility and required Maintenance of Effort (MOE) in the Block Grant have contributed to transformation. However, representatives from three States (15.8 percent) see negative effects from that same flexibility, expressing the opinion that the Block Grant does not include programmatic assistance and does not emphasize collaboration. State representatives shared their disappointment that transformation is expected in the absence of additional funding for all States.

Stakeholders’ recommendations to improve Federal leadership:

- Allocate more resources to the Block Grant; some Federal representatives reported a perception that SAMHSA and CMHS focus more on discretionary grant programs than on the Block Grant.
- Increase programmatic assistance and emphasize collaboration; provide additional resources and funding to help States achieve transformation.

Evidence-based practices

In addition to alleviating access barriers, the Block Grant has contributed to more effective treatment through evidence-based practices. URS data indicate that both the number of children receiving evidence-based practices and

Strengths Identified by Stakeholders

Federal leadership for the Block Grant:

- **Is perceived as largely positive and strong** by both State and Federal interviewees;
- **Has contributed to a focus on transformation** at both the State and national levels; and
- **Supports policy changes** by providing guidance to States.

Strengths Identified by Stakeholders

Use of evidence-based practices:

- **Has contributed to more effective treatment** thanks to Block Grant funding;
- **Has increased annually**, both in the number of evidence-based practices offered and in the number of adults and children receiving treatment with evidence-based practices.

the number of evidence-based practices established in the 48 contiguous States, Alaska, and Hawaii increased from 2004, when no children were reported to receive evidence-based practices, to 6,198 in 2006. The number of adults reported to receive evidence-based practices increased from 7,415 to 20,555 during the same period, but this increase was not statistically significant. Figure 7 displays median numbers of consumers receiving evidence-based practices per State.

With regard to the demographics of those receiving evidence-based practices, more adults than children receive evidence-based practices. The three evidence-based practices most commonly received by adults were supported housing, supported employment, and Assertive Community Treatment. Few adults received family psychoeducation, integrated treatment for dual disorders, illness self-management, or medication management in 2006. Therapeutic

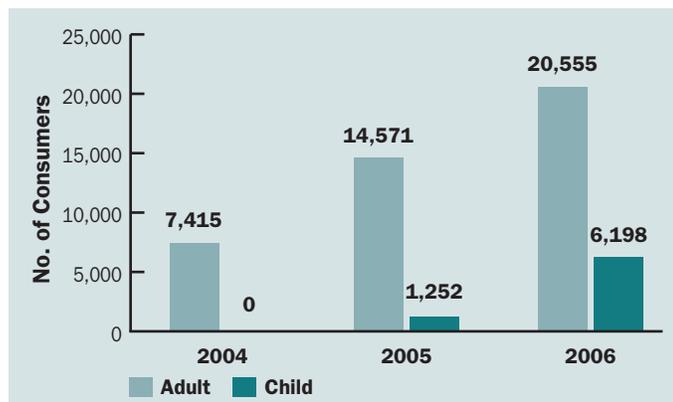


Figure 7. Median number of consumers receiving treatment with evidence-based practices per State (N=59). Within the 48 contiguous States, Alaska, and Hawaii, there was a statistically significant increase in the median number of children receiving treatment with evidence-based practices from 2004 to 2006 ($\chi^2=6.267$; $p=0.0436$). Data from the Uniform Reporting System, SAMHSA.

Foster Care was the most common evidence-based practice that States offered to children. Very few offered Functional Family Therapy and Multisystemic Therapy in 2006. Overall, there is little diversity in the evidence-based practices offered. (Appendix D contains figures that represent data on evidence-based practices in general and also specific practices.)

From 2004 to 2006, the number of evidence-based practices in States increased. In 2004, nearly 34 percent of States had no evidence-based practices in place, and the majority had only 2 to 3. By 2006, the number offered had increased significantly: although 18 percent of States continued to offer no evidence-based practices, the majority offered 2 to 5.

Stakeholder perceptions of increase in use of evidence-based practices match the increase shown in the data. One hundred twenty-six (65.6 percent) of 192 Planning Council members who responded to the Web-based survey agree with the statement that there has been an increase in the number of evidence-based practices and innovative services available because of the Block Grant program. Only 9.9 percent (19 of 192) strongly or somewhat disagreed with this statement.

In 2006, only 2 (3.6 percent) of 55 States monitored more than half of their evidence-based practices for fidelity, and most States did no monitoring. Supported employment, Assertive Community Treatment, and integrated treatment for dual disorders were more likely to be monitored for fidelity than other evidence-based practices.

The Evaluation Team also examined the number and location of States that offered 7 or more of the 10 evidence-based practices States must report to URS. In 2004, only 3 (5.5 percent) of 55 States used seven or more evidence-based practices; by 2006, that number climbed to eight States (Figure 8).

Stakeholders' recommendations to improve evidence-based practices:

- States need the resources and support to offer a wider range of evidence-based practices to adults and children receiving services through the State system.
- To effectively connect treatment with outcomes, States need additional funding, training and TA, and Federal support to conduct fidelity monitoring.

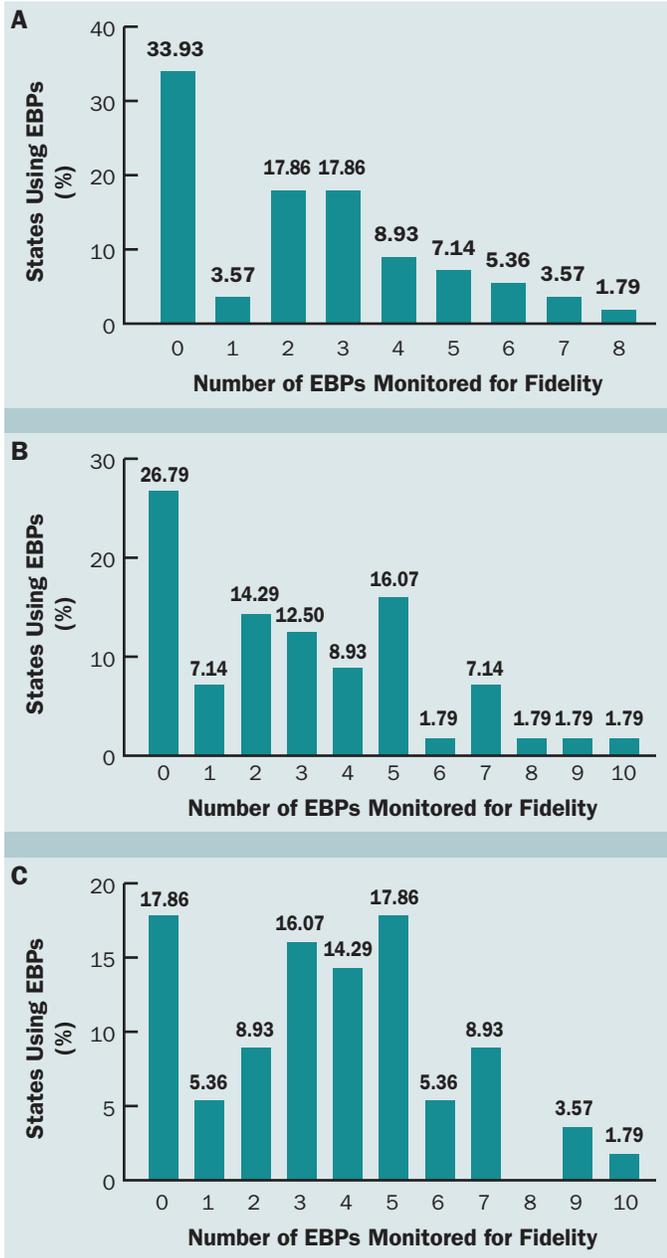


Figure 8. Bar graphs showing the percentage of evidence-based practices monitored for fidelity during (A) FY 2004, (B) FY 2005, and (C) FY 2006. Data from the Uniform Reporting System, SAMHSA.

Leveraging Block Grant resources for maximum impact

Although the Block Grant represents a small proportion of State funding for public mental health services, many States reported that the impact of the Block Grant often is greater than the size of individual State grants would indicate.

Maximizing the Impact of the Block Grant:

- **Is dependent on the program’s flexibility** to allow States to focus on their unique needs and priorities;
- **Is supported by the MOE requirement**, which helps States to protect mental health funding;
- **Extends to multiple aspects of the program**, including funding, training and TA, and policy and data reporting requirements.

Flexibility. Often, this greater impact is a direct result of the flexibility that the Block Grant provides to States. For example, many States report using Block Grant funding as “seed money” to initiate new programs targeting identified needs and gaps or to address special target populations. (“Question 3: Does the Block Grant Promote Innovation?” Provides additional detail on innovation resulting from use of funds to launch new programs and practices.) This allows States to support and nurture new programs and activities before applying for other Federal, State, community, or private funding to ensure long-term stability.

For example, one State provided seed money for drop-in centers in underserved areas; these drop-in centers were later supported through county funds. In addition, States offer multiple examples of using Block Grant funds to collect information on the outcomes of promising programs, which is useful for attracting funding from other sources. One State used the Block Grant to fund a County Systems of Care program and measure its outcomes. That program was ultimately absorbed into a larger, 10-county network supported by a new funding source.

Several States noted that the Block Grant’s flexibility is critical to its ability to achieve this kind of impact. In the words of one State representative, the Block Grant allows States to “take chances on new programs.” Other States said that Block Grant funding is particularly valuable because it can be used for initiatives that have no other funding source, such as improving service coordination or targeting system changes to more effectively meet local needs. One State representative remarked, “There is no other money available to States to invest in infrastructure and services transformation.”

States have used Block Grant funds to launch new programs such as school-based services, a “gatekeeper” program

for older adults, suicide prevention programs, outreach and education, stigma reduction efforts, and evaluation and consumer satisfaction activities. States have also used Block Grant monies to cover startup costs and certification for Community Support Program and Crisis and Coordinated Services, fund case management programs, develop peer services and certification programs, and integrate mental health and primary care in Federally Qualified Health Centers.

Often, the Block Grant funding invested in these kinds of infrastructure initiatives has a “multiplier effect” on system transformation. For example, one State used Block Grant funds to establish an annual consumer reimbursement fund of \$25,000 to send consumers to educational and training events and have them advise the SMHA on policy development. After this investment, counties then paid for trained consumers to present at local recovery conferences.

Training and TA. Several States indicated that the value of Block Grant funding is magnified by the fact that it is accompanied by training and TA to maximize the effectiveness of State Block Grant initiatives. In many cases, this Federal support has helped States leverage additional dollars or other resources to support services for Block Grant-eligible populations, for example, in States receiving TA to help train State staff and contractors on billing Medicaid for covered services. Another State received training for parent advocates, who were then hired as staff through other funding sources to continue providing training to other families.

Block Grant requirements. Many of the Block Grant’s requirements provide not only strong motivation but also effective leverage for States to push for changes in policy and programs and to move forward with transformation activities. As one State representative noted, “If we didn’t have that push from the Feds, people might drag their feet.”

One example is the Block Grant’s MOE requirement, which gives State legislators and departments strong incentive to protect mental health funding. Without the MOE requirement, said one State representative, general mental health funding from the State would dwindle to a point “worse than it already is. The MOE helps us maintain what we do.”

Similarly, requirements that Planning Councils must be involved in developing, reviewing, and commenting on State Mental Health Plans makes more meaningful the role of the Planning Council in helping to prioritize issues and influence State policy regarding mental health.

In addition, the Block Grant’s data reporting requirements push States to collect and analyze data that is also used to support planning and to demonstrate to legislators exactly what impact effective mental health systems of care have on consumers in the State. According to State representatives, in some States the Block Grant application and implementation report are the only current, accurate descriptions of the strengths and weaknesses of the mental health system and its various components. One State representative said that Block Grant data “drive policy and shape the system.”

The Block Grant’s emphasis on building systems of care for children’s services is another tool that allows States to cultivate greater cross-agency collaboration and advocate for pooling scarce resources. The list of agencies and organizations with which States collaborate to address the needs of children with serious emotional disturbances is long and expansive, including departments of juvenile justice, public health, education, housing, public safety, substance abuse, child protective services, and Medicaid, as well as providers, parents, and advocacy groups. A representative from one State described partnership between the mental health agency and Medicaid to “braid” funding for wraparound services for children. States cited similar types of collaborations involved in building a community-based system of care for their adult populations.

Size of the Block Grant. Overall, States have demonstrated success in using the Block Grant to effect policy change and attract resources that exceed the monetary value of the State’s Block Grant allocation. However, some States indicated that the fact that the Block Grant represents such a small proportion of overall State mental health funding limits its effectiveness. Four (21 percent) of the 19 States interviewed specifically said that they have not been able to use Block Grant resources to effect policy changes because of this constraint. Three (16 percent) of the 19 States expressed that, in spite of Block Grant expectations that funds will be used to improve service coordination, the funding is too limited to actually drive or sustain the changes necessary.

Several State representatives described situations in which they used Block Grant money to fund small-scale or pilot programs to implement evidence-based practices, but had not been able to sustain them, transfer them to a State funding source, or provide staff or TA resources to support

them beyond the life of the Block Grant funding. Similarly, eight (42 percent) of the 19 States interviewed report that they have not used Block Grant funds to develop startup programs because of concern that it is “too risky” and that those programs will not be sustainable.

Stakeholders’ recommendations to improve leveraging:

- Increased funding would make all aspects of the Block Grant more compelling motivators for change because Block Grant monies would constitute a larger proportion of State mental health funding.

QUESTION 3 – Does the Block Grant promote innovation?

One way the Block Grant fulfills its purpose to support community-based mental health services for adults with serious mental illnesses and children with serious emotional disturbances is by facilitating innovation and the use of innovative practices that strengthen State mental health systems and improve outcomes.

When asked specifically about “innovative” use of funds, State representatives describe several promising practices that have not been designated as evidence-based practices by SAMHSA, but which reportedly have been successful at the State or local levels. (The evaluators did not query States as to their criteria for success or the extent to which evidence has been analyzed.) Since 2004, CMHS has provided grantees with information on evidence-based practices through their Web site and other materials. Several representatives referred to the importance of using Block Grant funds as seed money that allows them to establish evidence-based demonstration projects with the expectation that the programs will eventually find other sources of revenue to sustain them.

Twelve (63.2 percent) of the 19 States interviewed indicated that programs initiated by Block Grant funds have continued to be supported by State-appropriated and other funds. Such programs represent a wide range of services for different populations, from school-based services to jail-diversion programs (there was no observable trend in the types of new programs cited). By using Block Grant funds as seed or startup monies, States can demonstrate effectiveness of new or expanded programs, which in turn makes them more effective in seeking additional financial resources such as Medicaid reimbursement or other government funds. However, at the

time of the interviews most of these new programs continued to be somewhat dependent on Block Grant funding.

One State used funds to integrate primary and mental health care in Federally Qualified Health Centers. A second State reported using Block Grant monies to incorporate evidence-based practices into physician prescribing practices. Additionally, State representatives said Block Grant funds have helped build programs around suicide prevention; outreach and education; stigma reduction; evaluation and consumer satisfaction; and support programs directed toward rural, transitional, and veteran populations.

Examples of innovation among Block Grant recipients

The FY 2006 Block Grant applications and implementation reports provided a wealth of detail about efforts States consider innovative. The following programs were among those described in States’ accounts of their key accomplishments.

Criminal justice. Some States have established standards for the services available to consumers in the criminal justice system, including monitoring criteria and prison re-entry. Many of the measures reported focus specifically on adults with serious mental illnesses in the criminal justice system, and several State reports described the need for services for youth in the juvenile justice system. In one State, a community mental health services agency placed full-time staff in local juvenile justice offices.

Several States used Block Grant funds to support, in part, jail diversion programs or other interventions directed toward consumers involved with the criminal justice system. Examples include:

- Reentry programs to improve coordination and linkages between county jails and the community mental health system, and to provide care management and treatment services to facilitate transition to the community;
- Adapted or enhanced Assertive Community Treatment teams to serve the needs of professionals working with consumers in the criminal justice system;
- A day treatment program for individuals with a severe psychiatric disability who can be referred pretrial, post-conviction, or toward the end of their sentence; and
- A part-time social worker at a county jail who focuses on continuity of care for individuals after release.

Suicide prevention. Several States established a suicide prevention workgroup or council to address increasing rates (or recognition) of suicide. Other activities include:

- Implementing a statewide suicide prevention plan;
- Convening suicide prevention conferences;
- Establishing common reporting requirements for coroners and medical examiners who document occurrences of suicide;
- Collaborating with school districts and local school principals to develop school-based suicide prevention curricula; and
- Supporting “gatekeeper” training for those who work closely with youth to identify warning signs of suicide.

Older adults. To meet the needs of an aging population, one State introduced a requirement that community mental health programs specifically address older adult services in their plans. That State formed staff teams to focus on improving utilization management to divert persons from the State hospital and to move persons into lower levels of care when appropriate. As part of this program, State personnel educated nursing home staff on elderly mental health issues and physicians on the uses and benefits of newer generation medications.

Information technology. Some States reported the use of telemedicine to increase access to services in rural and frontier areas. Examples include:

- Using videoconference technology for involuntary emergency admissions at a State psychiatric hospital;
- Using telemedicine to link consumers and mental health professionals;
- Establishing a workgroup to address barriers and promote telemedicine services;
- Supporting training activities on the specialized needs of consumers in areas with low population density;
- Collaborating with universities on workforce development, including online education programs and psychiatric residency rotations in rural areas; and
- Providing electronic personal health records that also enable consumers to access Web-based mental health resources and information.

Increased access. States described changes in eligibility requirements and allowances for more self-directed care to increase access to and choices of recovery options for children and families with private insurance who have uncovered service needs, juvenile offenders who have lost Medicaid eligibility, and adult family members of children with serious emotional disturbances. Changes include:

- Changing regulations to allow families to access mental health services without juvenile court or child welfare system intervention;
- Strengthening parents’ ability to secure home- and community-based services or to voluntarily place their children in short-term, out-of-home services without relinquishing legal custody of their children;
- Establishing new regulations to allow an increase in self-directed care for mental health disorders, which increases the number of individuals seeking and obtaining mental health services; and
- Instituting requirements that State-funded programs must allow and encourage clients to be involved in their own recovery plans.

Other changes include unbundling services, allowing out-of-network care, using peer supports, and enhancing person-centered planning to support consumer choice and options. In one State, consumers have their own budgets and information on treatment and support services, which they can use to make their own service selections.

Disaster responses. Hurricanes Katrina and Rita affected the mental health systems of several States, both those directly hit by the storms and those affected by the influx of evacuees. As a result of these disasters, several States reportedly reevaluated their respective abilities to function in a crisis and developed emergency service delivery and crisis response plans. To improve the amount and quality of services offered immediately following a disaster, the States developed and maintained collaborative agreements and partnerships with other agencies and organizations within the State and even across the States. Examples include:

- Establishing 24/7 behavioral health crisis shelters to provide services to those displaced by the hurricanes;
- Dispatching mental health counselors and other workers to affected areas to provide disaster mental health services;
- Extending mental health clinic hours to assist with needs of those affected by the disasters;
- Establishing special toll-free hotlines that were staffed around the clock to meet the surge in mental health needs; and
- Offering frequent education and support sessions to adults and children, including disaster-related education and mental health services in schools.

CMHS update on ongoing improvements

Since this evaluation took place, CMHS has worked to improve administration of the Block Grant. Following are brief highlights of those ongoing improvements as they relate to the stakeholder recommendations contained in this evaluation report. In large part, these changes are a direct result of the open dialogue between the CMHS and Block Grant stakeholders, which allowed CMHS to anticipate a number of the needs identified herein.

Planning Councils. In FY 2009, CMHS awarded a new contract for Planning Council TA. This contract provides for development of a Web-based training portal for Planning Council members. This is the first time an additional contract has supplemented the onsite training and technical assistance (TA) already provided. The portal is planned for launch in FY 2010.

Application guidance and instructions. CMHS implemented a continuous quality improvement initiative in FY 2008 to address States' concerns about the requirements of the Block Grant program. In particular, they focused on reducing the program's reporting burden while improving the quality and usability of content provided by States.

A workgroup comprising State Planners, Planning Council members, consumers and family members, advocates, and contractor staff proposed several recommendations to enhance the application guidance and instructions. The workgroup also proposed changes to policy and to the Block Grant statute to better align them with the Federal direction of policy and procedures. Most of the policy recommendations were accepted and have been implemented into the FY 2009-2011 application guidance and instructions. Recommended changes to the Block Grant statute are under consideration as of this writing.

Regional reviews. In FY 2009, CMHS streamlined the regional reviews from five locations to three, with simultaneous reviews for two regions occurring in two of them. This new arrangement allows State representatives to network with other States in their own region as well as in other regions. In addition, CMHS piloted alternative ways to conduct the reviews in an effort to maximize the opportunities for States to interact substantively with peer review panels on topics important to them and to CMHS. CMHS also piloted reviews via videoconference with three States. In FY 2010, CMHS will work toward transitioning into a review process that focuses primarily on the States' implementation reports.

Monitoring site visits. CMHS piloted a revised monitoring tool for use by the Block Grant Monitoring Team during FY 2009. A key change was the addition of questions specifically designed to more clearly capture an understanding of State efforts toward coordination, collaboration, and system change. The revision also eliminated redundancies from the previous tool. The initial evaluation of this new process began at the end of the FY 2009 monitoring schedule.

The intent of the revised tool is to elicit more information from SMHA leaders about their strategic directions and progress toward the Block Grant goal of a comprehensive, community-based system of care that addresses the needs of adults with serious mental illnesses and children with serious emotional disturbances. Collectively, these changes have contributed to a more focused site visit, a shorter and more useful report, and better-informed choices for TA that respond directly to States' strategic needs, while still meeting the Block Grant's compliance requirements.

Technical assistance. Stakeholder input, particularly from grantees, has been of primary importance to CMHS in improving TA provided to States through the Block Grant program. As a result, CMHS has implemented the use of Web-based technology through its training and TA contract to maintain a comprehensive, consolidated inventory of TA materials and resources while creating the potential for Web-based training delivery. CMHS has also committed to prioritizing peer-to-peer TA through program initiatives.

Uniform Reporting System (URS) data. In-depth performance and outcomes data are important to achieving the Block Grant program's goals of accountability and transparency. Currently, States report data to the URS, which has been developed collaboratively by States and CMHS. To reduce the reporting burden for States and to ensure that stakeholders have access to data on the most valuable measures, CMHS is reassessing the measures and their utility and investigating solutions to streamline the current reporting process. CMHS is also exploring ways to include local providers and stakeholders more directly in discussions about the URS.

Client-level data. CMHS partnered with nine States to initiate a pilot project for collection and reporting of client-level data in 2009. Working together, CMHS and the States developed a standard data protocol and States have already submitted data at two time intervals. Data analysis is currently underway and CMHS anticipates receiving a final report in early 2010.

V. CONCLUSION

This independent evaluation of the Community Mental Health Services Block Grant program sought to answer three important questions about the Block Grant: 1. Is it being implemented according to congressional intent? 2. Is it achieving the results it was created to achieve? 3. Does it promote innovation?

Taken together, the findings of this independent evaluation demonstrate that the Community Mental Health Services Block Grant program has proven effective in helping develop a stronger mental health system both in individual States and nationwide. States use Block Grant funds to serve men, women, and children of diverse ethnic, racial, and clinical backgrounds. Data indicate consistently high levels of satisfaction among adults and children and show increasing use and availability of evidence-based practices. The Block Grant also promotes innovation by providing grantees with seed monies to launch new programs, services, and supports that otherwise would have been impossible according to State representatives who participated in this evaluation.

States also leverage the Block Grant to increase its effects on the mental health system of care. For example, States have been able to effect system change and pilot innovative programs and practices that exert an impact far greater than the size of the individual grants would indicate. Also of note, the Block Grant's flexibility has been critical for helping States respond to major mental health demands of disasters, such as those presented by Hurricanes Katrina and Rita.

Important limitations to be considered in relation to this evaluation include the relatively limited time and resources available to conduct the evaluation, resulting in a narrow timeframe and a limited proportion of States participating in in-depth interviews; use of numerous data sources with

varying levels of completeness, quality, and objectivity; and the low response rate for the Planning Council survey.

Despite these limitations, this independent evaluation of the Block Grant uncovered key information about the administration and implementation of the program and measurable impacts of Block Grant funds. Most important, the review determined that the Block Grant is indeed encouraging and facilitating the development of effective community-based mental health service systems that promote Federal priorities and support recovery and resiliency for adults with serious mental illnesses and children with serious emotional disturbances. The Block Grant is fulfilling its congressional mandate and being administered according to congressional intent. Further, the Block Grant is also reducing unmet treatment need and contributing to positive client outcomes.

State and Federal representatives interviewed in the course of the evaluation offered a number of recommendations for improving the Block Grant. In addition to the nearly universal suggestion to increase Block Grant funding, interviewees also offered ideas to streamline State applications and implementation reports, regional reviews, and monitoring site visits; reduce the reporting burden associated with program requirements while making data more meaningful; and leverage new technology and stronger infrastructure to save money, increase the impact of training and technical assistance, and ensure data integrity. Across all recommendations, State and Federal interviewees stressed the importance of involving States and subrecipients to support implementation and ensure that any adjustments are shaped in part by contributions from these important stakeholders.

Glossary of Abbreviations

CMHS—Center for Mental Health Services

FFT—Functional Family Therapy

FPO—Federal Project Officer

GIS—Geographic Information System

MOE—Maintenance of Effort

PART—Program Assessment Rating Tool

SAMHSA—Substance Abuse and Mental Health Services Administration

SMHA—State mental health agency

TA—Technical Assistance

URS—Uniform Reporting System

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Appendix A: Evaluation Framework

CMHS Block Grant Draft Evaluation Framework

CMHS Block Grant Program Implementation

Federal Implementation (for all Federal implementation categories: How do Federal implementation activities fulfill the CMHS BG legislative requirements?)

Federal funding distribution

- What is the process by which the Federal Government allocates BG funds to States?
- What Federal administrative activities are supported by the BG?

Development of application guidance for states

- What is the process for the development of the application guidance for States?
 - Who is involved?
 - If there are Federal staff members who are not involved, how are changes to the guidance communicated to them?
 - Is there a process for Federal staff to obtain feedback about the application guidance? If so, what is it?
 - What is involved in order to change the application guidance? (e.g., the process for obtaining OMB approval)
 - How are any revisions to the application guidance communicated to States?
 - What is the timeframe for the development and distribution of the application guidance for each year? (e.g., Are there challenges related to keeping the timeframe?)
 - What is the intended purpose of the Application Guidance (e.g., to guide the States' planning processes? To establish Federal expectations of the States' performance?)
- What are the strengths of the process for the development of the application guidance for States?
- What are the challenges of the process for the development of the application guidance for States?
- What are supports to the process for the development of the application guidance for States?

- What are the barriers to the process for the development of the application guidance for States?
- What are recommended changes to the process for the development of the application guidance for States?

Application review and approval

- What is the process by which applications are reviewed and approved?
 - What role do State Project Officers play in the review of applications?
- What is the process for the regional review of applications?
 - What are the strengths of the regional review process?
 - What are the weaknesses of the regional review process?
 - What are recommendations for improving the regional review process?
 - What are unintended positive or negative results of the regional review process?
- What is the process by which applications are approved?
 - How is approval status communicated to other Federal staff and to the States?

Implementation report review and approval

- What is the purpose of the implementation report (e.g., To guide the state? To monitor BG activity/assess compliance? To identify TA needs)?
- What is the process by which implementation reports are reviewed and approved?
 - What role do State Project Officers play in the review and approval of implementation reports?
 - What is the process for the regional review of implementation reports?
 - *What are the strengths of the implementation report review process?*
 - *What are the weaknesses of the implementation report review process?*
 - *What are recommendations for improving the implementation report review process?*
 - *How is approval status communicated to other Federal staff and to the States?*

Program oversight

- What are the goals of program oversight for the CMHS BG program?

- How does CMHS oversee State compliance to the BG requirements (legislation and CMHS policies)?
 - How are potential issues with State compliance identified?
 - Who decides what potential issues require Federal or State action?
 - How are issues that require action communicated to the States?
- What are the strengths of the process by which CMHS oversees State compliance with the BG program?
- What are the weaknesses of the process by which CMHS oversees State compliance with the BG program?
- What are recommendations for improving the process by which CMHS oversees compliance with the BG program?
- How useful is the oversight process to the State? How could it be more useful?
- What are unintended positive or negative results of the oversight process?

Monitoring site visits

- Do the site visitors receive training about how to conduct the site visits? If so, what training do they receive?
- What is the timeframe for monitoring site visitor training (e.g., how long before the actual site visits does the training occur)?
- What materials are provided?
- What instructions are provided?
- What guidance does Federal staff provide to States concerning the site visit process?
 - What materials are provided?
 - What instructions are provided?
- What products result from the monitoring site visits to States? (e.g., site visit report and recommendations)
 - What is the timeliness of the submission of site visit products?
 - How do Federal staff (program staff and grants management) use site visit products?
 - Do States receive the site visit products (reports)? What do they do with them?
 - How do States use the site visit process to improve their BG program/implementation (e.g., request TA, get guidance, etc.)

Grants management

- What role does SAMHSA Grants Management staff play in the monitoring of State compliance with the BG program?
- Are there grants management policies that govern monitoring of State compliance with the BG program? If so, what are they? How are they enforced?

Block Grant development and support

- How does CMHS provide BG program development and support to States?
 - What type of support is provided?
 - What resources are available (e.g., TA, training)?
 - Who provides BG program development and support (including TA, training)?
 - SPOs? If so, in what areas?
 - Federal contractors? If so, through what vehicles and in what areas?
- What are the strengths of BG program development and support provided by CMHS to States?
- What are the weaknesses of BG program development and support provided by CMHS to States?
- What are recommendations for improving BG program development and support provided by CMHS to States?

Data collection, analysis, reporting (e.g., URS, NOMs), and dissemination

- How does CMHS collect data on the BG program?
 - What types of data are collected?
 - Does CMHS solicit feedback from States about BG data collection? If so, what are some examples of State feedback?
- How does CMHS analyze data on the BG program?
 - Who analyzes data on the BG program?
 - To what extent were BG data used to improve Federal administration and management of the BG program?
- How does CMHS report data on the BG program?
 - What are examples of reports that are developed on BG program data?
 - Who are the audiences for these reports on BG program data?
- How are CMHS BG program data disseminated?
- How do Federal staff use BG program data?
- How do State staff use Federally-disseminated CMHS BG program data?

- What are the strengths of CMHS BG data collection, analysis, and reporting?
- What are the weaknesses of CMHS BG data collection, analysis, and reporting?
- What are recommendations for improving CMHS BG data collection, analysis, and reporting?
- What are unintended positive or negative results of CMHS BG data collection, analysis, reporting, and dissemination?

State Implementation (for all State implementation categories: How do State implementation activities fulfill the CMHS Block Grant legislative requirements?)

Planning Activities

Development of state plan

- How does the State develop a plan for providing comprehensive services to adults with SMI and children with SED?
 - Who approves the plan (at the State level)?
 - Who is involved?
 - What is the timeframe?

Planning council

- Do all of the States' Planning Councils participate in the following activities? If so, how?
 - Review the State plan for providing comprehensive services to adults with SMI and children with SED.
 - Serve as advocates for adults with SMI, children with SED, and other individuals with mental illnesses or emotional problems.
 - Monitor, review, and evaluate the allocation and adequacy of mental health services within the State.
- Other activities?
 - How much time did the Planning Council have to review the Federal Fiscal Year (FFY) 2005 application?
- How significant is the Planning Councils' role in the development of the CMHS BG plans?
 - How does the Planning Council provide feedback about the plan?
 - To what extent is Planning Council feedback considered?
 - Are changes made to the plan based on the feedback from the Planning Council?
- Does the composition of the States' Planning Councils meet the Federal legislative requirements?

- What are the strengths of the Planning Councils' involvement in the CMHS BG?
- What are the weaknesses of the Planning Councils' involvement in the CMHS BG?
- What are recommendations for improving Planning Council involvement in the CMHS BG?
- What are the unintended positive or negative results of Planning Council involvement in SMHA activities?

Application development and submission

- What is the process for the development and submission of the State BG application?
 - Who is involved?
 - What is the timeframe?
 - Who approves the application on the State level?
 - How are modifications made?
- What are the strengths of the process for developing the State BG application?
- What are the weaknesses of the process for developing the State BG application?
- What are supports that facilitate the CMHS BG State application and development process?
- What are barriers to the CMHS BG State application and development process?
- What are recommendations for improving the process for developing the State BG application?
- What are unintended positive or negative results of the CMHS BG application development and submission process?

Implementation report development and submission

- What is the process for the development and submission of the implementation report?
 - Who is involved?
 - What is the timeframe?
 - Who approves the application on the State level?
- What are the strengths of the process for developing the implementation report?
- What are the weaknesses of the process for developing the implementation report?
- What are recommendations for improving the process for developing the implementation report?
- Is the implementation report used for anything other than satisfying BG requirements? If so, what are examples?

State funding allocation and distribution

- What is the process by which States allocate BG funds?
 - Who is involved?
 - What is the timeframe?
 - Are there State laws that impact how BG funds are allocated?
 - Who approves the allocation of funds on the State level?
- How do States distribute BG funds to subrecipients?
 - By which mechanisms?
 - How frequently are funds distributed?
- How many subrecipients receive BG funds? What are their funding allocations?
- What are the strengths of the process for allocating and distributing BG funds?
- What are the weaknesses of the process for allocating and distributing BG funds?
- What are recommendations for improving the process for allocating and distributing BG funds?
- How does the allocation of BG funds affect the way that other funds are distributed in the State?

Programs and services

- What service modalities are funded through the CMHS BG?
- What types of programs are funded through the CMHS BG?
- What target populations do they serve?
- What types of EBPs and innovative programs are funded through the CMHS BG?
- How many individuals receive services funded through the BG?
- What are the issues involved in knowing this information?
- Have any programs developed and/or supported by BG funds been funded subsequently by other means?

State-level administrative needs and initiatives

- What State administrative activities are supported by the CMHS BG?

Program development

- Do States use BG resources to provide program development and support to subrecipients? If so, how?
 - How are needs identified?
 - Who provides BG program development and support (including TA, training)?
 - State staff? If so, in what areas?
 - State contractors? If so, in what areas?

- How many TA and training events occurred in FFY 2005?
- How many subrecipient organizations received State TA and training in FFY 2005?
- What are some examples of changes that have been made as a result of BG-related TA?
- What are the strengths of BG program development and support provided by States to subrecipients?
- What are the weaknesses of BG program development and support provided by States to subrecipients?
- What are recommendations for improving BG program development and support provided by States to subrecipients?
- What are unintended positive or negative results of BG program development/support provided by States to subrecipients?

Evaluation of programs and services funded through the Block Grant

- How do States collect data on the BG program from subrecipients?
 - What types of data are collected?
 - Do States solicit feedback from subrecipients about data collection? If so, what are examples of this feedback?
- Do States analyze data on the BG program? If so, for what purposes?
- Do States develop reports using data on the BG program? If so, what are examples of this?
 - Who are the audiences for these reports?
- What are the strengths of State BG data collection, analysis, and reporting?
- What are the weaknesses of State BG data collection, analysis, and reporting?
- What are recommendations for improving State BG data collection, analysis, and reporting?
- What are unintended positive or negative results of State BG data collection, analysis, and reporting?

CMHS BG Program Outcomes

Federal Outcomes

Short-term

- To what extent do States submit complete applications, State plans, and implementation reports?

- To what extent do the regional review and monitoring site visit processes improve Federal/State information exchange?
- To what extent is there State compliance with statutory requirements?
- As a result of the data collection activities, to what extent does the Federal Government have an improved ability to describe State BG program outcomes?
- To what extent were BG program data used to improve Federal administration and management of the BG program?

Long-term

- As a result of BG data collection and analysis activities, to what extent does the Federal Government have an improved capability to respond to Congressional information requests?
- To what extent were BG data used to make major improvements in Federal administration and management of the BG program?
- Does CMHS provide leadership to States related to the CMHS BG program? If so, how?
- Through the CMHS BG program, does CMHS play a national leadership role in mental health system transformation? If so, how?

State Outcomes

Short-term

- To what extent is the Planning Council an active, integrated part of the State planning process for the BG?

- Has there been an increase in positive client perceptions of care?
- To what extent has the target population specified in the legislation been served using BG funds?
- As a result of BG activities, to what extent have States improved their documentation of State mental health activities?

Long-term

- As a result of BG activities, to what extent have States improved their coordination of State mental health services/programs?
- To what extent has there been an increase in the number of EBPs and innovative services available because of the BG program?
- To what extent has the BG program contributed to improving the quality of States' mental health services?
- To what extent has the BG program contributed to a decrease in unmet treatment need?
- As a result of CMHS BG activities, has there been an increase in consumer involvement in the State mental health system? If so, how?
- Has there been an increase in utilization of community-based treatment services?
- To what extent have programs initiated with CMHS BG funds been continued using State and other funding sources (e.g., leveraging)?
- To what extent have States leveraged CMHS BG resources to implement policy change?

Appendix B: Data Collection Instruments

Interview Guide for Federal Staff Involved with the CMHS Block Grant Program

Estimates of Burden for the Collection of Information

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0289. Public reporting burden for this collection of information is estimated to average 90 minutes per interview, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland, 20857.

Organization: _____

Interviewer: _____

Address: _____

Date of Interview: _____

Study ID No.: _____

Respondent: _____

Title: _____

Phone: _____

Fax: _____

E-mail: _____

Introduction

Thank you so much for taking the time to participate in this interview. We know that you are extremely busy, and we greatly appreciate your input. As you know, the Center for Mental Health Services contracted with Altarum to conduct an evaluation of the Community Mental Health Services Block Grant Program (CMHS BG). The purpose of our discussion today is to learn how the CMHS BG is implemented at the Federal level and to understand the impact of the CMHS BG within States. As part of this evaluation, we are collecting information about activities in Fiscal Year 2006 and the planning process for these activities.

Your agency's name, location, and your general job title (e.g., Public Health Advisor) may be identified in reports prepared for this study and in data files provided to the Center for Mental Health Services. However, none of your responses during the interview will be released in a form that identifies you or any other Federal staff member by name. Please remember that this study is not part of an audit or management review of Federal operations. Your participation in the interview is completely voluntary.

The estimated total time to complete this interview is 120 minutes, which can be done over two sessions.

Do you have any questions before we begin?

1. What is your title and how long have you been in this position?
2. Briefly describe your responsibilities with regard to the CMHS BG.

Federal Funding Distribution

3. How does the Center for Mental Health Services allocate CMHS BG funds to States?

Probes:

- a) Is there an allocation formula? If so, on what is the allocation formula based?
 - b) Who is involved? What roles do they play?
 - c) What is the time frame by which the allocation follows?
 - d) What role do State Project Officers (SPOs) play in the allocation of CMHS BG funds?
 - e) Do you feel the allocation formula can be improved? If so, in what ways?
4. What administrative activities are supported by the CMHS BG within the Division of State and Community Systems Development?

Development of Application Guidance for States

5. What is the intended purpose of the application guidance?
6. What is the process for the development of the application guidance for States?

Probes:

- a) Who is involved?
- b) How are changes to the guidance communicated to stakeholders (e.g., other Federal staff members, State stakeholders)?

- c) What is involved in order to make changes to the application guidance?
 - d) What have some of the most recent changes been, and why? What future changes are anticipated?
 - e) What is the time frame for the development and distribution of the application template and guidance each year?
 - f) Are there challenges related to keeping the time frame?
7. What are the strengths of the application guidance document?
 8. What are the weaknesses of the application guidance document?
 9. Is the application guidance used in ways by States beyond its intended purpose? If so, what are other uses?
 10. How would you improve the application guidance document?
 11. How would you improve the process of developing the application guidance?
 12. Do the five criteria provide an adequate framework for States to describe their State mental health systems? Please explain.
 13. Are there other criteria that could be helpful in developing States' plan?

Application Review and Approval

14. How are CMHS BG applications reviewed and approved?
Probe:
 - a) What role do SPOs play in the review and approval of applications?
 - b) How is approval status communicated to other Federal staff members and to the States?
15. What are the strengths of the regional review process?
16. What are the weaknesses of the regional review process?
17. How would you improve the regional review process?
18. Have there been any unintended positive or negative results of the regional review process? If so, please describe.

Implementation Report Review and Approval

19. What is the purpose of the implementation report?
20. What is the process by which implementation reports are reviewed and approved?

Probe:

- a) What role do SPOs play in the review and approval of implementation reports?
 - b) How is approval status communicated to other Federal staff members and to the States?
21. What are the strengths of the implementation report review process?
 22. What are the weaknesses of the implementation report review process?
 23. How would you improve the process of reviewing and approving implementation reports?
 24. Do you use States' implementation reports? If so, in what ways?

Program Oversight

25. How does the Center for Mental Health Services oversee State compliance to the CMHS BG requirements?
26. How are potential issues with State compliance identified?
Probe:
 - a) Who decides what potential issues require Federal or State action?
 - b) How are issues that require action communicated to States?
 - c) Is there followup from the Center for Mental Health Services to determine if potential issues have been addressed?
27. What are the strengths of CMHS BG program oversight?
28. What are the weaknesses of CMHS BG program oversight?
29. How would you improve CMHS BG program oversight?
30. Have there been any unintended positive or negative results of CMHS BG program oversight? If so, what are they?

Monitoring Site Visits

31. What is the selection process for determining which States will receive site visits in a particular year?
32. Do site visitors receive training about how to conduct the CMHS BG program site visits? If so, what training do they receive?
Probe: -
 - a) What training materials are provided?

- b) What instructions are provided?
- c) How long before the actual site visits does the training occur?

33. What guidance do you or other SPOs provide to States concerning the monitoring site visits?

Probe:

- a) What materials are provided?
- b) What instructions are provided?

34. What products result from monitoring site visits?

35. What is the timeliness of the submission of site visit products?

36. Do you use site visit products (e.g., reports)? If so, in what ways?

Grants Management

37. What role does Grants Management play in monitoring compliance with the CMHS BG program?

Probe:

- a) Are there specific grants management policies that govern the monitoring of compliance with the CMHS BG program?
- b) If so, what are they?
- c) How are they enforced?

38. How would you improve the services provided by Grants Management to States?

Block Grant Development and Support

39. How does the Center for Mental Health Services provide CMHS BG-related support (e.g., training, technical assistance) to States?

Probe:

- a) What types of support are provided?
- b) Who provides CMHS BG-related support to States?
- c) If SPOs, in what areas do they provide support?
- d) If contractors, in what areas and through what vehicles do they provide support?

40. What are the strengths of the CMHS BG-related support that the Center for Mental Health Services provides to States?

41. What are the weaknesses of the CMHS BG-related support that the Center for Mental Health Services provides to States?

42. How would you improve the CMHS BG-related support that the Center for Mental Health Services provides to States?

Data Collection (e.g., Uniform Reporting System, National Outcome Measures), Analysis, and Dissemination

43. How does the Center for Mental Health Services collect data on the CMHS BG program? For what purposes?

Probe:

- a) What types of data are collected?

44. Does the Center for Mental Health Services solicit feedback from States about CMHS BG data collection? If so, how?

45. Does the Center for Mental Health Services incorporate State feedback about CMHS BG data collection? If so, please provide examples of State feedback that the Center for Mental Health Services has incorporated.

46. How does the Center for Mental Health Services analyze data on the CMHS BG program?

Probe:

- a) Who analyzes data on the CMHS BG program?

47. How does the Center for Mental Health Services disseminate data on the CMHS BG program?

Probe:

- a) What are examples of reports that are developed using CMHS BG program data?
- b) Who are the audiences for these reports on CMHS BG program data?
- c) Does the Center for Mental Health Services share CMHS BG data with States? If so, how?
- d) What other stakeholders receive CMHS BG program data? For what purposes?

48. Do you use CMHS BG program data? If so, in what ways (e.g., Federal administration and management)?

49. How useful are CMHS's data collection activities (including the NOMS and URS) in helping describe your State's mental health agency activities?

50. What are the strengths of CMHS BG data collection, analysis, and dissemination?

51. What are the weaknesses of CMHS BG data collection, analysis, and dissemination?

52. How would you improve CMHS BG data collection, analysis, and dissemination?

53. Have CMHS BG program data been used for purposes other than those originally intended? If so, please describe?

54. Have there been any unintended positive or negative results of CMHS BG data collection, analysis, and dissemination? If so, please describe.

Federal Outcomes

- 55. Do the regional reviews and monitoring site visits improve State and Federal communication and information exchange? Please explain.
- 56. Does the Center for Mental Health Services provide leadership to States related to the CMHS BG program? If so, please describe.
- 57. Through the CMHS BG program, does the Center for Mental Health Services play a national leadership role in mental health system transformation? If so, how?

Closing

Thank you very much for your time. Your participation is greatly appreciated. If you think of anything else you would like to add, feel free to get in touch with me.

Interview Guide for State Staff Involved With the CMHS BG Program

Estimates of Burden for the Collection of Information

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0289. Public reporting burden for this collection of information is estimated to average 150 minutes per interview, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland, 20857.

State: _____
Interviewer: _____
Date of Interview: _____
Study ID No: _____
Organization: _____
Address: _____

Respondent 1: _____
Title: _____
Phone: _____
Fax: _____
E-mail: _____

Respondent 2: _____
Title: _____
Phone: _____
Fax: _____
E-mail: _____

Respondent 3: _____
Title: _____
Phone: _____
Fax: _____
E-mail: _____

Respondent 4: _____
Title: _____
Phone: _____
Fax: _____
E-mail: _____

Respondent 5: _____
Title: _____
Phone: _____
Fax: _____
E-mail: _____

Respondent 6: _____
Title: _____
Phone: _____
Fax: _____
E-mail: _____

Introduction

Thank you so much for taking the time to participate in this interview. We know that you are extremely busy, and we greatly appreciate your input. As you know, the Center for Mental Health Services contracted with Altarum to conduct an evaluation of the Community Mental Health Services Block Grant Program (CMHS BG). The purpose of our discussion today is to learn how the CMHS BG is implemented in your State and to understand the impact of the CMHS BG in your State. As part of this evaluation, we are collecting information about CMHS BG activities and the planning

process for these activities. As described in the letter we sent you earlier, your agency's name, location, and your general job title (e.g., State Mental Health Commissioner, State Planner) may be identified in reports prepared for this study and in data files provided to the Center for Mental Health Services. However, none of your responses during the interview will be released in a form that identifies you or any other State staff member by name. Please remember that this study is not part of an audit or management review of State operations. Your participation in the interview is completely voluntary. Failure to complete the interview will not affect your State's CMHS BG in any way.

The estimated total time to complete this interview is 3 hours although we will have a 10 minute break approximately halfway through the survey. In addition, if we are spending too long on any given section of the protocol, I will interrupt gently to move us forward so that we can complete the interview within the allotted timeframe. We greatly appreciate your detailed feedback; however, we want to be respectful of your busy schedules.

Do you have any questions before we begin?

Background

1. What is your title and how long have you been in this position?
2. Briefly describe your responsibilities with regard to the CMHS BG (please be sure to gather this information from all State participants).

Federal Activities

3. Do you feel the allocation formula can be improved? If so, in what ways?

Application Guidance for States

4. Is there a formal mechanism for your State to provide feedback on the application guidance?
5. For the FY 2005 application year, there were changes to the application guidance. Was there any official notification regarding these changes prior to the release of the application guidance?
6. For the FY 2005 application, how far in advance of the application deadline did your State receive the guidance? Were you satisfied with this time frame?
7. How would you improve the application guidance or its dissemination?

8. Do the five criteria provide an adequate framework to describe your State mental health system? Please explain.
9. Are there other criteria that could be helpful in developing your State's plan?

Application Review and Approval

10. What are the benefits of the peer consultative review of applications?
11. What is the impact of State team members participating in the regional reviews?
12. What are the weaknesses of the regional reviews as they are currently conducted?
13. During the regional reviews for the FY 2005 applications, did your State receive any specific programmatic or policy advice from the peer reviewers? From other State teams? From Federal Project Officers? If so, please describe the advice and whether your State was able to use it.
14. To what extent would you agree that each of the following potential changes would improve the regional review process?
Potential changes:
 - a) Submit a joint CMHS BG application and implementation report on December 1.
 - b) Develop a more structured CMHS BG application in order to make it easier to review.
 - c) Review the CMHS BG application and previous year's implementation report simultaneously.
 - d) Formally identify State technical assistance (TA) needs as part of the regional review.
 - e) Utilize technology to determine CMHS BG compliance prior to the onsite regional review.
 - f) Create a regional partnership program to promote opportunities for inter-State information exchange.
 - g) Provide separate TA to States and reviewers on developing appropriate performance indicators.
 - h) Provide TA on developing the CMHS BG State plan.
 - i) Provide TA on submitting National Outcome Measures.
 - j) Provide TA on evidence-based practices.

Interviewer Note: Please prompt respondents to explain their responses to each potential change.

Implementation Report Review and Approval

15. What is the purpose of the implementation report review?
16. Does your State receive any feedback on its implementation report? If so, from whom? (e.g., Federal Project Officer, reviewer)
17. What are the benefits of the implementation report review?
18. What are the weaknesses of the implementation report review?
19. How would you improve the review of implementation reports?

Program Oversight

20. What is the purpose of the monitoring site visits? (e.g., compliance, program improvement)
21. Prior to a monitoring site visit, does your State receive guidance from the Federal staff about expectations of State staff members or materials that should be prepared for the site visit? If so, please describe.
22. What products does your State receive after a monitoring site visit? Approximately how long after a site visit do you receive the products? Are you satisfied with this time frame?
23. What changes, if any, have been made as a result of monitoring site visits and the subsequent products (e.g., report and recommendations)?
24. How does your State use the monitoring site visit reports?
25. If there are issues with State compliance, who decides what action should be taken? (Federal level and State level).
26. What are the benefits of the current monitoring process? Are the monitoring site visits worthwhile?
27. What are the weaknesses of the current monitoring process?
28. How would you improve the Federal oversight process (including the site visits)?

[Facilitators: If more than 1 hour has passed, speed up the interview.]

CMHS BG TA and Training (Federal to State)

29. In the past year, has your State received TA and training through Federal CMHS BG resources? If yes, in what areas? In what formats?
30. What, if any, specific changes has your State made as a direct result of Federal TA or training?
31. How would you improve Federal TA and training to States?

Data Collection, Analysis, and Reporting

32. Does the Center for Mental Health Services solicit feedback from the States about federally expected data collection? If so, how?
33. How useful are CMHS's data collection activities (including the NOMS and URS) in helping describe your State's mental health agency activities?
34. Has your State ever provided feedback – either officially or unofficially – about CMHS BG data collection for Uniform Reporting System and National Outcome Measures? If so, please describe. Was the Center for Mental Health Services responsive to your feedback? Please explain.
35. Does your State receive Federal reports based on data from the CMHS BG Program? If so, how does your State use these reports?
36. Have there been any unanticipated positive or negative results from complying with CMHS BG data collection, analysis, and reporting? If so, please describe.
37. What are the strengths of the federally required CMHS BG data collection?
38. What are the weaknesses of the federally required CMHS BG data collection?
39. How would you improve the data collection process?

State Activities

CMHS Block Grant State Plan

40. Is the CMHS BG State plan the same as the overall State plan for a mental health system of care? If not, how do the two plans differ?
41. Please describe the CMHS BG State plan development process.
 - Probes:
 - a) Who is involved?
 - b) How long does it take to produce the plan?
42. Please describe how your State's CMHS BG Planning Council reviews the CMHS BG State plan.
43. How much time did the CMHS BG Planning Council have to review the FY 2005 BG State plan?
44. Are CMHS BG Planning Council recommendations incorporated into the plan? If so, please provide examples of incorporated feedback.
45. If CMHS BG Planning Council recommendations are not incorporated, is there a formal way to communicate the reasons that their input was not accepted? If so, please describe.

Planning Council

46. Please describe the activities of your State's CMHS BG Planning Council.
- Probes:
- Reviewing the State mental health plan submitted as part of the CMHS BG application
 - Serving as advocates for adults with serious mental illness and children with severe emotional disorders
 - Monitoring the allocation of resources and services in the State
 - Other activities
47. Does the CMHS BG Planning Council have responsibilities other than working on the CMHS BG? If so, please describe.
- Probe: -
- Is their expertise leveraged in any way?
48. What are the advantages of having a CMHS BG Planning Council?
49. What are the disadvantages of having a CMHS BG Planning Council?
50. How would you improve the involvement of the CMHS BG Planning Council in CMHS BG activities?
51. Have there been any unanticipated positive or negative results from the CMHS BG Planning Council's involvement with the CMHS BG? If so, please describe.

[Facilitators: Take a 10-minute break now; If more than 2 hours have passed, be prepared to speed up the second half of the interview.]

Block Grant Application Development

52. Please describe the CMHS BG application development process.
- Probes:
- Who is involved (roles rather than names)?
 - How long does the process take?
 - What feedback is sought?
53. What are the strengths and benefits of the application process?
54. What are the weaknesses of the application process?
55. How would you improve the CMHS BG application process?
56. Have there been any unanticipated positive or negative results from producing the CMHS BG application? If so, please describe.

Implementation Report

57. Please describe the CMHS BG implementation report development process.
- Probes:
- Who is involved (roles rather than names)?
 - How long does the process take?
 - What feedback is sought?
58. Is the implementation report used for any purposes at the State-level other than fulfilling the CMHS BG requirement? If so, please describe.
59. Could the implementation report be made more useful for States? If so, how?
60. What are the benefits of developing an implementation report?
61. What are the disadvantages of developing an implementation report?

State Funding Allocation

62. What is the process by which your State allocates CMHS BG funds (e.g., allocation formula)?
- Probes:
- Who is involved (roles rather than names)?
 - How long does the process take?
63. Are there any State laws that impact how CMHS BG funds are allocated? If so, please describe.
64. What are the advantages of your State's CMHS BG funding allocation process?
65. What are the disadvantages of your State's CMHS BG funding allocation process?
66. How would you improve your State's process for allocating CMHS BG funds?

Programs and Services Funded through the CMHS Block Grant

67. What types of service modalities are funded, at least in part, by the CMHS BG?
68. What types of programs offered through the State system receive funding from the CMHS BG?
69. Which populations are served by programs that receive funding from the CMHS BG?
70. Please describe any evidence-based practices or innovative programs that receive funding from the CMHS BG.
71. Using your best estimate, how many individuals receive services from organizations and programs that are funded in part by the CMHS BG?

Probe:

a) Discuss organizations that provide direct services as well as organizations that conduct other activities.

72. Have any programs developed or supported using CMHS BG funds graduated to other means of support? If so, please describe the programs.
73. Are there any State-level administrative activities that are directly supported by CMHS BG funds? If so, please describe.

[Facilitators: If more than 3 hours have passed, move the interviewees along more quickly in the last quarter of the interview.]

TA and Training Provided to Subrecipients

74. In the past year, has your State used CMHS BG resources to provide TA or training to subrecipients? If so, please describe the types of TA and training that your State has provided.
75. What is the process for deciding what TA and training should be offered to CMHS BG subrecipients?

Probe:

a) Who identifies training or TA needs?

76. Who has provided TA or training? State staff members, contractors, other?
77. Using your best estimate, how many TA and training events were conducted in the past year?
78. Using your best estimate, how many different subrecipients participated in the TA and training events?
79. To the extent that you are aware, please describe any programmatic changes that have occurred as a result of receiving TA or training.
80. How would you improve TA and training to subrecipients?
81. Have there been any unanticipated positive or negative results from providing TA and training to subrecipients? If so, please describe.

State Monitoring of Programs and Services That Receive CMHS BG Funding

82. How does your State collect data from subrecipients? Does your State provide data collection forms or templates to subrecipients? If so, please describe.
83. Is there a formal process for subrecipients to provide feedback to the State about the data collection for the CMHS BG? If so, please describe the process.
84. What types of feedback have subrecipients provided to the State about data collection?

85. Has this feedback been incorporated? If so, please provide examples of incorporated feedback.
86. How does your State use the data provided by CMHS BG subrecipients (e.g., produce CMHS BG State plan, implementation report, other reports)?
87. Have CMHS BG program data been used for purposes other than those originally intended?
88. Have there been any unanticipated positive or negative results from collecting, analyzing, and reporting subrecipient CMHS BG data? If so, please describe.
89. How would you improve the subrecipient-to-State data collection process?

CMHS BG Program Outcomes

Federal Outcomes

90. Do the regional reviews and monitoring site visits improve State and Federal communication and information exchange? Please explain.
91. Does the Center for Mental Health Services provide leadership to States related to the CMHS BG program? If so, please describe.
92. Through the CMHS BG program, does the Center for Mental Health Services play a national leadership role in mental health system transformation? If so, how?

State Outcomes

93. As a result of CMHS BG activities, has your State improved its coordination of mental health services and programs? If so, please describe any improvements and how the CMHS BG contributed to them.
94. Has there been an increase in the number of evidence-based practices and innovative services available because of the CMHS BG program? If so, please describe the newer services and how the CMHS BG contributed to their availability.
95. Has the CMHS BG program contributed to a decrease in unmet treatment need? If so, how?
96. As a result of the CMHS BG, has there been an increase in consumer involvement in the State mental health system? If so, please describe.
97. As a result of the CMHS BG, has there been an increase in utilization of community-based treatment services? If so, please describe.
98. As a result of the CMHS BG, have there been any changes in the number and types of mental health workers who have credentials? If so, please describe.

99. Approximately how many mental health workers in the State currently possess individual credentials? What types of credentials are common?
100. As a result of the CMHS BG, have there been any changes in the number and types of programs that are accredited? If so, please describe.
101. How many programs does each accrediting body currently accredit?
102. As a result of the CMHS BG, is there TA and training available to support workforce development that otherwise would not be available?
103. As a result of the CMHS BG, has the SMHA strengthened its formal connections with other State agencies, including MOUs, joint appointments, and joint funding for projects? If so, please provide examples.
104. As a result of the CMHS BG, has your State implemented any new policies or changes to existing policies regarding the mental health system of care? If so, please provide examples.
105. As a result of the CMHS BG, has your State initiated but not yet implemented any new policies or changes to existing policies? If so, please provide examples.

Closing

Thank you very much for your time. Your participation is greatly appreciated. If you think of anything else you would like to add, feel free to get in touch with me.

The Independent Evaluation of the CMHS Block Grant Program

Estimates of Burden for the Collection of Information

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0289. Public reporting burden for this collection of information is estimated to average 60 minutes per survey, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland, 20857.

Dear Planning Council Member:

The Community Mental Health Services Block Grant (CMHS BG), funded by Congress to develop community-based systems of care for adults with serious mental illness and children with a serious emotional disturbance, is the largest Federal program dedicated to improving community mental health services. The sponsor of the program, the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services, has contracted with Altarum, to conduct an independent evaluation of this program.

We are soliciting feedback about the CMHS BG from key program stakeholders. As members of the State Planning Council, you have important insights and views about the intent, implementation, and impact of the CMHS BG in your State. We therefore would appreciate greatly your assistance with the evaluation by completing this survey. Most of the questions are closed-ended questions, where you will be asked to check the appropriate answer or answers. In addition, there are several open-ended questions, where you have the opportunity to comment. We urge you to be as honest and thoughtful as possible.

Please be assured that your answers will be strictly confidential. We will report responses to questions only in the aggregate, and we will never attribute specific comments to particular individuals. Your responses will not have any repercussions for your State and will not be used by the sponsoring organization to assess State compliance with the CMHS BG requirements; they will be used solely for the purposes of evaluating the CMHS BG as a whole.

Thank you very much for taking the time to participate.

Background Questions

- 1) What group do you formally represent on your CMHS BG Planning Council? (Check one)
 - Consumers
 - Family members
 - Advocacy organization representatives
 - Mental health providers
 - State officials
 - Health-related professionals (e.g., physician, nurse)
 - Other (please describe)

- 2) In what month and year did you become a member of the CMHS BG Planning Council?
Month: _____ Year: _____

Application Development and Review

3a) Do the five criteria provide an adequate framework for States to describe their State mental health systems?
 Yes No

3b) Please explain.

3c) Are there other criteria that could be helpful in developing States' plan?
 Yes No

3d) If so, please discuss.

4) What are the strengths of the process for developing the State CMHS BG State plan?

5) What are the weaknesses of the process for developing the State CMHS BG State plan?

6) What are supports that facilitate CMHS BG Planning Council involvement in the CMHS BG State plan development process?

7) What do you see as the barriers to CMHS BG Planning Council involvement in the CMHS BG State plan development process?

8a) Do you have any recommendations for improving the process of developing the State CMHS BG State plan?
 Yes No

8b) If so, what are they?

9a) Are there unintended positive results of CMHS BG Planning Council involvement in the CMHS BG State plan development and submission process?
 Yes No Cannot answer

9b) If so, please describe.

9c) Are there unintended negative results of CMHS BG Planning Council involvement in the CMHS BG State plan development and submission process?
 Yes No Cannot answer

9d) If so, please describe.

Planning Council Involvement in CMHS Block Grant Activities

10) In Fiscal Year (FY) 2005, how involved was the CMHS BG Planning Council in the following activities?

Activity	Not involved	Somewhat involved	Moderately involved	Very involved	Extremely Involved	Cannot answer
Reviewing the State's CMHS BG State plan						
Monitoring and evaluating the allocation and adequacy of State mental health services funded in part through the CMHS BG						
Educating legislators						
Providing information to the public						
Creating study groups to develop recommendations for the State's CMHS BG State plan						
Developing products (e.g., documents related to cultural competence)						
Implementing surveys (e.g., consumer surveys)						
Drafting State legislation						
Implementing special projects						
Developing the State's CMHS BG State plan						

Activity	Not involved	Somewhat involved	Moderately involved	Very involved	Extremely Involved	Cannot answer
Participating in a needs assessment						
Reviewing data from the State mental health information system						

Other (please describe).

11a) Did you have an opportunity to review the FY 2005 State plan?

- Yes No Cannot answer

11b) If so, how much time did you, as a CMHS BG Planning Council member, have to review the State's FY 2005 CMHS BG State plan?

- Less than a week
 1 week to 2 weeks
 2 weeks to a month
 More than a month
 Cannot answer

12) How much time did the CMHS BG Planning Council have to review the State's FY 2005 CMHS BG State plan?

- Less than a week
 1 week to 2 weeks
 2 weeks to a month
 More than a month
 Cannot answer

13) To what extent do you agree that the amount of time that the CMHS BG Planning Council had to review the FY 2005 CMHS BG State plan was adequate?

- Strongly disagree
 Somewhat disagree
 Neither agree nor disagree
 Somewhat agree
 Strongly agree
 Cannot answer

14) How frequently does your CMHS BG Planning Council meet in a typical year?

- We don't meet at least once a year
 Once or twice

- 3 to 4 times
 5 or more times
 Cannot answer

15) How does the CMHS Planning Council provide feedback about the State's CMHS BG State plan to the State Mental Health Agency (SMHA)?

16) Please rate the extent to which you agree with each of the following statements.

Statement	Strongly disagree	Somewhat disagree	Neither disagree nor agree	Somewhat agree	Strongly agree	Cannot answer
The CMHS BG Planning Council solicits my opinion as a council member						
The CMHS BG Planning Council respects my opinion as a council member						
The SMHA staff respects the opinions of the CMHS BG Planning Council						
The SMHA staff solicits the opinions of the CMHS BG Planning Council beyond what is legislatively required						
The CMHS BG Planning Council supports my participation (e.g., transportation, reimbursement for expenses, stipend)						

17a) Does the CMHS BG Planning Council work with the SMHA to implement CMHS BG activities?

- Yes No Don't know

17b) If so, please describe the quality of this working relationship.

18) What are the strengths of the CMHS BG Planning Council's involvement in the CMHS BG Program?

19) What are the weaknesses of the CMHS BG Planning Council's involvement in the CMHS BG Program?

20a) Do you have any recommendations for improving the CMHS BG Planning Council's involvement in the CMHS BG Program?

- Yes No

20b) If so, what are they?

21a) Are there unintended positive results of the CMHS BG Planning Council involvement in SMHA activities?

- Yes No Cannot answer

21b) If so, please describe.

21c) Are there unintended negative results of the CMHS BG Planning Council involvement in SMHA activities?

- Yes No Cannot answer

21d) If so, please describe.

22a) Do you think that your CMHS BG Planning Council influences State-level policy?

- Yes No Don't know

22b) If so, which of the following activities did your CMHS BG Planning Council engage in to influence State-level policy? (Check all that apply.)

- Developing special reports
- Providing testimony
- Sponsoring public meetings or hearings
- Collaborating with other agencies or groups
- Advocating within the council (e.g., for a specific issue or population)
- Disseminating planning-related information
- Other (please describe.)

22c) If yes to question 22a, please describe how State-level policy was influenced by your CMHS BG Planning Council's activities.

CMHS Block Grant Allocation and Distribution

23) What are the strengths of the process for allocating and distributing CMHS BG funds?

24) What are the weaknesses of the process for allocating and distributing CMHS BG funds?

25a) Do you have any recommendations for improving the process for allocating and distributing CMHS BG funds?

- Yes No

25b) If so, what are they?

Regional Review Process

26) What are the strengths of the regional review process?

27) What are the weaknesses of the regional review process?

28a) Are there unintended positive results of the regional review process?

- Yes No Cannot answer

28b) If so, please describe.

28c) Are there unintended negative results of the regional review process?

- Yes No Cannot answer

28d) If so, please describe.

Implementation Report Process

- 29) In a typical year, does the CMHS BG Planning Council review the draft implementation report?
 Yes No Cannot answer
- 30) Please rate the extent to which your State’s implementation report examines adherence
 Not at all
 Somewhat
 Mostly
 Completely
 Cannot answer
- 31) What impact does the ability to modify your State’s CMHS BG application (including target performance indicators) after Federal approval have on the implementation report’s utility in assessing adherence to the CMHS BG State plan?
 No impact
 Some impact
 Moderate impact
 Considerable impact
 Cannot answer
- 32) What are the strengths of the implementation report?

- 33) What are the weaknesses of the implementation report?

- 34a) Do you have any recommendations for improving the implementation report?
 Yes No
- 34b) If so, what are they?

- 35a) Is the implementation report used for anything other than satisfying CMHS BG requirements?
 Yes No Don’t know
- 35b) If so, how is it used?

Program Development and Support

- 36) - What are the strengths of CMHS BG program development and support provided by your State to subrecipients?

- 37) - What are the weaknesses of CMHS BG program development and support provided by your State to subrecipients?

- 38a) Do you have any recommendations for improving CMHS BG program development and support provided by your State to subrecipients?
 Yes No
- 38b) If so, what are they?

- 39a) Are there any unintended positive results of CMHS BG program development and support provided by your State to subrecipients?
 Yes No Cannot answer
- 39b) If so, please describe.

- 40a) Are there any unintended negative results of CMHS BG program development and support provided by your State to subrecipients?
 Yes No Cannot answer
- 40b) If so, please describe.

- CMHS Block Grant-related Outcomes**
- 41a) In FY 2005, did your CMHS BG Planning Council receive CMHS BG-related technical assistance (TA)?
 Yes No Cannot answer
- 41b) If so, on what topics?

41c) Has your CMHS BG Planning Council experienced a change because of that TA?

- Yes No Cannot answer

41d) If so, please discuss that change.

42) Please rate the extent to which you agree with each of the following statements.

Statement	Strongly disagree	Somewhat disagree	Neither disagree nor agree	Somewhat agree	Strongly agree	Cannot answer
The CMHS BG Planning Council is an active, integrated part of the State CMHS BG planning process						
As a result of CMHS BG activities, States have improved their coordination of State mental health services and programs						
There has been an increase in the number of evidence-based practices and innovative services available because of the CMHS BG program						
The CMHS BG program has contributed to improving the quality of States' mental health services						
The CMHS BG program has contributed to a decrease in unmet treatment need						
As a result of CMHS BG activities, there has been an increase in consumer involvement in the State mental health system						
As a result of CMHS BG activities, there has been an increase in utilization of community-based treatment services						
Programs initiated with CMHS BG funds have been continued using State and other funding sources						
States have leveraged CMHS BG resources to implement policy changes						

43) How has your CMHS BG Planning Council helped move your State's mental health system in a positive direction?

Evaluation of the CMHS Block Grant Program

Estimates of Burden for the Collection of Information

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Dear Planning Council Chair:

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We are soliciting feedback about the CMHS BG from key program stakeholders. As the Chair of the State Planning Council, you have important insights and views about the intent, implementation, and impact of the CMHS BG in your State. We therefore would appreciate greatly your assistance with the evaluation by completing this survey. Most of the questions are closed-ended questions, where you will be asked to check the appropriate answer or answers. In addition, there are several open-ended questions, where you have the opportunity to comment. We urge you to be as honest and thoughtful as possible.

Please be assured that your answers will be strictly confidential. We will report responses to questions only in the aggregate, and we will never attribute specific comments to particular individuals. Your responses will not have any repercussions for your State and will not be used by the sponsoring organization to assess State compliance with the

CMHS BG requirements; they will be used solely for the purposes of evaluating the CMHS BG as a whole.

Thank you very much for taking the time to participate.

Background Questions

1) What group do you formally represent on your CMHS BG Planning Council? (Check one)

- Consumers
 - Family members
 - Advocacy organization representatives
 - Mental health providers
 - State officials
 - Health-related professionals (e.g., physician, nurse)
 - Other (please describe)
-

2) In what month and year did you become a member of the CMHS BG Planning Council?

Month: _____ Year: _____

3) In what month and year did you become the chair of the CMHS BG Planning Council?

Month: _____ Year: _____

Application Development and Review

4a) Do the five criteria provide an adequate framework for States to describe their State mental health systems?

- Yes No

4b) Please explain.

4c) Are there other criteria that could be helpful in developing States' plan?

- Yes No

4d) If so, please discuss.

5) Who was involved in the development of your State's Fiscal Year (FY) 2005 CMHS BG State plan? (Check all that apply)

- Governor
- State Mental Health Director
- State CMHS BG Planner

- State Data Analysts
 - CMHS BG Planning Council
 - Planning council other than the CMHS BG Planning Council
 - State agency other than the mental health agency (e.g., criminal justice, housing agency)
 - Other (please describe)
-

6) What strategies or activities did your State use in the development of its FY 2005 CMHS BG State plan? (Check all that apply)

- An inventory of services
 - A needs assessment
 - State mental health strategic planning
 - Stakeholder surveys
 - Literature reviews
 - Stakeholder interviews
 - Other (please describe)
-

7) What resources did your State use in the development of its FY 2005 CMHS BG State plan? (Check all that apply)

- Surgeon General's Report on Mental Health
 - New Freedom Commission Report
 - FY 2004 CMHS BG application
 - State mental health strategic plan
 - State-collected mental health data
 - Other (please describe)
-

8) Who was involved in the review of your State's FY 2005 CMHS BG State plan prior to submission? (Check all that apply)

- Governor
 - State Mental Health Director
 - State CMHS BG Planner
 - State Data Analysts
 - CMHS BG Planning Council
 - Planning council other than the CMHS BG Planning Council
 - State agency other than the mental health agency (e.g., criminal justice, housing agency)
 - Other (please describe)
-

9) Did your CMHS BG Planning Council invite and receive feedback from the public on the State's FY 2005 CMHS BG State plan? If so, please indicate how. (Check all that apply)

Mechanism	Invited public comment? (Yes, No, Cannot answer)	Received public comment? (Yes, No, Cannot answer)
Web sites		
Public hearings at one location within the State		
Public hearings at multiple locations within the State		
Focus or consensus groups		
Review by sub-State CMHS BG planning authorities (e.g., counties planning boards)		

Other (please describe)

10) How accurately did your State's FY 2005 State plan reflect current issues affecting its State mental health system?

- Not accurate
- Somewhat accurate
- Very accurate
- Completely accurate
- Cannot answer

11) What are the strengths of the process for developing the State CMHS BG State plan?

12) What are the weaknesses of the process for developing the State CMHS BG application?

13) What are supports that facilitate CMHS BG Planning Council involvement in the CMHS BG State plan development process?

14) What do you see as the barriers to CMHS BG Planning Council involvement in the CMHS BG State plan development process?

15a) Do you have any recommendations for improving the process of developing the State CMHS BG State plan?

- Yes
- No

15b) If so, what are they?

16a) Are there unintended positive results of CMHS BG Planning Council involvement in the CMHS BG State plan development and submission process?

- Yes
- No
- Cannot answer

16b) If so, please describe.

16c) Are there unintended negative results of CMHS BG Planning Council involvement in the CMHS BG State plan development and submission process?

- Yes
- No
- Cannot answer

16d) If so, please describe.

Planning Council Involvement in CMHS Block Grant Activities

17) In FY 2005, how involved was the CMHS BG Planning Council in the following activities?

Activity	Not involved	Somewhat involved	Moderately involved	Very involved	Extremely involved	Cannot answer
Reviewing the State's CMHS BG State plan						
Monitoring and evaluating the allocation and adequacy of State mental health services funded in part through the CMHS BG						
Educating legislators						
Providing information to the public						
Creating study groups to develop recommendations for the State's CMHS BG State plan						
Developing products (e.g., documents related to cultural competence)						
Implementing surveys (e.g., consumer surveys)						
Drafting State legislation						

Independent Evaluation of the Community Mental Health Services Block Grant -

Activity	Not involved	Somewhat involved	Moderately involved	Very involved	Extremely involved	Cannot answer
Implementing special projects						
Developing the State's CMHS BG State plan						
Participating in a needs assessment						
Reviewing data from the State mental health information system						

Other (please describe)

18a) Did you have an opportunity to review the FY 2005 State plan?

Yes No Cannot answer

18b) If so, how much time did you, as a CMHS BG Planning Council member, have to review the State's FY 2005 CMHS BG State plan?

- Less than a week
 1 week to 2 weeks
 2 weeks to a month
 More than a month
 Cannot answer

19) To what extent do you agree that the amount of time that the CMHS BG Planning Council had to review the FY 2005 CMHS BG State plan was adequate?

- Strongly disagree
 Somewhat disagree
 Neither agree nor disagree
 Somewhat agree
 Strongly agree
 Cannot answer

20) For each CMHS BG Planning Council group below, please rate the level of participation in the review of the State's FY 2005 CMHS BG State plan.

CMHS BG Planning Council Group	Not involved	Somewhat involved	Moderately involved	Very involved	Extremely involved	Cannot answer
Consumers						
Family members						
Advocacy organization representatives						
Mental health providers						
State officials						

CMHS BG Planning Council Group	Not involved	Somewhat involved	Moderately involved	Very involved	Extremely involved	Cannot answer
Health-related professionals (e.g., physician, nurse)						

Other (please describe)

21) How frequently does your CMHS BG Planning Council meet in a typical year?

- We don't meet at least once a year
 Once or twice
 3 to 4 times
 5 or more times
 Cannot answer

22) How does the CMHS BG Planning Council provide feedback about the State's CMHS BG State plan to the State Mental Health Agency (SMHA)?

23) Please rate the extent to which you agree with each of the following statements.

Statement	Strongly disagree	Somewhat disagree	Neither disagree nor agree	Somewhat agree	Strongly agree	Cannot answer
The CMHS BG Planning Council solicits my opinion as a council member						
The CMHS BG Planning Council respects my opinion as a council member						
The SMHA staff respects the opinions of the CMHS BG Planning Council						
The SMHA staff solicits the opinions of the CMHS BG Planning Council beyond what is legislatively required						
The CMHS BG Planning Council supports my participation (e.g., transportation, reimbursement for expenses, stipend)						

24a) Does the CMHS BG Planning Council work with the SMHA to implement CMHS BG activities?

- Yes No Don't know

24b) If so, please describe the quality of this working relationship.

25a) How often does the SMHA make modifications to the State CMHS BG State plan based on the feedback from the CMHS BG Planning Council?

- Never
 Rarely
 Sometimes
 Frequently
 Always
 Don't know

25b) Does the State communicate back to the CMHS BG Planning Council about whether recommendations were incorporated?

- Yes No Don't know

25c) If so, how?

26) What are the strengths of the CMHS BG Planning Council's involvement in the CMHS BG Program?

27) What are the weaknesses of the CMHS BG Planning Council's involvement in the CMHS BG Program?

28a) Do you have any recommendations for improving the CMHS BG Planning Council's involvement in the CMHS BG Program?

- Yes No

28b) If so, what are they?

29a) Are there unintended positive results of the CMHS BG Planning Council involvement in SMHA activities?

- Yes No Cannot answer

29b) If so, please describe.

29c) Are there unintended negative results of the CMHS BG Planning Council involvement in SMHA activities?

- Yes No Cannot answer

29d) If so, please describe.

30a) Do you think that your CMHS BG Planning Council influences State-level policy?

- Yes No Don't know

30b) If so, which of the following activities did your CMHS BG Planning Council engage in to influence State-level policy? (Check all that apply)

- Developing special reports
 Providing testimony
 Sponsoring public meetings or hearings
 Collaborating with other agencies or groups
 Advocating within the council (e.g., for a specific issue or population) -
 Disseminating planning-related information -
 Other (please describe)

30c) If yes to question 30a, please describe how State-level policy was influenced by your CMHS BG Planning Council's activities.

CMHS Block Grant Allocation and Distribution

31) What are the strengths of the process for allocating and distributing CMHS BG funds?

32) What are the weaknesses of the process for allocating and distributing CMHS BG funds?

33a) Do you have any recommendations for improving the process for allocating and distributing CMHS BG funds?

Yes No

33b) If so, what are they?

Regional Review Process

34) What are the strengths of the regional review process?

35) What are the weaknesses of the regional review process?

36) Please rate the extent to which you agree that each possible change listed below would improve the regional review process.

Potential change	Strongly disagree	Somewhat disagree	Neither disagree nor agree	Somewhat agree	Strongly agree	Cannot answer
Submit a joint CMHS BG application and implementation report on December 1						
Develop a more structured CMHS BG application in order to make it easier to review						
Review the CMHS BG application and previous year's implementation report simultaneously						
Formally identify State technical assistance (TA) needs as part of the regional review						
Utilize technology to determine CMHS BG compliance prior to the onsite regional review						
Create a regional partnership program to promote opportunities for inter-State information exchange						

Potential change	Strongly disagree	Somewhat disagree	Neither disagree nor agree	Somewhat agree	Strongly agree	Cannot answer
Provide separate TA to States and reviewers on developing appropriate performance indicators						
Provide TA on developing the CMHS BG State plan						
Provide TA on submitting National Outcome Measures						
Provide TA on evidence-based practices						

Other (please describe)

37a) Are there unintended positive results of the regional review process?

Yes No Cannot answer

37b) If so, please describe.

37c) Are there unintended negative results of the regional review process?

Yes No Cannot answer

37d) If so, please describe.

Implementation Report Process

38) Who was involved in the development of your State's FY 2005 implementation report? (Check all that apply)

- Governor
- State Mental Health Director
- State CMHS BG Planner
- State Data Analysts
- CMHS BG Planning Council
- Planning council other than the CMHS BG Planning Council
- State agency other than the mental health agency (e.g., criminal justice, housing agency)
- Other (please describe)

- 39) What strategies or activities did your State use in the development of its FY 2005 implementation report? (Check all that apply)
- Review of FY 2005 State CMHS BG State plan
 - Analysis of State-collected mental health data
 - Other (please describe)
-

- 40) In a typical year, does the CMHS BG Planning Council review the draft implementation report?
- Yes No Cannot answer

- 41) Please rate the extent to which your State's implementation report examines adherence to the CMHS BG State plan.
- Not at all
 - Somewhat
 - Mostly
 - Completely
 - Cannot answer

- 42) What impact does the ability to modify your State's CMHS BG application (including target performance indicators) after Federal approval have on the implementation report's utility in assessing adherence to the CMHS BG State plan?
- No impact
 - Some impact
 - Moderate impact
 - Considerable impact
 - Cannot answer

- 43) What are the strengths of the implementation report?
-
-

- 44) What are the weaknesses of the implementation report?
-
-

- 45a) Do you have any recommendations for improving the implementation report?
- Yes No

- 45b) If so, what are they?
-
-

- 46a) Is the implementation report used for anything other than satisfying CMHS BG requirements?
- Yes No Don't know

- 46b) If so, how is it used?
-
-

Program Development and Support

- 47) What are the strengths of CMHS BG program development and support provided by your State to subrecipients?
-
-

- 48) What are the weaknesses of CMHS BG program development and support provided by your State to subrecipients?
-
-

- 49a) Do you have any recommendations for improving CMHS BG program development and support provided by your State to subrecipients?
- Yes No

- 49b) If so, what are they?
-
-

- 50a) Are there any unintended positive results of CMHS BG program development and support provided by your State to subrecipients?
- Yes No Cannot answer

- 50b) If so, please describe.
-
-

- 50c) Are there any unintended negative results of CMHS BG program development and support provided by your State to subrecipients?
- Yes No Cannot answer

- 50d) If so, please describe.
-
-

CMHS Block Grant-related Outcomes

51a) Has the availability of CMHS BG funds made it possible for the State to fund programs/initiatives that it otherwise would not have been able to fund?

- Yes No Cannot say

51b) If so, what types of programs/initiatives?

52a) Has the availability of CMHS BG funds made it possible for the State to follow Federal policy recommendations (e.g., recommendations from the New Freedom Commission Report) that it otherwise would not have been able to follow?

- Yes No Cannot say

52b) If so, which Federal policy recommendations were followed and how?

53a) In FY 2005, did your CMHS BG Planning Council receive CMHS BG-related TA?

- Yes No Cannot say

53b) If so, on what topics?

53c) Has your CMHS BG Planning Council experienced a change because of that TA?

- Yes No Cannot say

53d) If so, please discuss that change.

54) Please rate the extent to which you agree with each of the following statements.

Statement	Strongly disagree	Somewhat disagree	Neither disagree nor agree	Somewhat agree	Strongly agree	Cannot answer
The CMHS BG Planning Council is an active, integrated part of the State CMHS BG planning process						
As a result of CMHS BG activities, States have improved their coordination of State mental health services and programs						
There has been an increase in the number of evidence-based practices and innovative services available because of the CMHS BG program						
The CMHS BG program has contributed to improving the quality of States' mental health services						
The CMHS BG program has contributed to a decrease in unmet treatment need						
As a result of CMHS BG activities, there has been an increase in consumer involvement in the State mental health system						
As a result of CMHS BG activities, there has been an increase in utilization of community-based services						
Programs initiated with CMHS BG funds have been continued using State and other funding sources						
States have leveraged CMHS BG resources to implement policy changes						

55) How has your CMHS BG Planning Council helped move your State's mental health system in a positive direction?

The Independent Evaluation of the CMHS Block Grant Program

Estimates of Burden for the Collection of Information

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0289. Public reporting burden for this collection of information is estimated to average 60 minutes per survey, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland, 20857.

Dear Regional Reviewer:

The Community Mental Health Services Block Grant (CMHS BG), funded by Congress to develop community-based systems of care for adults with serious mental illness and children with a serious emotional disturbance, is the largest Federal program dedicated to improving community mental health services. The sponsor of the program, the Substance Abuse and Mental Health Services Administration’s Center for Mental Health Services, has contracted with Altarum to conduct an independent evaluation of this program.

We are soliciting feedback about the CMHS BG from key program stakeholders. As a Regional Reviewer, you have important insights and views about the intent, implementation, and impact of the CMHS BG in a number of States. We therefore would appreciate greatly your assistance with the evaluation by completing this survey. Most of the questions are closed-ended questions, where you will be asked to check the appropriate answer or answers. In addition, there are several open-ended questions, where you have the opportunity to comment. We urge you to be as honest and thoughtful as possible.

Please be assured that your answers will be strictly confidential. We will report responses to questions only in the aggregate, and we will never attribute specific comments to particular individuals. Your responses will not be used by the sponsoring organization to assess State compliance with the

requirements and will not have any repercussions for any particular State; they will be used solely for the purposes of evaluating the CMHS BG as a whole.

Thank you very much for taking the time to participate.

1a) Do the five criteria provide an adequate framework for States to describe their State mental health systems?

- Yes No

1b) Please explain.

1c) Are there other criteria that could be helpful in developing States’ plan?

- Yes No

1d) If so, please discuss.

Regional Review Process

2) How effective was the CMHS BG regional review process at assessing compliance with CMHS BG legislation in Fiscal Year (FY) 2005?

- Very ineffective -
- Somewhat ineffective -
- Neither effective nor ineffective -
- Somewhat effective -
- Very effective -
- Cannot answer -

3a) Are you aware that an objective of the CMHS BG program is to promote Federal-State information exchange on States’ mental health systems of care?

- Yes No Cannot answer

3b) How effective was the CMHS BG regional review process at generating Federal-State information exchange on States’ mental health systems of care in FY 2005?

- Very ineffective -
- Somewhat ineffective -
- Neither effective nor ineffective -
- Somewhat effective -
- Very effective -
- Cannot answer -

4a) How effective is feedback from the regional review panel in helping States to identify strengths and weaknesses of their State mental health system of care?

- Very ineffective
- Somewhat ineffective
- Neither effective nor ineffective
- Somewhat effective
- Very effective
- Cannot answer

4b) Please discuss.

5a) How effective is feedback from the regional review panel in helping States to identify technical assistance (TA) needs regarding CMHS BG-related activities?

- Very ineffective
- Somewhat ineffective
- Neither effective nor ineffective
- Somewhat effective
- Very effective
- Cannot answer

5b) Please discuss.

6a) For FY 2005, did you receive training about the regional review process?

- Yes
- No
- Don't know

6b) If so, how prepared did you feel following the training to perform your duties as a regional reviewer?

- Not at all
- A little
- Somewhat
- Very
- Completely
- Cannot answer

7a) For FY 2005, did you receive training materials about the regional review process?

- Yes
- No
- Don't know

7b) If so, please rate how helpful these materials were in enabling you to understand your responsibilities as a reviewer.

- Very unhelpful
- Somewhat unhelpful
- Neither helpful nor unhelpful
- Somewhat helpful
- Very helpful
- Cannot answer

8a) Are there any training materials or supplemental information that you did not receive that would have been helpful?

- Yes
- No
- Don't know

8b) If so, what are they?

9a) Do you feel that the time allotted for the review of the CMHS BG applications is sufficient for a comprehensive review?

- Yes
- No
- Cannot answer

9b) If not, please discuss.

10) Please rate the extent to which you felt that your contributions to the FY 2005 CMHS BG application review process were valued by other members of the review panel.

- Not at all
- A little
- Somewhat
- Very
- Completely
- Cannot answer

11) Please rate the extent to which you agree that each possible change listed below would improve the regional review process.

Potential change	Completely disagree	Somewhat disagree	Neither disagree nor agree	Somewhat agree	Completely agree	Cannot answer
Submit a joint CMHS BG application and implementation report on December 1						
Develop a more structured CMHS BG application in order to make it easier to review						
Review the CMHS BG application and previous year's implementation report simultaneously						
Formally identify State TA needs as part of the regional review						
Utilize technology to determine CMHS BG compliance prior to the onsite regional review						
Create a regional partnership program to promote opportunities for inter-State information exchange						
Provide separate TA to States and reviewers on developing appropriate performance indicators						
Provide TA on developing the CMHS BG plan and submitting National Outcome Measures						
Provide TA on developing the CMHS BG plan and submitting evidence-based practices						

Other (please describe)

12) What are the strengths of the regional review process? -

13) What are the weaknesses of regional review process?

14a) Are there any unintended positive results of the regional review process?
 Yes No Don't know

14b) If so, what are they?

15a) Are there any unintended negative results of the regional review process?
 Yes No Don't know

15b) If so, what are they?

16) How effective is the implementation report review process at assessing compliance with States' CMHS BG State Plan?
 Very ineffective
 Somewhat ineffective
 Neither effective nor ineffective
 Somewhat effective
 Very effective
 Cannot answer

17a) For FY 2005, did you receive training about the implementation report review process?
 Yes No Don't know

17b) If yes, how prepared did you feel following the training to perform your duties with regard to reviewing State implementation reports?
 Not at all
 A little
 Somewhat
 Very
 Completely
 Cannot answer

18a) For FY 2005, did you receive training materials about the implementation report review process?

- Yes No Don't know

18b) If so, please rate how helpful these materials were in enabling you to understand how to review State implementation reports.

- Very unhelpful
 Somewhat unhelpful
 Neither helpful nor unhelpful
 Somewhat helpful
 Very helpful
 Cannot answer

19a) Do you have recommendations for improving the training that reviewers receive?

- Yes No Don't know

19b) If so, what are they?

20a) Do you think the time allotted for the review of the implementation reports is sufficient for a comprehensive review?

- Yes No Cannot answer

20b) If not, please discuss.

21) What are the strengths of the process for reviewing the implementation report?

22) - What are the weaknesses of the process for reviewing the implementation report?

23a) Do you have recommendations for improving the process of reviewing States' implementation reports?

- Yes No Don't know

23b) If so, what are they?

The Independent Evaluation of the CMHS Block Grant Program

Estimates of Burden for the Collection of Information

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0289. Public reporting burden for this collection of information is estimated to average 60 minutes per survey per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland, 20857.

Dear Site Visit Monitor:

The Community Mental Health Services Block Grant (CMHS BG), funded by Congress to develop community-based systems of care for adults with serious mental illness and children with a serious emotional disturbance, is the largest Federal program dedicated to improving community mental health services. The sponsor of the program, the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services, has contracted with Altarum to conduct an independent evaluation of this program.

We are soliciting feedback about the CMHS BG from key program stakeholders. As a past Site Visit Monitor, you have important insights and views about the intent, implementation, and impact of the CMHS BG from your visits to States. We therefore would appreciate greatly your assistance with the evaluation by completing this survey. Most of the questions are closed-ended questions, where you will be asked to check the appropriate answer or answers. In addition, there are several open-ended questions, where you have the opportunity to comment. We urge you to be as honest and thoughtful as possible.

Please be assured that your answers will be strictly confidential. We will report responses to questions only in the aggregate, and we will never attribute specific comments to particular individuals. Your responses will not be used by the sponsoring organization to assess State compliance with the

requirements and will not have any repercussions for any particular State; they will be used solely for the purposes of evaluating the CMHS BG as a whole.

Thank you very much for taking the time to participate.

1a) Do the five criteria provide an adequate framework for States to describe their State mental health systems?

- Yes No

1b) Please explain.

1c) Are there other criteria that could be helpful in developing States' plan?

- Yes No

1d) If so, please discuss.

2a) How effective are monitoring site visits at verifying State mental health activities described in a State's CMHS BG State plan?

- Not at all
 Somewhat
 Mostly
 Completely
 Cannot answer

2b) Please discuss.

3a) How effective is the monitoring site visit process in helping States identify technical assistance (TA) needs regarding CMHS BG-related activities?

- Not at all
 Somewhat
 Completely
 Cannot answer

3b) Please discuss.

4) Do you review all of the legislative requirements before site visits?

- Yes No

5) How often does a State representative identify compliance issues for the site visit monitors during the visits?

- Never
 Sometimes
 Usually
 Always
 Cannot answer

6) When conducting monitoring visits, how often do you identify potential issues for Federal or State action?

- Never
 Rarely
 Sometimes
 Usually
 Always
 Cannot answer

7) How are issues that require a substantive response communicated to the States? (Check all that apply)

- E-mail contact
 Phone contact
 Exit interview at the conclusion of site visit
 Site visit monitoring report
 Other site visit products
 Other (please describe)

8) How are issues that require a substantive response from States communicated to the CMHS? (Check all that apply)

- E-mail contact
 Phone contact
 Exit interview at the conclusion of site visit
 Site visit monitoring report
 Other site visit products
 Other (please describe)

9) What are the strengths of the current site visit monitoring process?

10) What are the weaknesses of the current site visit monitoring process?

- 11) To what extent do you agree that the monitoring site visits are useful to States?
- Strongly disagree
 - Somewhat disagree
 - Neither disagree nor agree
 - Somewhat agree
 - Strongly agree
 - Cannot answer
- 12) Please list any ways in which you feel the monitoring site visits could be more useful to States.
- _____
- _____

Site Visits

- 13a) For FY 2005, did you receive training on the monitoring site visit process?
- Yes No
- 13b) If not, had you received training on the monitoring site visit process previously?
- Yes No
- 13c) If so, what types of training did you receive to prepare you for conducting the monitoring site visits? (Check all that apply)
- In-person training
 - Written instructions
 - No training received
 - Other (please describe)
- _____

- 14) How prepared did you feel following the training to perform your duties as a monitoring site visitor? -
- Not at all
 - Somewhat
 - Mostly
 - Completely
 - Cannot answer

- 15a) If you received in-person training, please rate the usefulness of the training you received.
- Not useful
 - A little useful
 - Somewhat useful
 - Mostly useful
 - Extremely useful
 - Cannot answer

- 15b) If you received in-person training, how long before the actual site visits began did the training occur? (Check one)
- Within 1 week
 - Within 2 to 3 weeks
 - Within 1 month
 - Within 2 months
 - Longer than 2 months
 - Other (please describe)
- _____

- 16a) If you received written instructions, please rate how useful they were.
- Not useful
 - A little useful
 - Somewhat useful
 - Mostly useful
 - Extremely useful
 - Cannot answer

- 16b) If you received written instructions, how long before the actual site visits began did you receive them? (Check one)
- Within 1 week
 - Within 2 to 3 weeks
 - Within 1 month
 - Within 2 months
 - Longer than 2 months
 - Other (please describe)
- _____

- 17) How useful were the CMHS BG monitoring prompts in helping to gather the information needed to prepare the site visit monitoring report?
- Not useful
 - A little useful
 - Somewhat useful
 - Mostly useful
 - Extremely useful
 - Cannot answer

- 18a) Do you think that there are aspects of the CMHS BG process that are not reflected adequately in the monitoring prompts?
- Yes No

18b) If so, please discuss.

19a) Were you provided any other materials in preparation for the site visits?

- Yes No

19b) If so, what other material?

19c) Please rate how helpful these additional materials were in enabling you to understand your responsibilities as a site visit monitor.

- Not helpful
 A little helpful
 Somewhat helpful
 Mostly helpful
 Extremely helpful
 Cannot answer

20a) Are there any training materials or supplemental information that you did not receive that would have been helpful?

- Yes No

20b) If so, what other material?

21) Please rate how prepared the last State you visited was for the site visit?

- Very unprepared
 Somewhat unprepared
 Minimally prepared
 Very prepared
 Completely prepared
 Cannot answer

22a) Do you feel that the time allotted for the monitoring site visit is sufficient for a comprehensive review?

- Yes No Cannot answer

22b) If not, please discuss.

23a) Do you have any recommendations for improving the training and preparation for the site visits to make you a more effective monitor?

- Yes No

23b) If so, what are they?

24) How long after a site visit do you typically submit your drafts of site visit products to CMHS? (Check one)

- Within 1 week
 Within 2 to 3 weeks
 Within 1 month
 Within 2 months
 Longer than 2 months
 Other (please describe)

- Don't know

25) How long after the submission of your drafts do States typically receive the finalized version of the site visit report (after CMHS staff edits are made)? (Check one)

- Within 1 week
 Within 2 to 3 weeks
 Within 1 month
 Within 2 months
 Longer than 2 months
 Other (please describe)

- Don't know

26a) Do you know how Federal program staff and grants management use site visit products?

- Yes No Don't know

26b) If so, how?

27a) Do you know how States use site visit products?

- Yes No Don't know

27b) If so, how?

28a) Do you have any recommendations for improving the dissemination of monitoring site visit products?

- Yes No Don't know

28b) If so, what are they?

29a) Do you have any recommendations for more effective uses of the monitoring site visit products?

- Yes No Don't know

29b) If so, what are they?

30a) Are there any unintended positive results of the monitoring site visit process?

- Yes No Don't know

30b) If so, what are they?

31a) Are there any unintended negative results of the monitoring site visit process?

- Yes No Don't know

31b) If so, what are they?

Appendix C: Client Perception of Care Charts

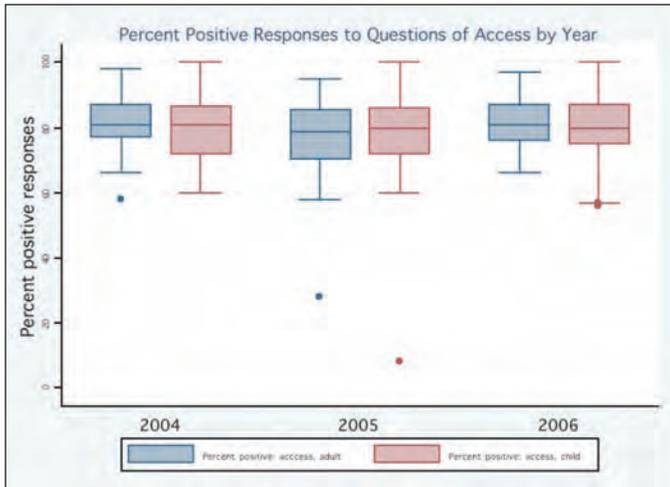


Figure C1. Box plot showing the percentage of positive responses to questions of access for adults and children, 2004-2006. Based on data from the Uniform Reporting System, Substance Abuse and Mental Health Services Administration.

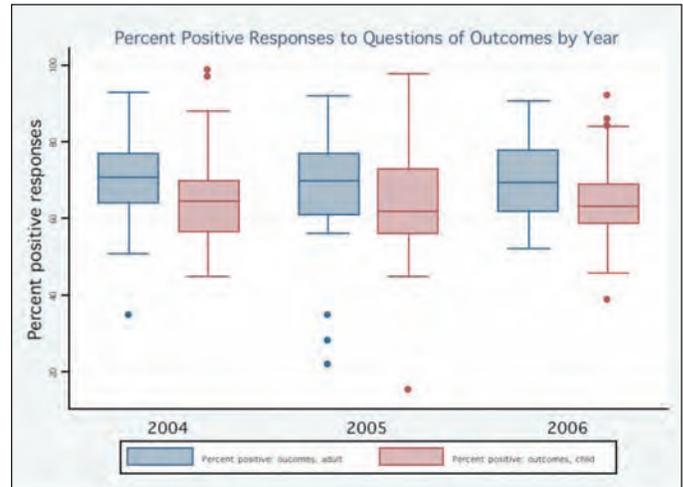


Figure C2. Box plot showing the percentage of positive responses to questions of outcomes for adults and children, 2004-2006. Based on data from the Uniform Reporting System, Substance Abuse and Mental Health Services Administration.

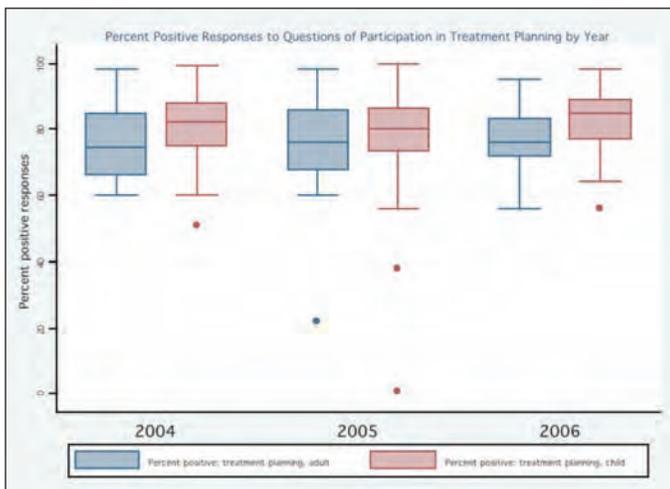


Figure C3. Box plot showing the percentage of positive responses to questions of participation in treatment planning for adults and children, 2004-2006. Based on data from the Uniform Reporting System, Substance Abuse and Mental Health Services Administration.

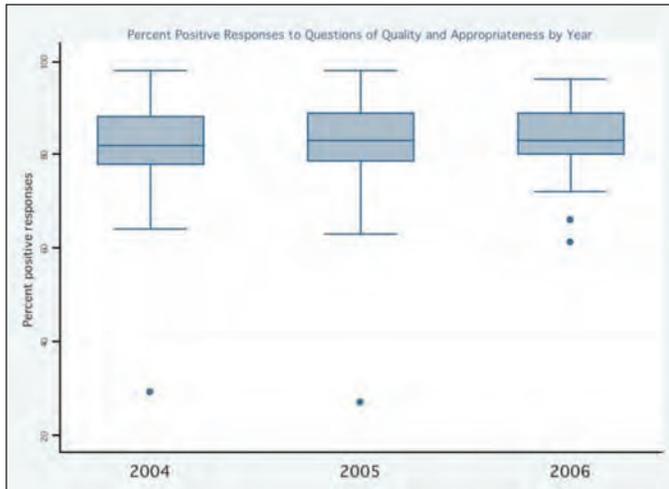


Figure C4. Box plot showing the percentage of positive responses to questions of quality and appropriateness, 2004-2006. Based on data from the Uniform Reporting System, Substance Abuse and Mental Health Services Administration.

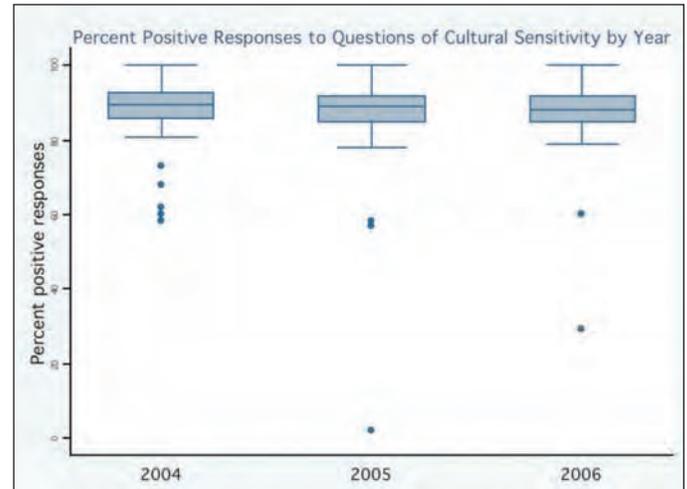


Figure C5. Box plot showing the percentage of positive responses to questions of cultural sensitivity, 2004-2006. Based on data from the Uniform Reporting System, Substance Abuse and Mental Health Services Administration.

Appendix D: Evidence-based Practices Charts

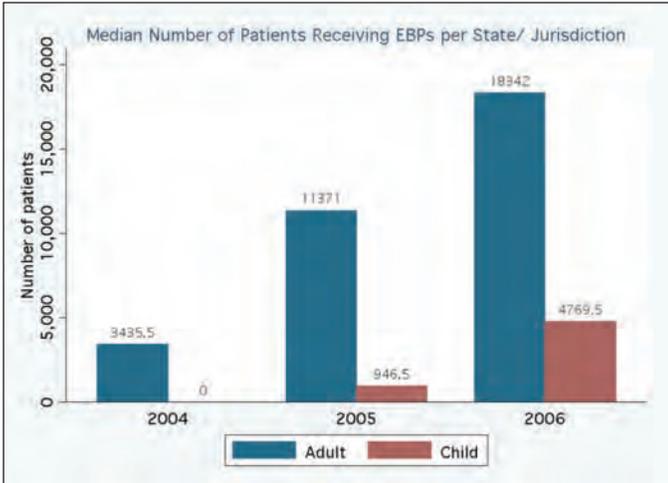


Figure D1. Bar graph showing the median number of adults and children receiving treatment with evidence-based practices, 2004-2006. The median ranged from 0 in 2004 to 4769.5 in 2006 for children and 3435.5 in 2004 to 18,342 in 2006 for adults. Based on data from the Uniform Reporting System, Substance Abuse and Mental Health Services Administration.

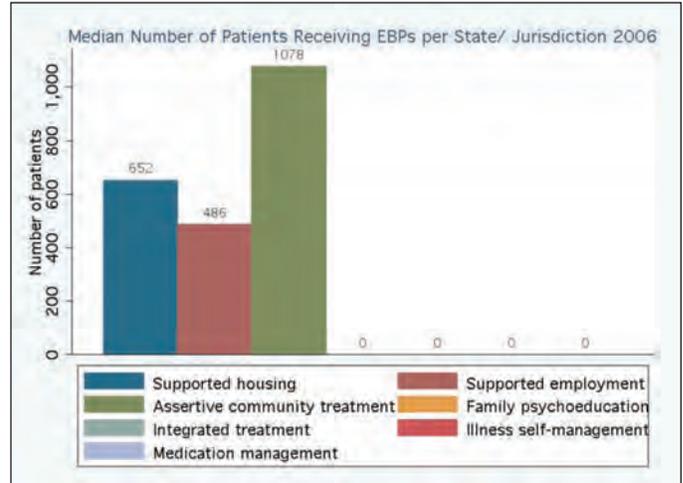


Figure D2. Bar graph showing the median number of adults and children receiving treatment with specific evidence-based practices in 2006. Assertive Community Treatment, n=1,079; supported housing, n=652; supported employment, n=486; all other practices, n=0. Based on data from the Uniform Reporting System, Substance Abuse and Mental Health Services Administration.

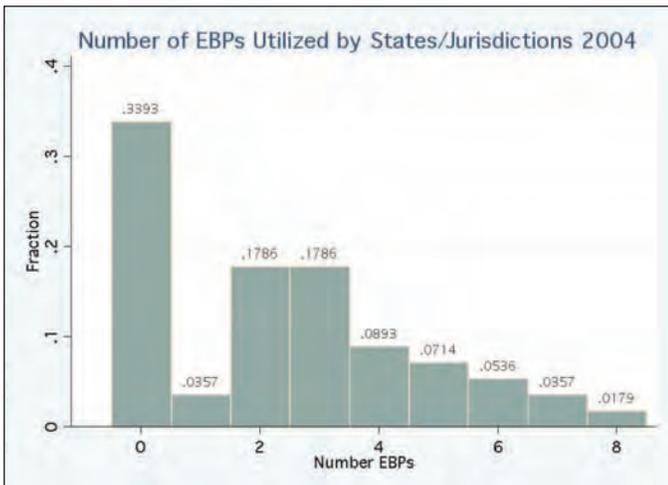


Figure D3. Bar graph showing the number of evidence-based practices used by States and jurisdictions in 2004. Approximately 33.9 percent of States used no evidence-based practices, with 1.8 percent using 8 practices. Based on data from the Uniform Reporting System, Substance Abuse and Mental Health Services Administration.

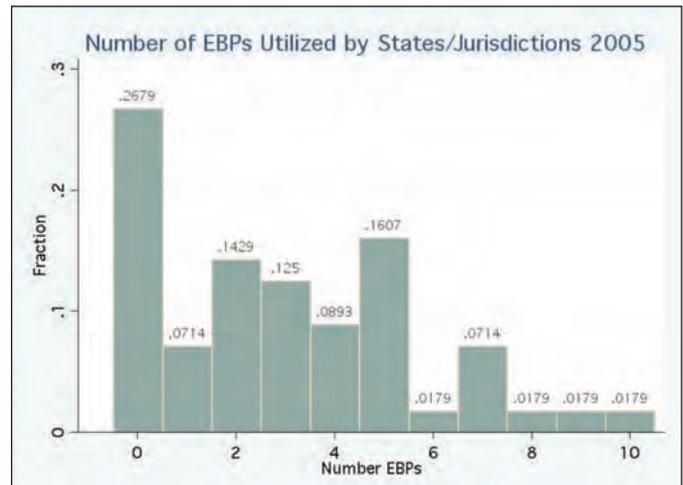


Figure D4. Bar graph showing the number of evidence-based practices used by States and jurisdictions in 2005. Approximately 26.8 percent of States used no evidence-based practices, with 1.8 percent each using 8, 9, or 10 practices, respectively. Based on data from the Uniform Reporting System, Substance Abuse and Mental Health Services Administration.

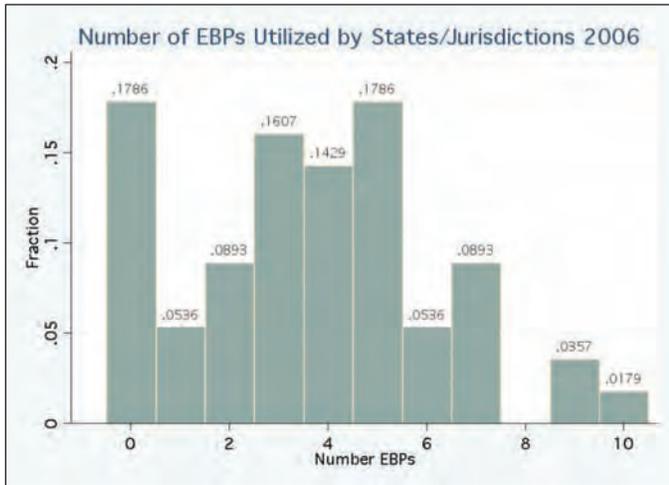


Figure D5. Bar graph showing the number of evidence-based practices used by States and jurisdictions in 2006. Approximately 17.9 percent of States used no evidence-based practices, with 3.6 percent using 9 practices and 1.8 percent using 10. Based on data from the Uniform Reporting System, Substance Abuse and Mental Health Services Administration.

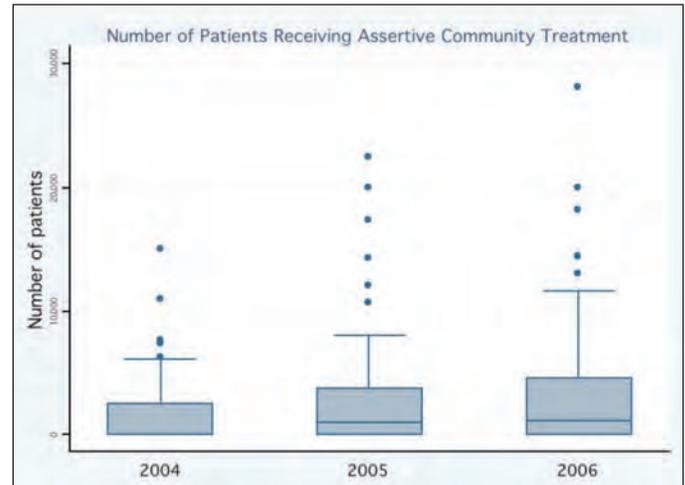


Figure D6. Box plot showing the number of consumers receiving Assertive Community Treatment, 2004-2006. Based on data from the Uniform Reporting System, Substance Abuse and Mental Health Services Administration.

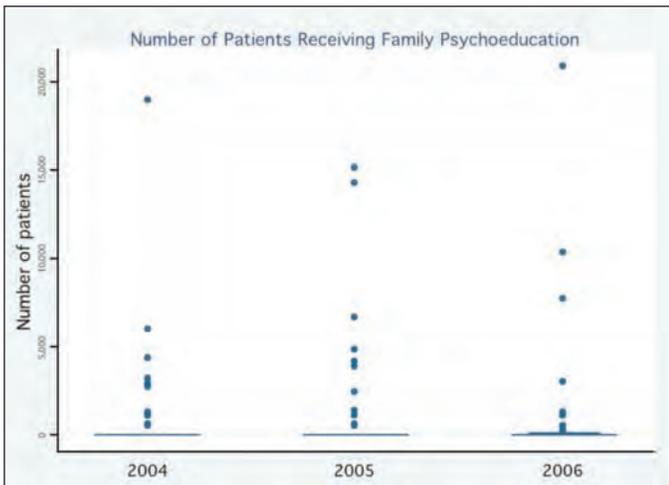


Figure D7. Box plot showing the number of consumers receiving family psychoeducation, 2004-2006. Based on data from the Uniform Reporting System, Substance Abuse and Mental Health Services Administration.

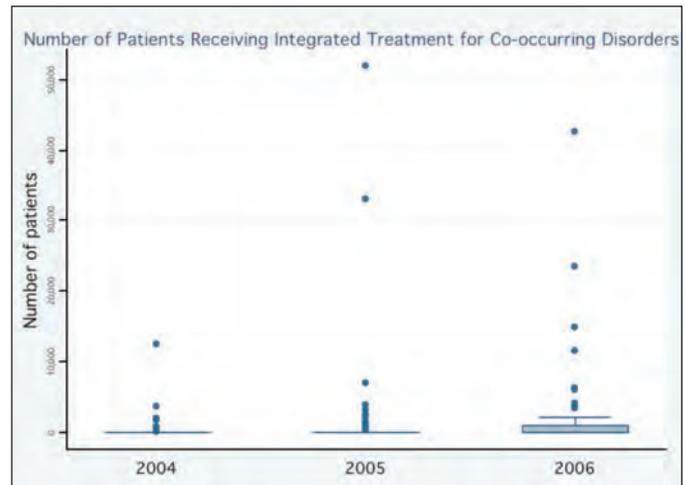


Figure D8. Box plot showing the number of consumers receiving integrated treatment for co-occurring disorders, 2004-2006. Based on data from the Uniform Reporting System, Substance Abuse and Mental Health Services Administration.

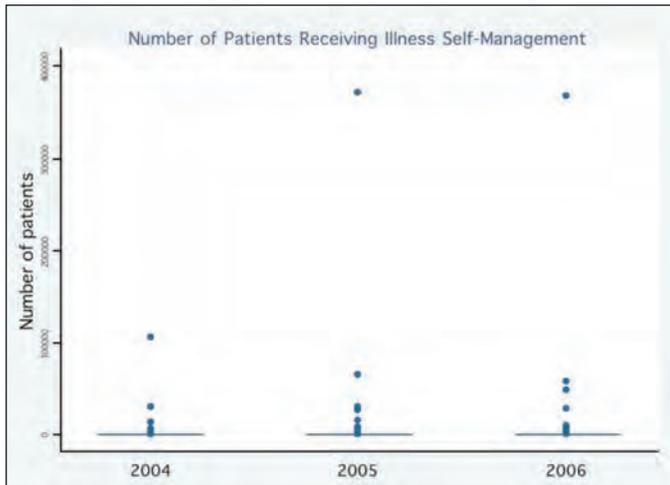


Figure D9. Box plot showing the number of consumers receiving illness self-management, 2004-2006. Based on data from the Uniform Reporting System, Substance Abuse and Mental Health Services Administration.

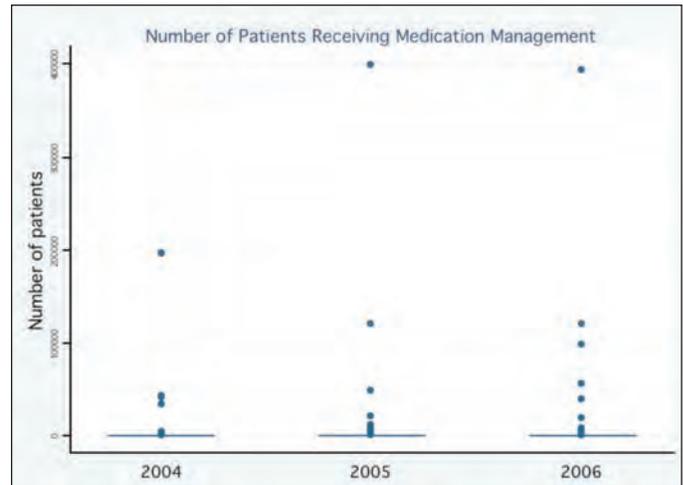


Figure D10. Box plot showing the number of consumers receiving medication management, 2004-2006. Based on data from the Uniform Reporting System, Substance Abuse and Mental Health Services Administration.

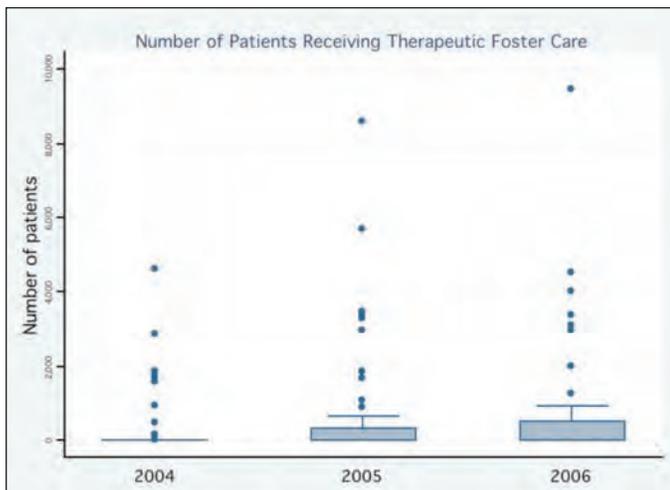


Figure D11. Box plot showing the number of consumers receiving therapeutic foster care, 2004-2006. Based on data from the Uniform Reporting System, Substance Abuse and Mental Health Services Administration.

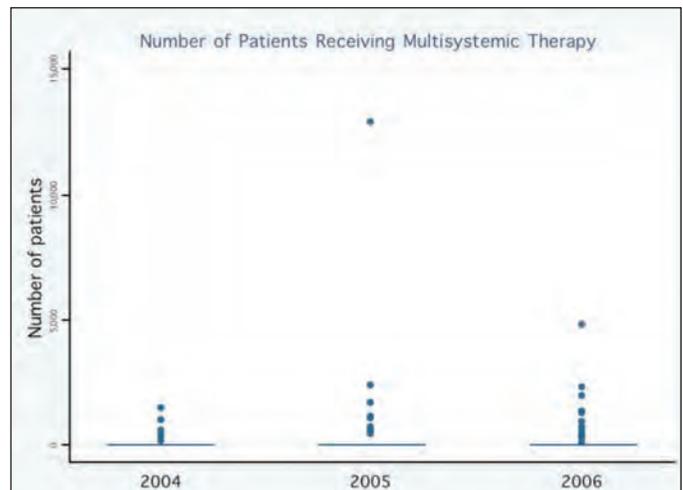


Figure D12. Box plot showing the number of consumers receiving multisystemic therapy, 2004-2006. Based on data from the Uniform Reporting System, Substance Abuse and Mental Health Services Administration.

Appendix E: Independent Evaluation of the Community Mental Health Services Block Grant Program

EVALUATION ADVISORY WORKGROUP ROSTER

Gregory Carlson, M.B.A.

Alabama Mental Health Planning Council Chair
Pelham, AL

Michael Fitzpatrick

Executive Director
NAMI
Arlington, VA

John Hudgens, M.Ed.

Director of Community-Based Services
Oklahoma Department of Mental Health and Substance Abuse Services
Oklahoma City, OK

Debra Kupfer, M.M.H.S.

Acting Director
Colorado Department of Human Services, Division of Mental Health
Denver, CO

Gloria Logsdon, M.S.

Tampa, FL

Oscar Morgan, M.H.C.A.

National Mental Health Association
Alexandria, VA

Daniel Powers, J.D.

Consumer Liaison
Nebraska Division of Behavioral Health Services
Lincoln, NE

Sandra Spencer

Executive Director
Federation of Families for Children's Mental Health
Alexandria, VA

Dave Wanser, Ph.D.

Deputy Commissioner of Community and Behavioral Health Services
Texas Department of State Health Services
Austin, Texas



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