

DATA INFRASTRUCTURE GRANT

Maine's Data Infrastructure Grant

DIG Purpose

The Data Infrastructure Grant emphasizes the collection of uniform data to provide a framework for a national set of performance measures and outcomes for mental health services. With support from SAMSHA, the State of Maine has developed the Maine Data Infrastructure Project to build capacity and necessary data infrastructure to support the collection and reporting of comprehensive and reliable mental health services data on all priority populations and to meet the data requirements of the SAMHSA National Data Infrastructure Project and National Outcome Measures.

DIG Objectives

Objective 1: Data Collection and Data Capture Tools and Methods

Develop new and refine existing data collection and data capture tools and methods necessary to reliably produce the required Federal URS data tables and performance indicators.

- Develop interim and long-term strategy and implementation plan for capturing complete URS Data on all Medicaid/non-Medicaid clients and service encounters for inclusion in FY2005 Federal Data submission
- Establish agreements/protocols to capture selected URS data from other state departments with an initial focus on piloting data linking and data transfer protocols with the Department of Corrections and Department of Educations.
- Establish agreements and data linking protocols to capture homeless and shelter use data from the Homeless Management Information System (HMIS).
- Develop and implement protocol for direct linkage to State Psychiatric Hospital data systems to capture state psychiatric hospital data elements.

Objective 2: Continued development, implementation and refinement of the data collection methodology for consumer, family and youth surveys.

- Make needed refinements to consumer and family survey tools to capture required National Outcome Measure elements and additional client descriptive data, including: social connectedness, criminal justice data elements and living arrangement.
- Refine and enhance mail survey sampling and data collection methodology
- Develop and test strategies to promote and enhance the use of a Web-Based electronic survey among mental health service recipients.
- Design and implement statewide consumer and family forums/feedback sessions to share survey and URS results, obtain ongoing stakeholder feedback, and provide additional opportunities for consumers and family members to participate in the annual survey, in collaboration with established consumer and family organizations.

Objective 3: Establish Evidence-Based Practices (EBP) Evaluation Mechanism

- Design and test fidelity assessment tools and structured review protocols for use in the evaluation of identified evidence-based practices, including ACT services, Supported Employment, Illness Self-Management/Recovery-Oriented Services, Supported Housing, Multi-Systematic Therapy, etc.
- Implement Adult Mental Health EBP fidelity assessment for Assertive Community Treatment, Supported Employment and Supported Housing Services
- Implement Child/Adolescent EBP fidelity assessments for MST services, Therapeutic Foster Care, Functional Family Therapy, etc.

Objective 4a. Assure Implementation of DIG Data and Reporting Requirements and Processes in the Enterprise Informational System (EIS).

- Incorporate the capacity and functionality of the EIS in DIG planning and implementation of surveys, data collection tools and processes, and reporting.

- Identify and define DIG needs and requirements for incorporating in the EIS, including specification of any needed enhancements to the EIS and/or related processes.

Objective 4b: Develop Automated Standard Ad Hoc Reports of the URS Data

- Design and produce, with ongoing stakeholder input, user-friendly ad hoc reports of URS client profile, service use and outcome information for use in services and system planning.
- Develop and produce a DIG report production and dissemination schedule and publish on DHHS website.
- Design and generate automated reports of Federal URS tables from the EIS using COGNOS report development functions.

Objective 5: Enhance/Expand Stakeholder Engagement and Participation at all Levels of the DIG Project.

- Develop a plan for the ongoing involvement and participation of consumers and family members in all aspects of the project design and implementation, in collaboration with the DHHS Office of Consumer Affairs, DIG Steering Committee and Block Grant Planning Council.
- Develop and implement formal mechanisms for the dissemination and review of DIG data to a broad array of Department stakeholders, including: consumer and family forums/discussions.
- Develop and implement strategies to involve consumers and family members in data collection, report preparation, and information dissemination and review activities.
- Develop formal communication linkages with statewide consumer and family organizations to facilitate broad-based dissemination of DIG Project updates and expanded review and feedback on mental health system performance data and trends.

Objective 6: Expand and Enhance Information Dissemination and Quality Improvement Review and Feedback Functions.

- Design and implement a formal process for broad, external stakeholder review and feedback around system and service quality issues. The State's Block Grant Planning Council, Quarter Regional

Consumer Forums, and the Maine Association of Mental Health Service Providers will serve as primary structures for external review and feedback on DIG service system performance information and trends.

- Expand and refine the existing Quality Improvement Review process to enhance participation and involvement of consumers and family members and service providers in the DHHS Quality Improvement review and feedback process.
- Develop capacity for Web-based reporting and dissemination of DIG related quality improvement reports, URS tables, and Project updates.

Objective 7: Quality Improvement Education and Training Initiatives

- In collaboration with consumer, families and service providers, plan and provide presentations on the use and understanding of mental health services data with particular emphasis on URS information.

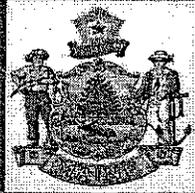
Objective 8: Data Quality Standards and Review Functions

- Review existing data quality review functions and develop and implement data quality standards and review procedures, in collaboration with the DHHS Office of Technology Services.
- Establish procedures and implement regular data quality reviews of all generated data reports that involve participation by internal and external project stakeholders.

Objective 9: Integration of DIG goals and activities with Departmental and other State integrated information infrastructure and data systems and projects in conjunction with the Office of Technology Services.

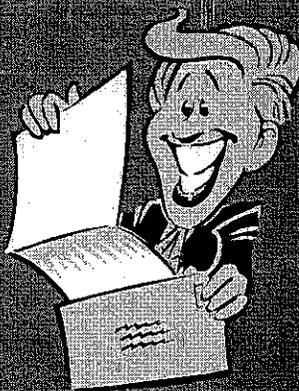
- Incorporate the capacity and functionality of the Phase III EIS design in DIG planning for, development of, and implementation of surveys, assessments, data collection tools and processes, and reporting, including access by providers, consumers, and family members.

Data Infrastructure Grant



Maine Department of Health and
Human Services

Why Is the DIG Survey Important?



- We want to know how you feel about your services
- Your answers help us to determine what services are important to you
- Your answers help us to determine what you feel are your service needs

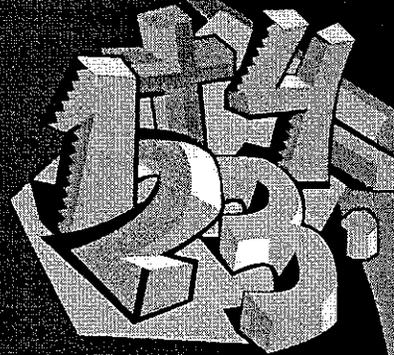
What Types of Questions are in the Survey

Satisfaction
Access
Quality
Outcome
Participation
Recovery

2005 Adult Consumer Survey: Total Number of Surveys

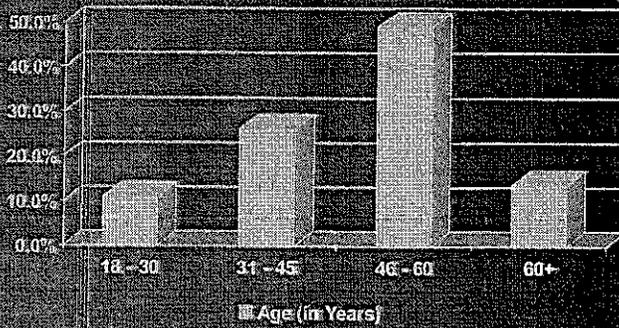
8% completed
and returned.

647 surveys
10,446 attempted
8,401 contacts were made.

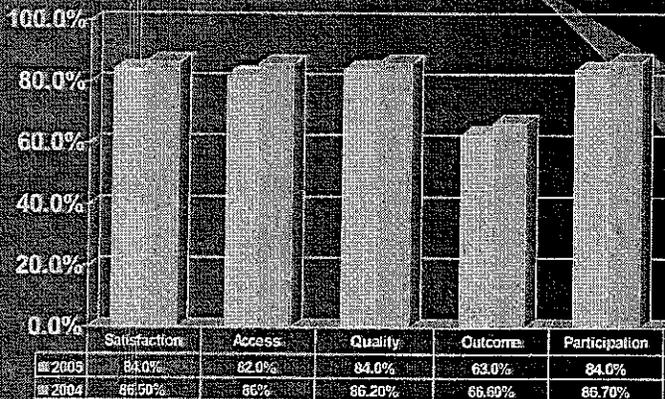


Who Completed the Survey in 2005: Adult Consumer

Female 59.1 %
Male 38.8%



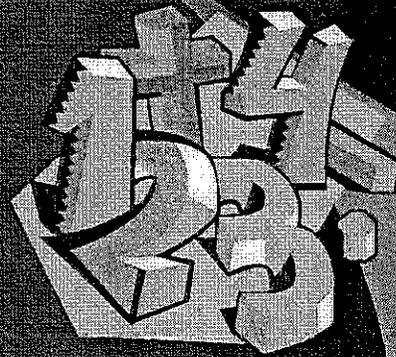
2005 Survey Results: Adult Consumer Survey



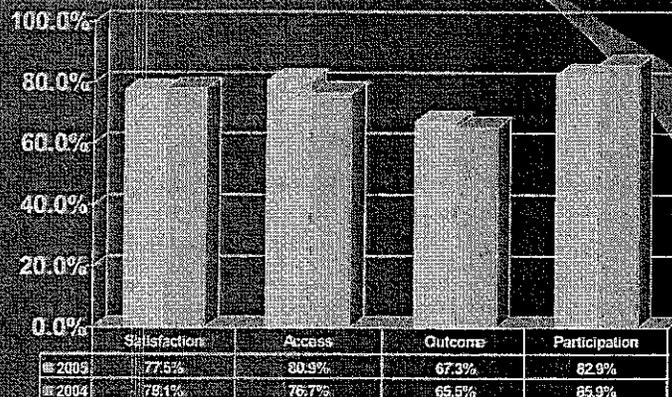
2005 Family and Youth : Total Number of Surveys

12% completed and returned.

1046 surveys
12,770 attempted
8,946 contacts were made.



2005 Survey Results: Family & Youth Survey



QIC Question

Are you aware that Maine has a Mental Health Planning Council, that reviews the State Plan (Block Grant Application) and how it spends 1.8 million dollars a year in Federal Mental Health Block Grant monies?

Adult Consumer Survey:

31% responded yes (N=620)

Family Survey:

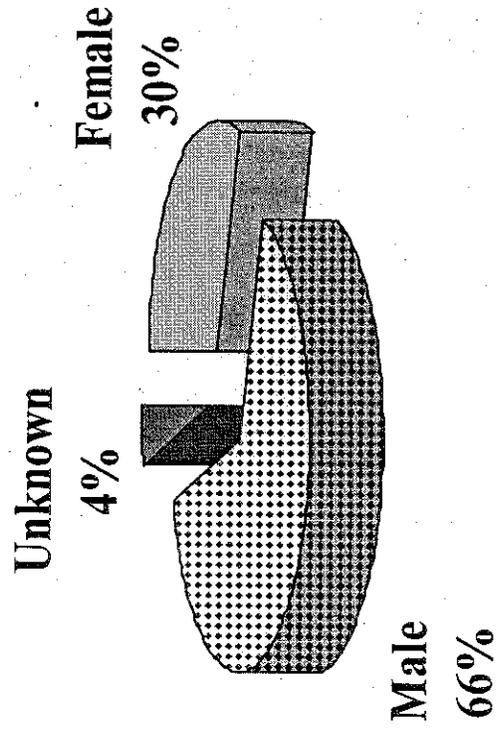
19.2% responded yes (N=588)

DIG Family Surveys

2004 and 2005 Comparison

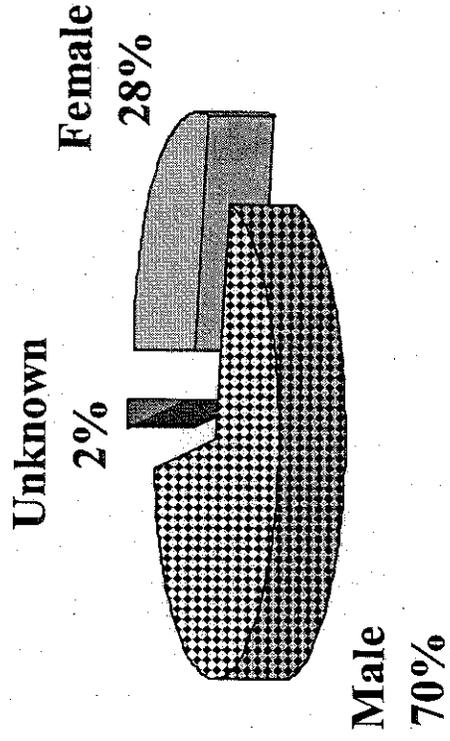
Demographics: Gender

2005



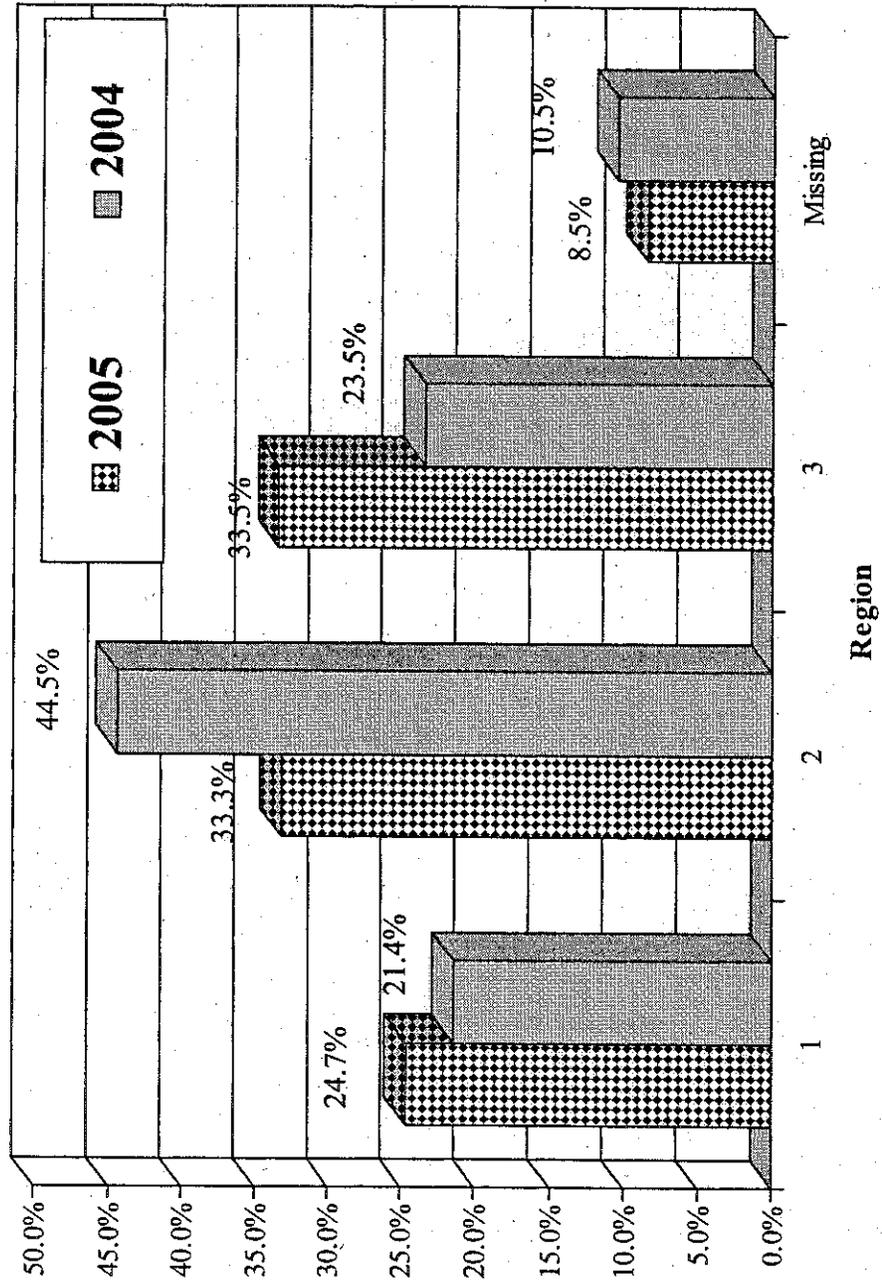
N=679

2004



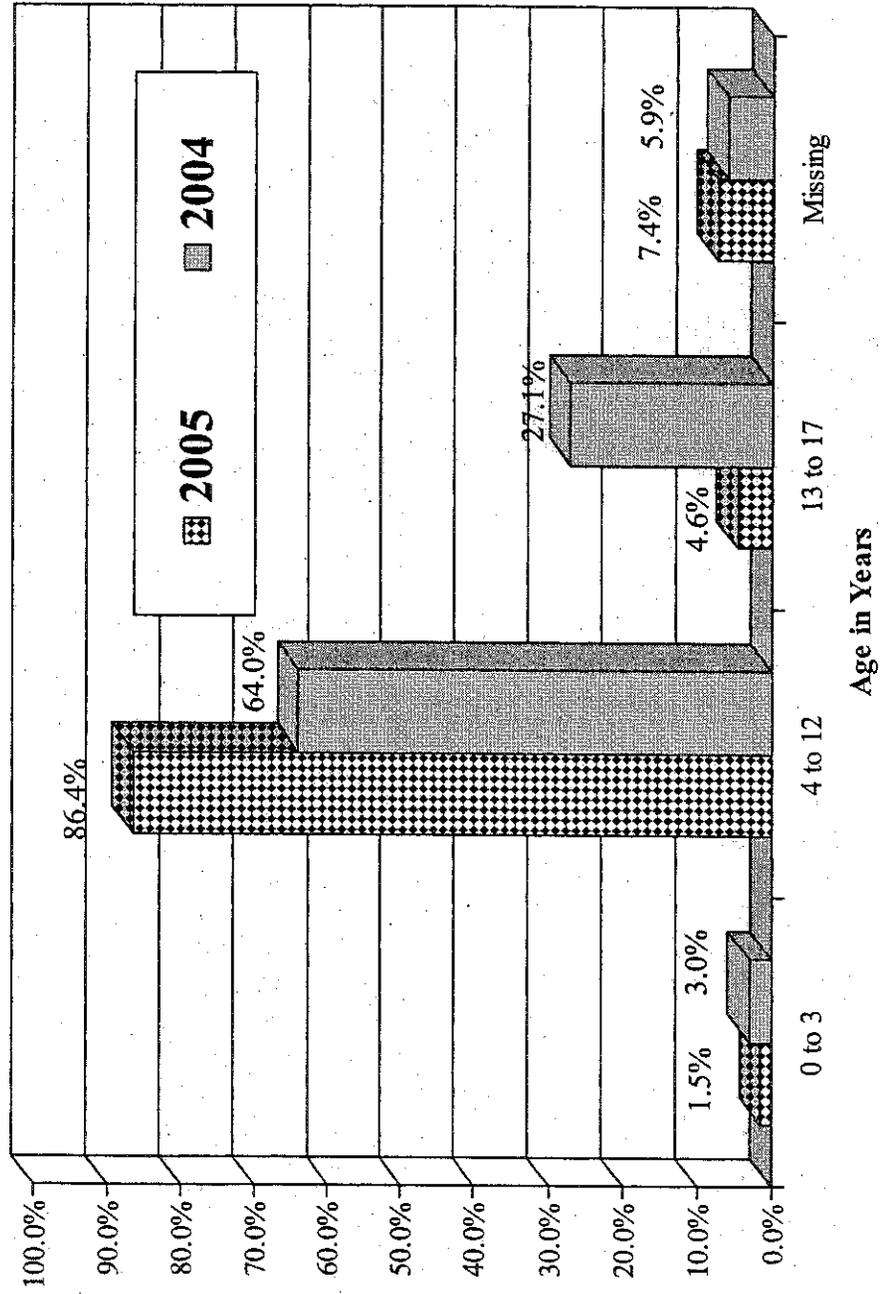
N=323

Demographics: Region



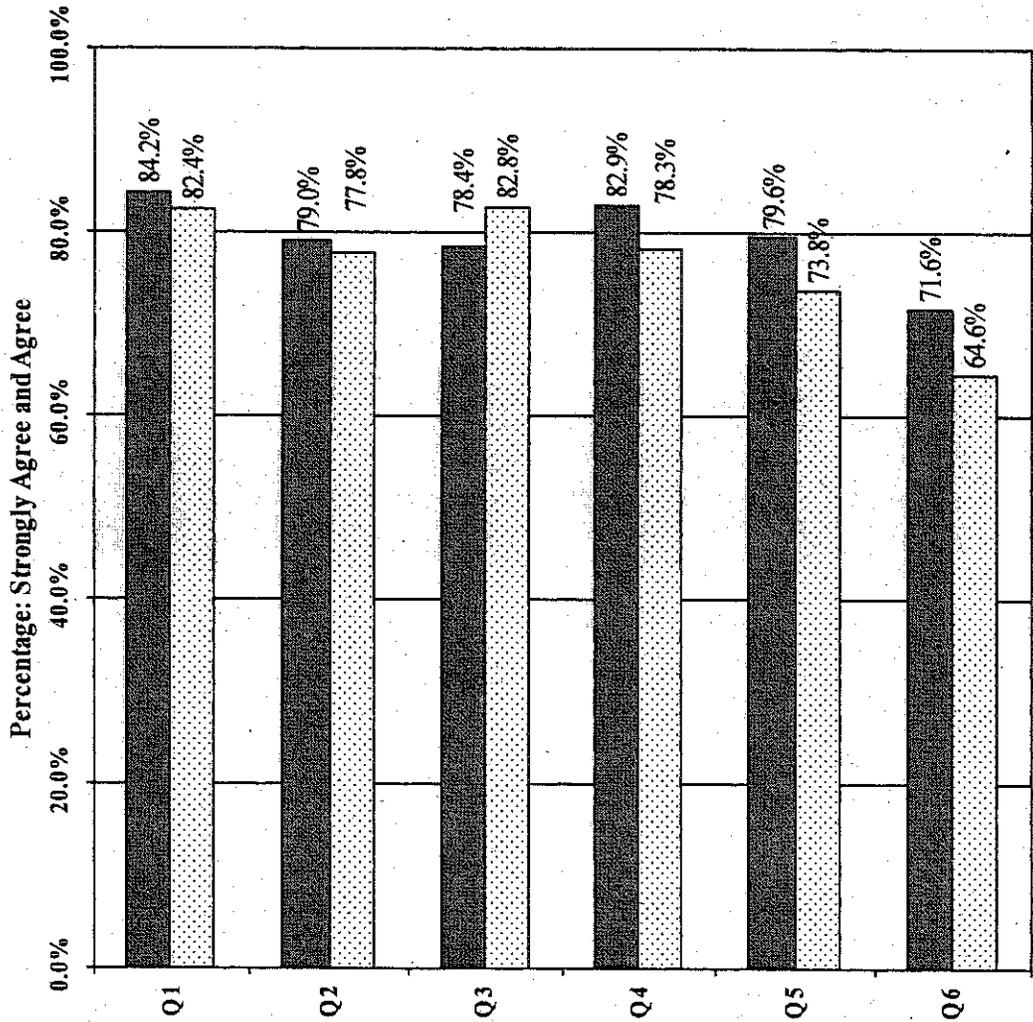
2004 N= 323
2005 N= 679

Demographics: Age



2004 N= 323
2005 N= 679

Family Satisfaction: 2004 and 2005 Comparison

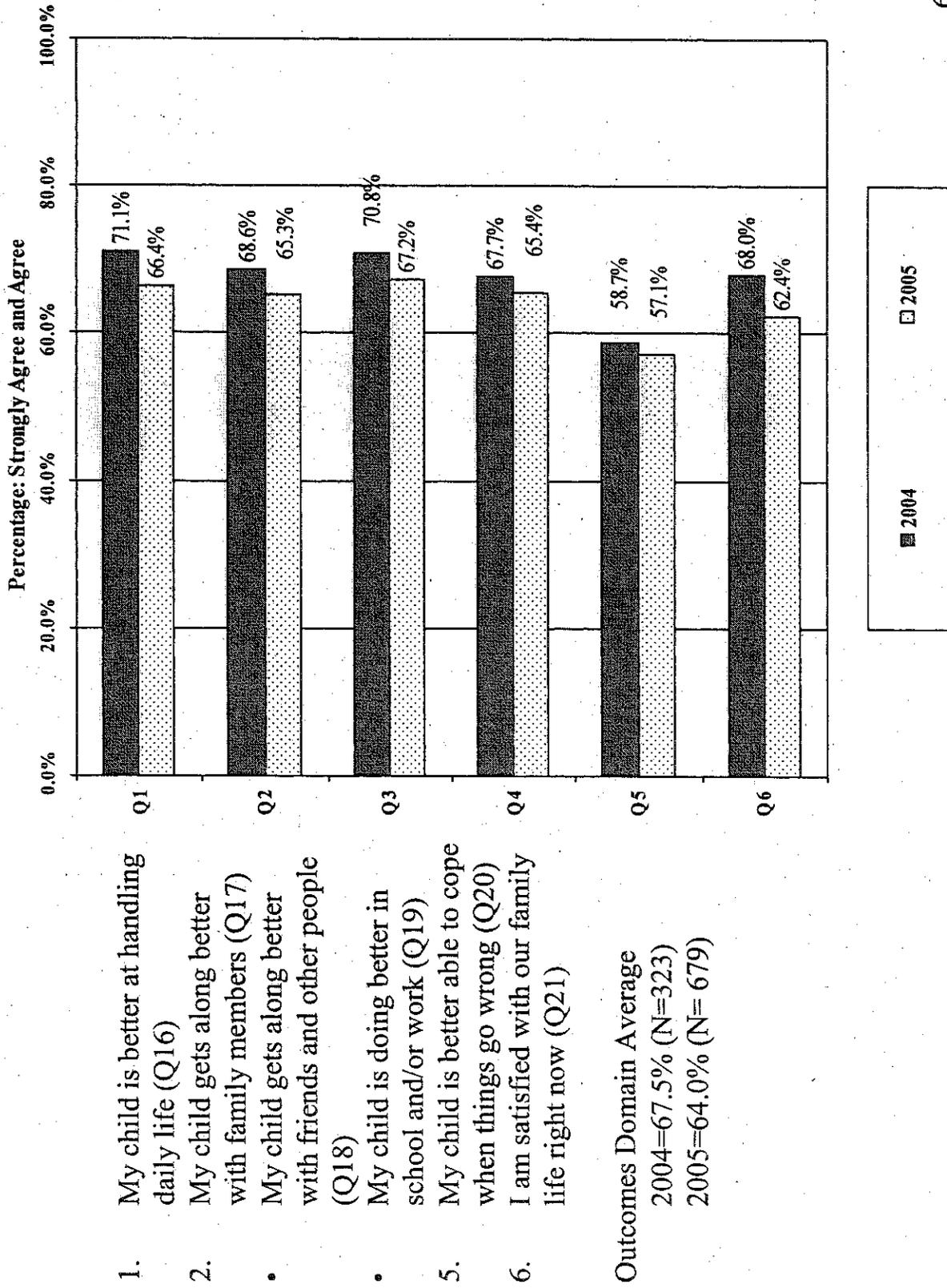


1. Overall, I am satisfied with the services my child received (Q1)
2. The people helping my child stuck with us no matter what (Q4)
3. I felt my child had someone to talk to when he/she was troubled (Q5)
4. The services my child and/or family member received were right for us (Q7)
5. My family got the help we wanted for my child (Q10)
6. My family got as much help as we needed for my child (Q11)

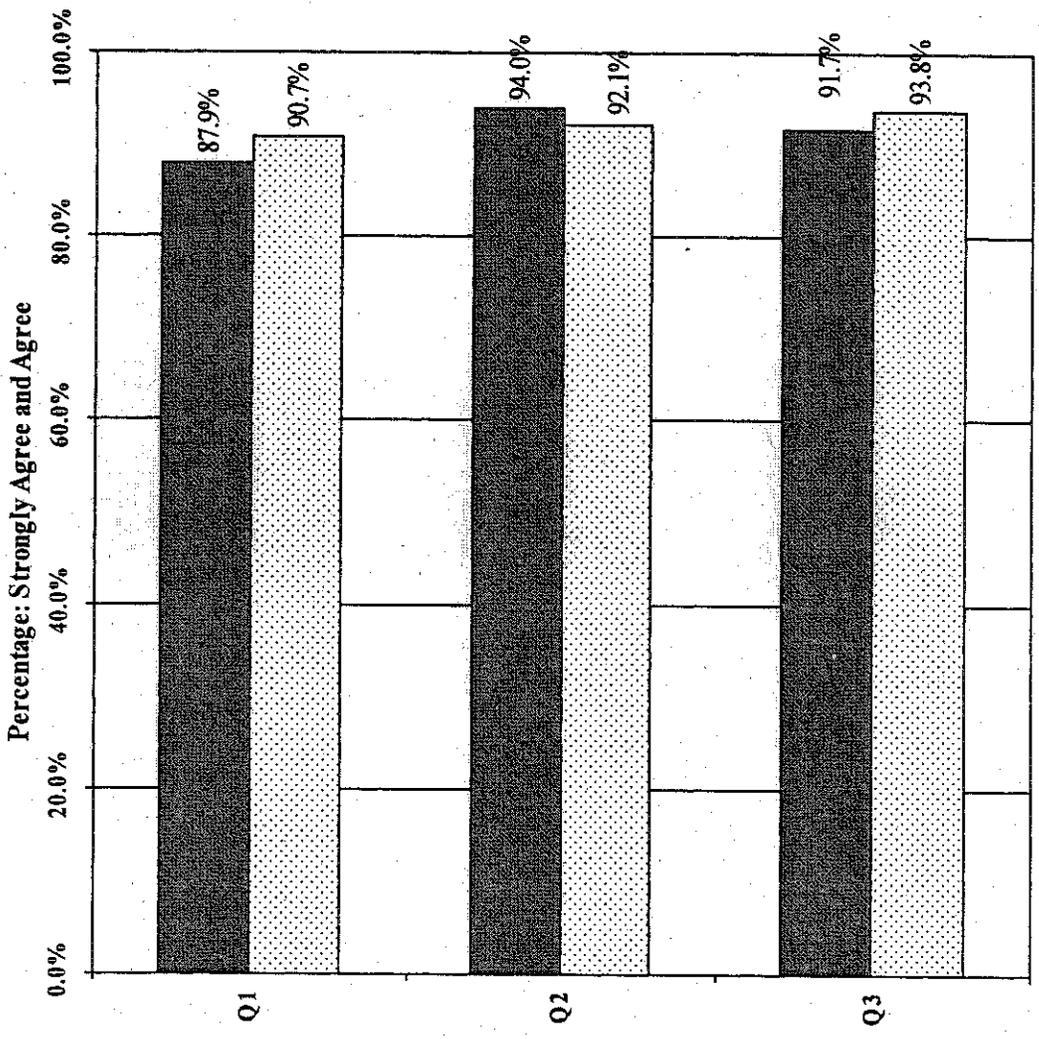
Satisfaction Domain Average
 2004=79.3% (N=323)
 2005=76.6% (N= 679)



Family Outcomes: 2004 and 2005 Comparison

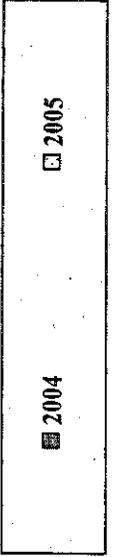


Family Treatment: 2004 and 2005 Comparison

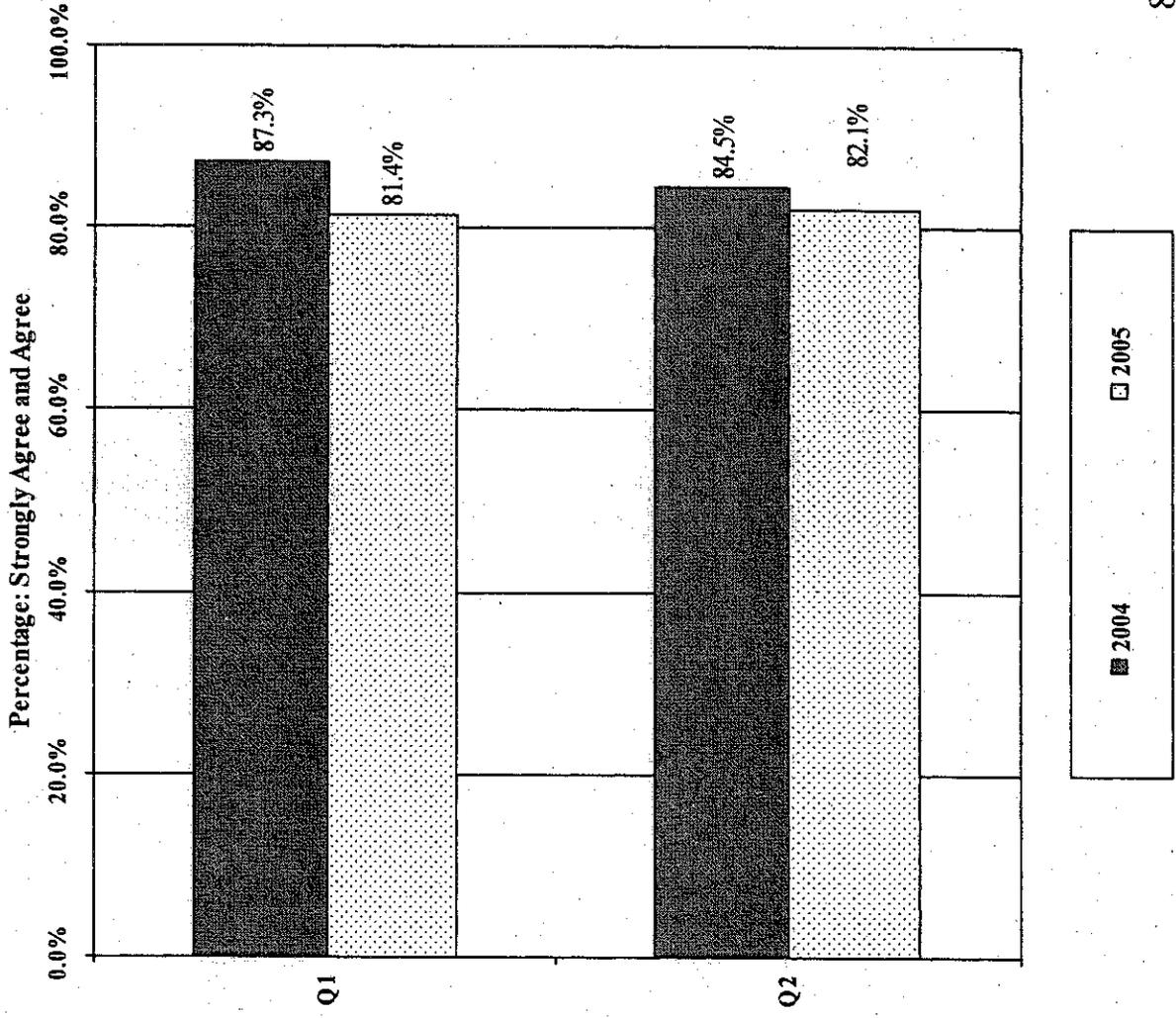


1. I helped to choose my child's services (Q2)
2. I helped to choose my child's treatment goals (Q3)
3. I participated in my child's treatment (Q6)

Treatment Domain Average
 2004=91.2% (N=323)
 2005=92.2% (N= 679)



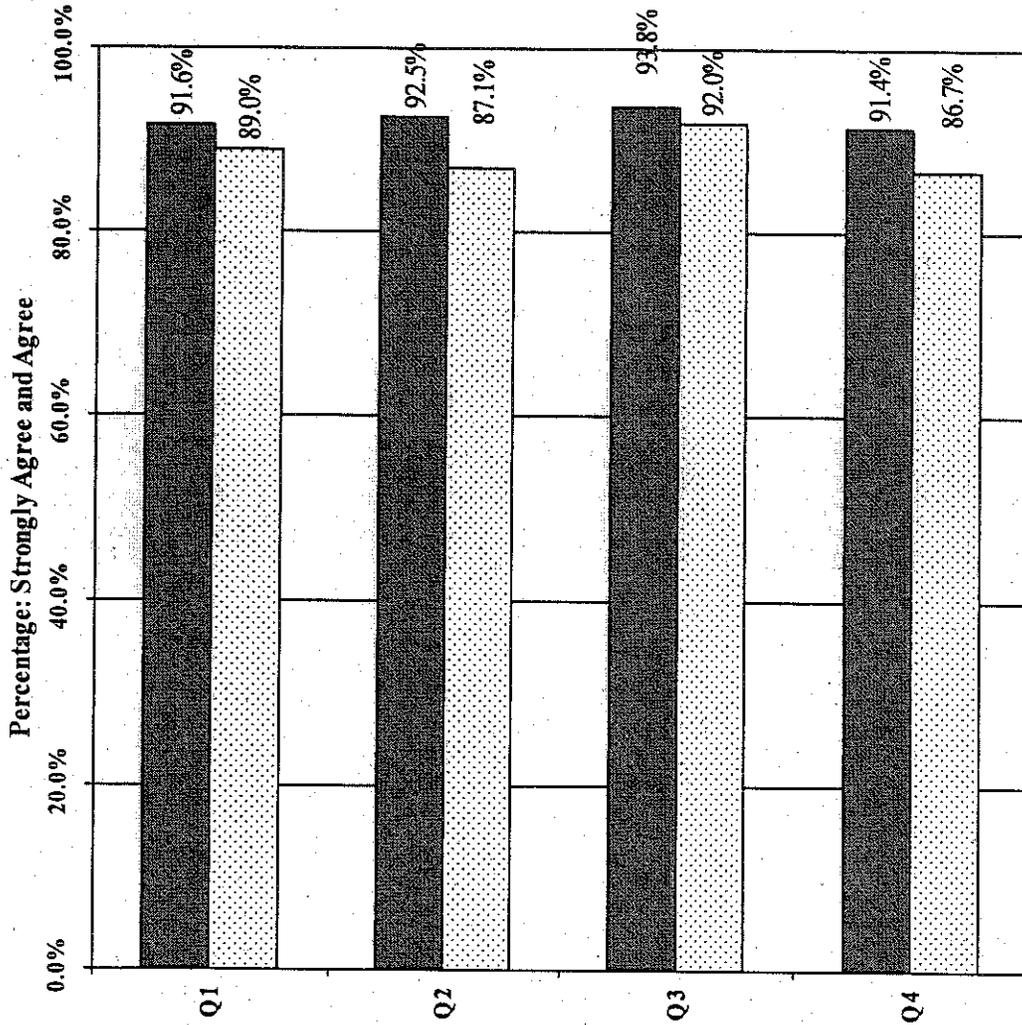
Family Access: 2004 and 2005 Comparison



1. The location of services was convenient for us (Q8)
2. Services were available at times that were convenient for us (Q9)

Access Domain Average
 2004=85.8% (N=323)
 2005=81.8% (N= 679)

Family Cultural Sensitivity: 2004 and 2005 Comparison



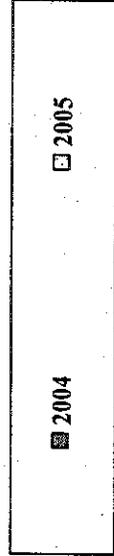
1. Staff treated me with respect (Q12)
2. Staff respected my family's religious/spiritual beliefs (Q13)
3. Staff spoke with me in a way that I understood (Q14)
4. Staff were sensitive to my cultural/ethnic background (Q15)

Cultural Sensitivity

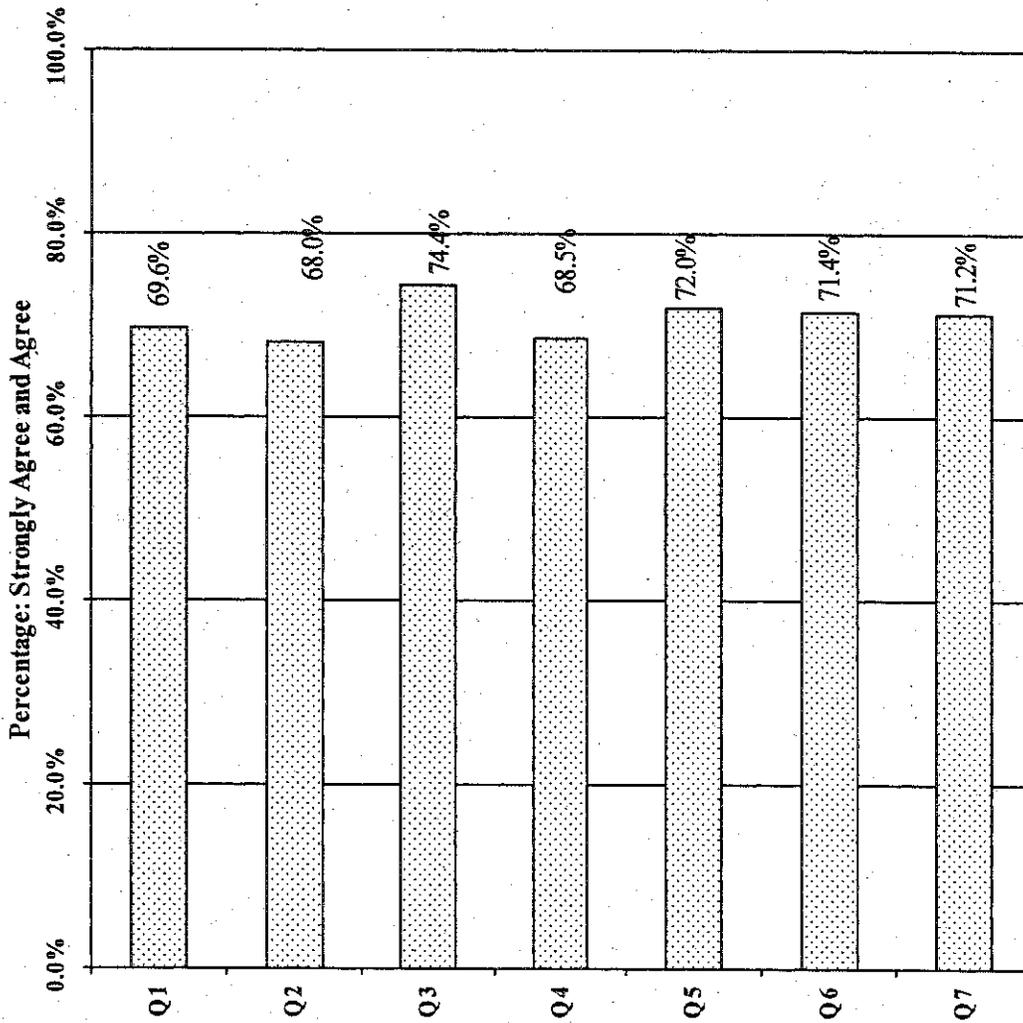
Domain Average

2004=92.3% (N=323)

2005=88.7% (N= 679)



**Family Community Connectedness:
2005**



Other than my service providers:

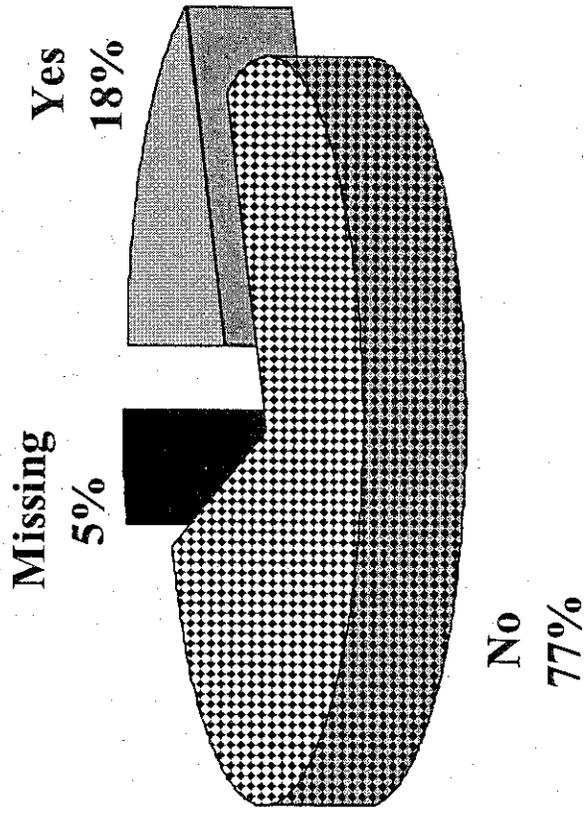
1. I know people who will listen and understand me when I need to talk. (Q22)
2. In a crisis, I would have the support I need from family or friends. (Q23)
3. I have people that I am comfortable talking with about my child's problems. (Q24)
4. I have people that I am comfortable talking to about private things. (Q25)
5. I have more than one friend. (Q26)
6. I am happy with the friendships I have. (Q27)
7. I have people with whom I can do enjoyable things. (Q28)

Community Connectedness

Domain Average

2005=70.7% (N=679)

Are you aware that Maine has a Mental Health Planning Council that reviews the State Plan (Block Grant Application) and how it spends 1.8 million dollars a year in Federal Mental Health Block Grant Monies?



2005 N=679

DIG Youth Surveys

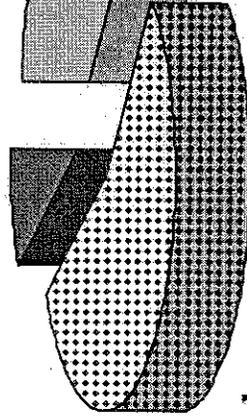
2004 and 2005 Comparison

Demographics: Gender

2005

Unknown

8%



Male

56%

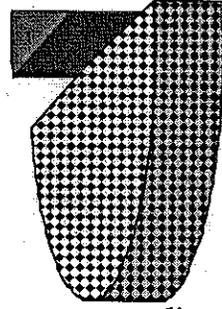
Female

36%

2004

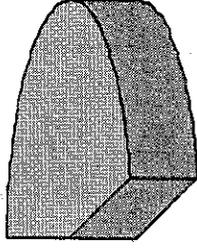
Unknown

4%



Male

50%



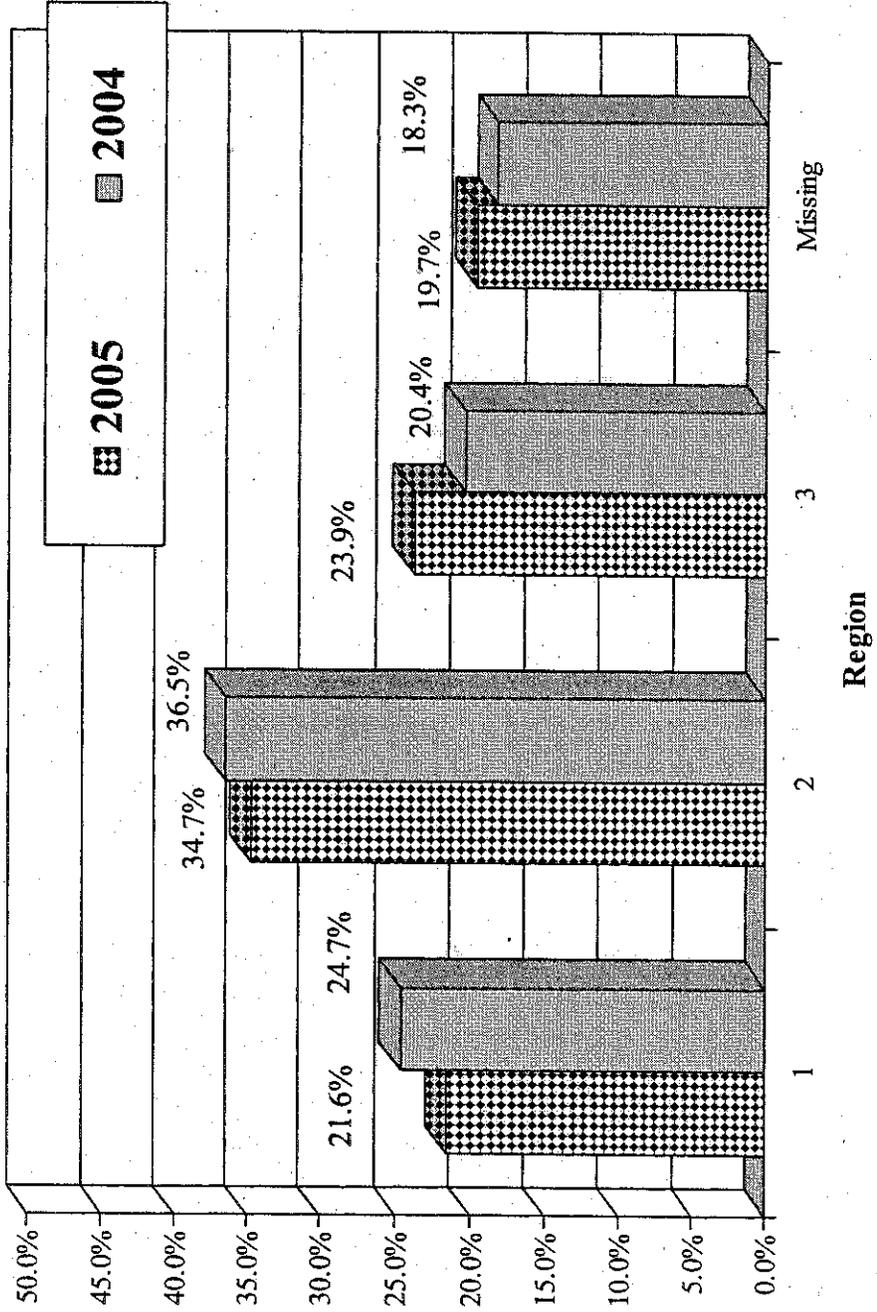
Female

46%

N=465

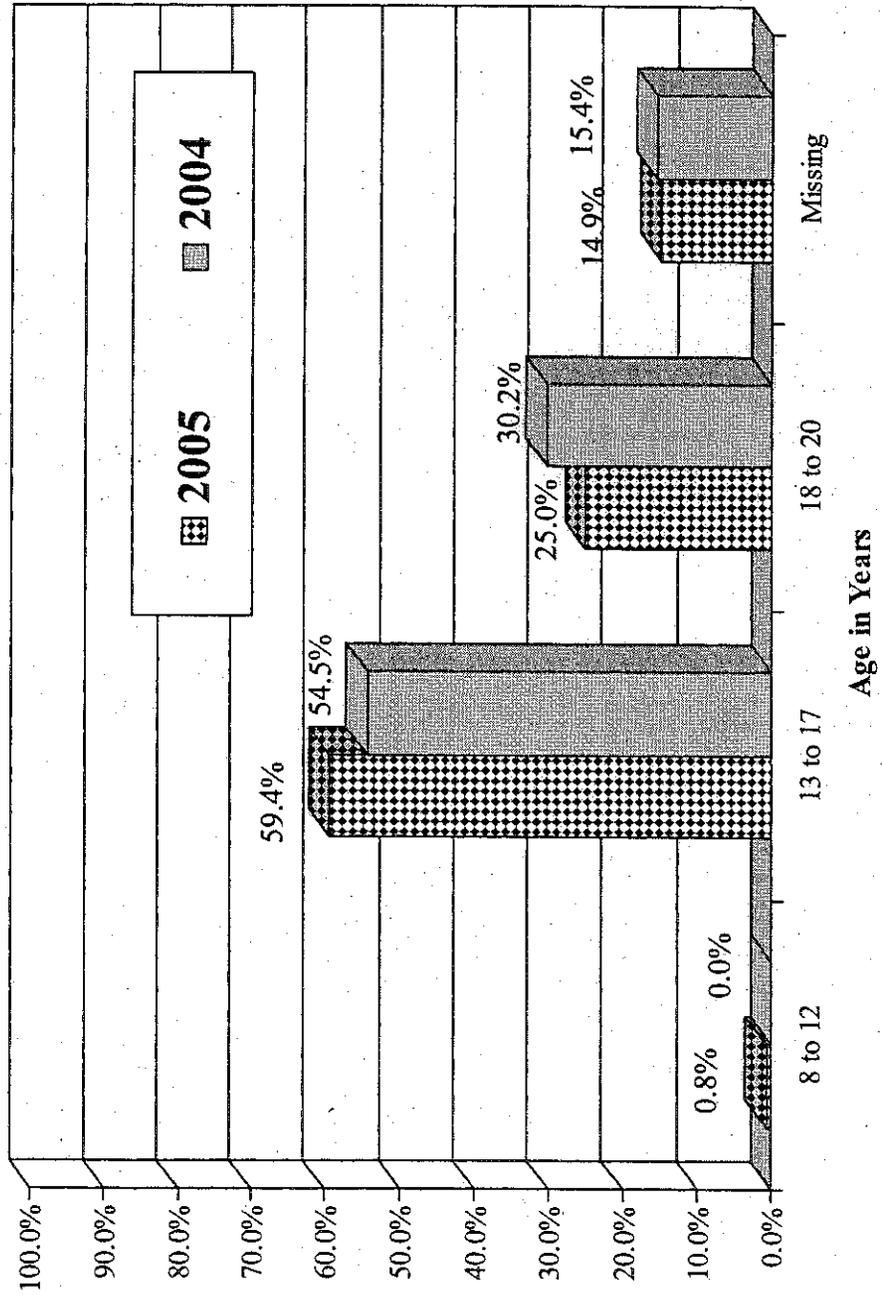
N=279

Demographics: Region



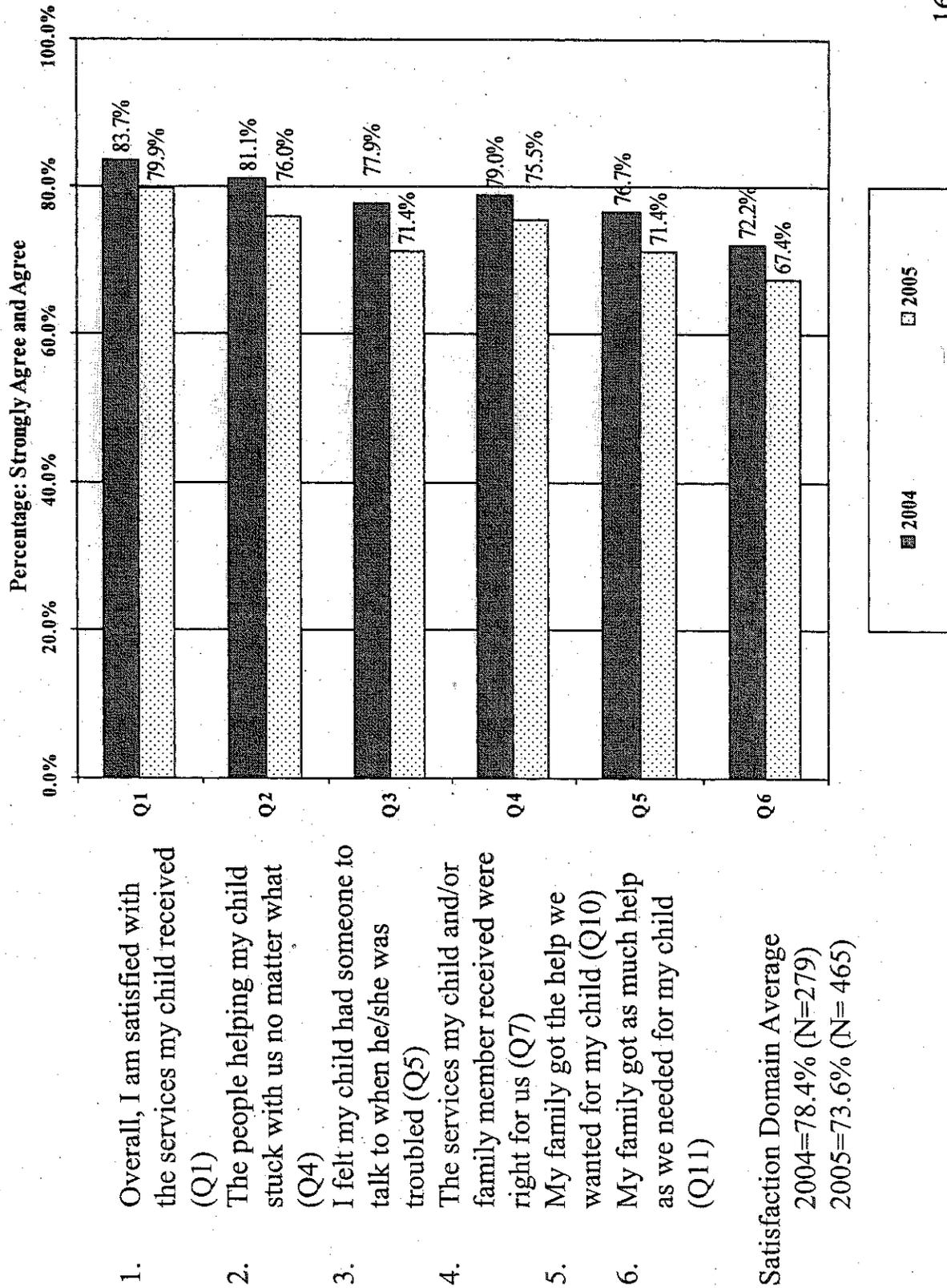
2004 N= 279
2005 N= 477

Demographics: Age

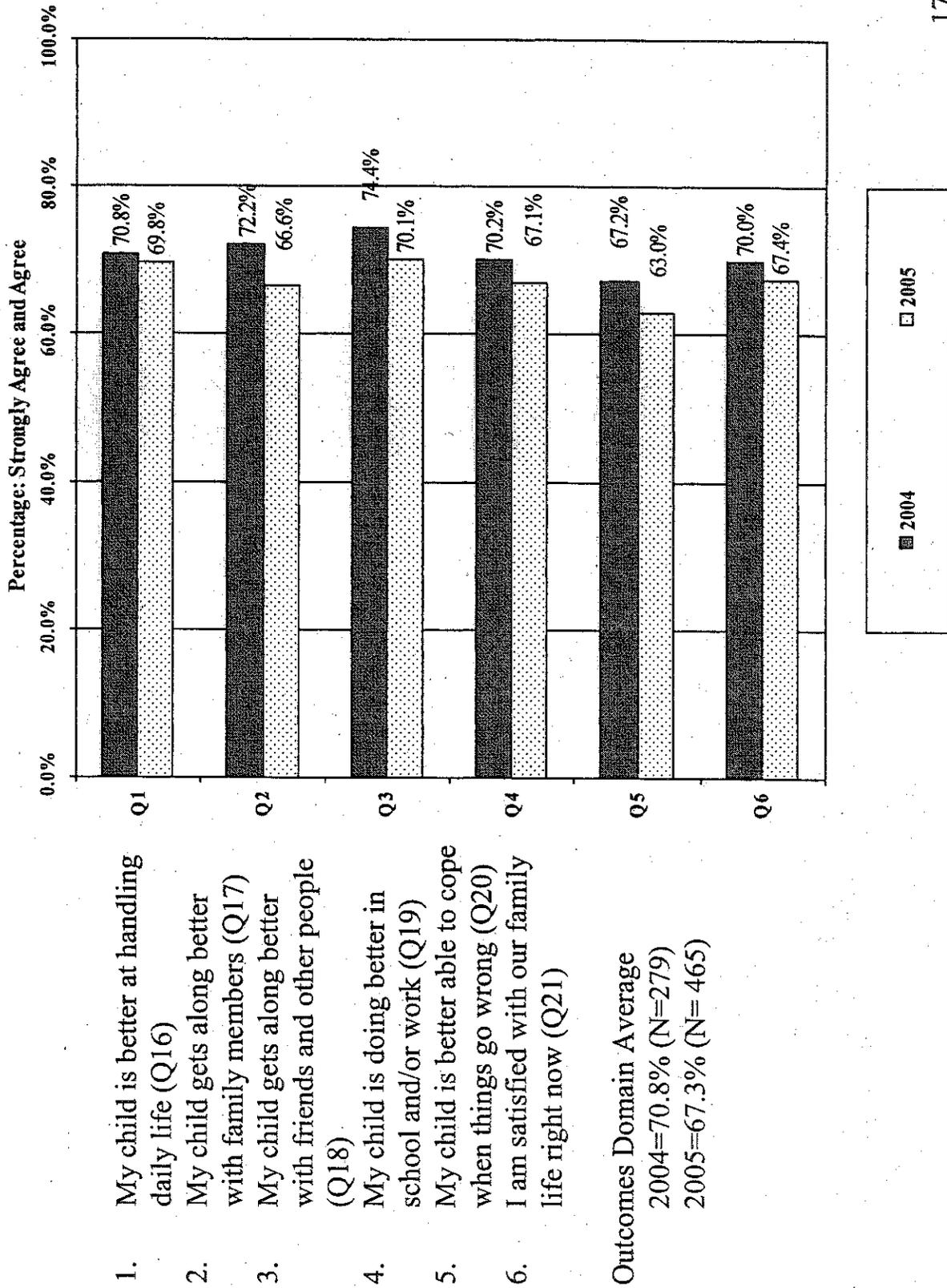


2004 N= 279
2005 N= 477

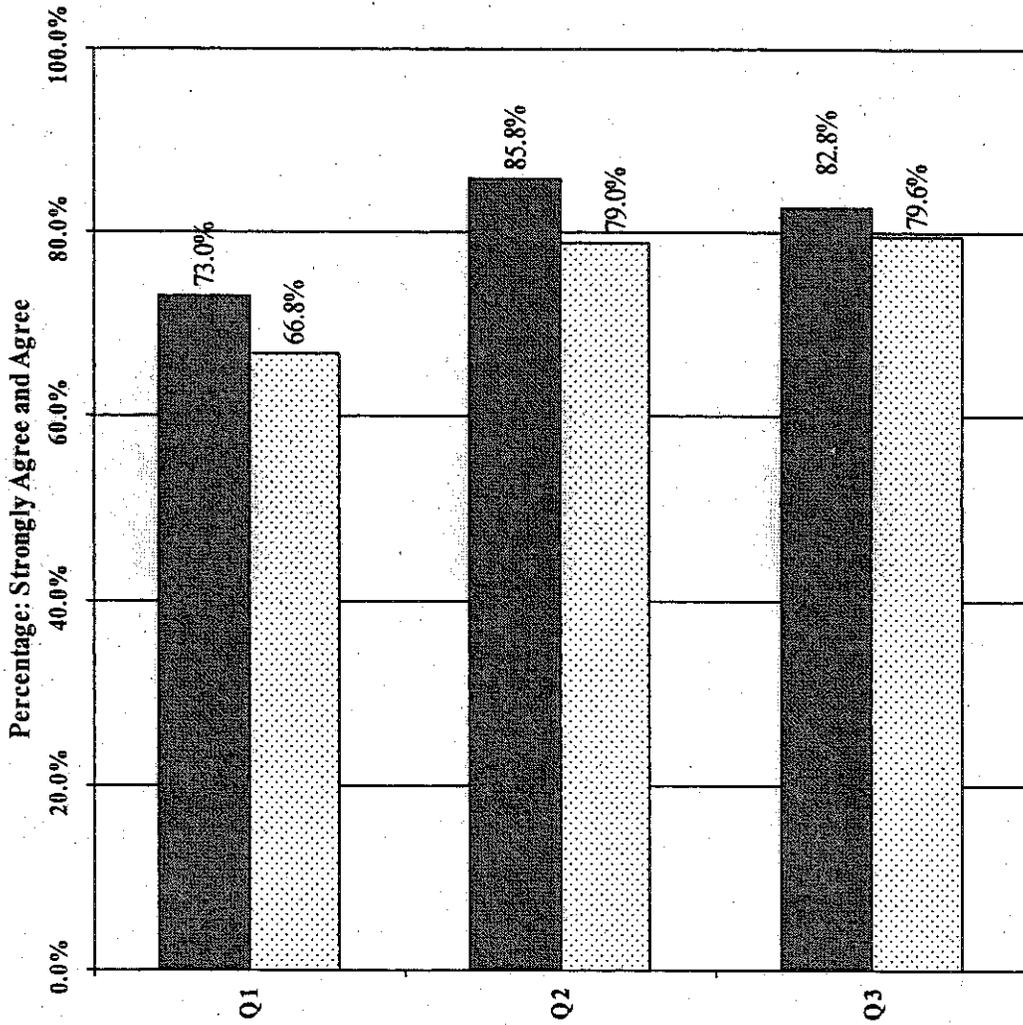
Youth Satisfaction: 2004 and 2005 Comparison



Youth Outcomes: 2004 and 2005 Comparison



Youth Treatment: 2004 and 2005 Comparison

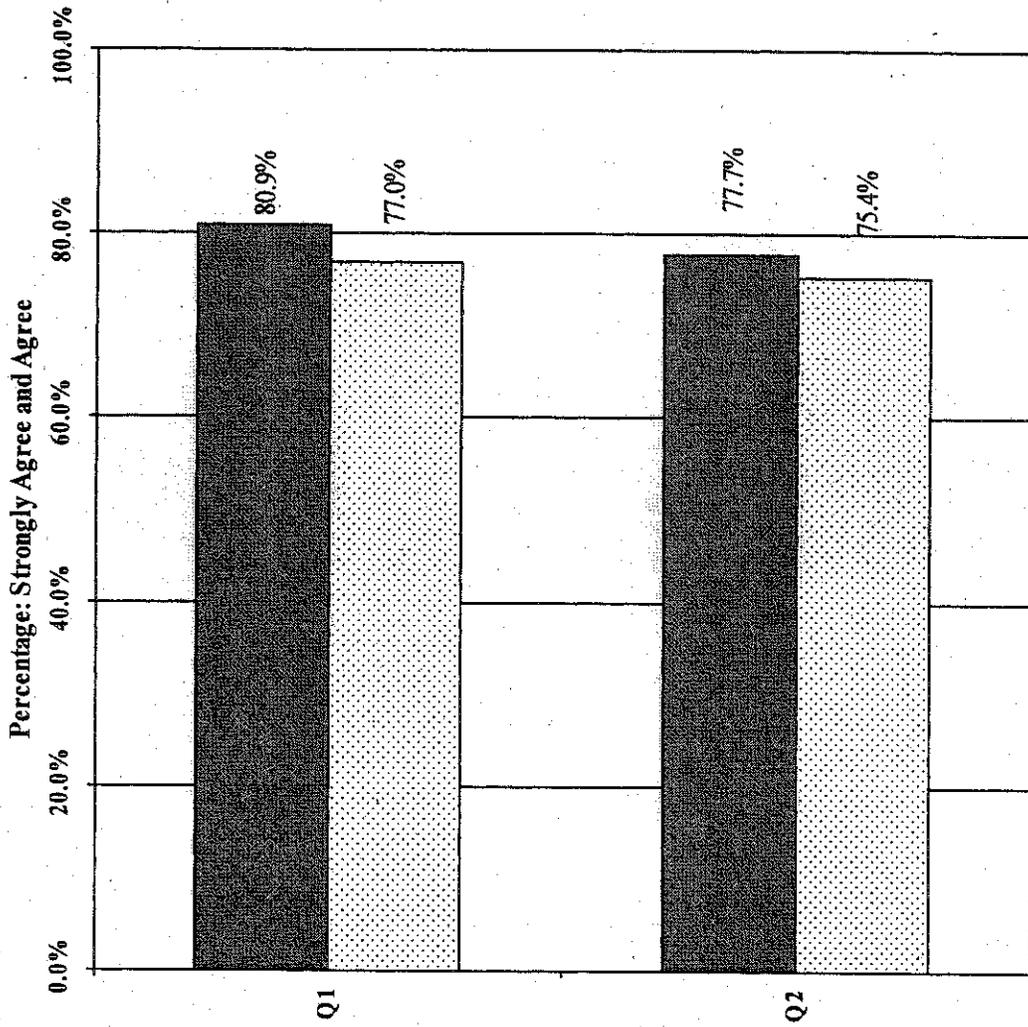


1. I helped to choose my child's services (Q2)
2. I helped to choose my child's treatment goals (Q3)
3. I participated in my child's treatment (Q6)

Treatment Domain Average
 2004=80.5% (N=279)
 2005=75.1% (N= 465)



Youth Access: 2004 and 2005 Comparison



1. The location of services was convenient for us (Q8)
2. Services were available at times that were convenient for us (Q9)

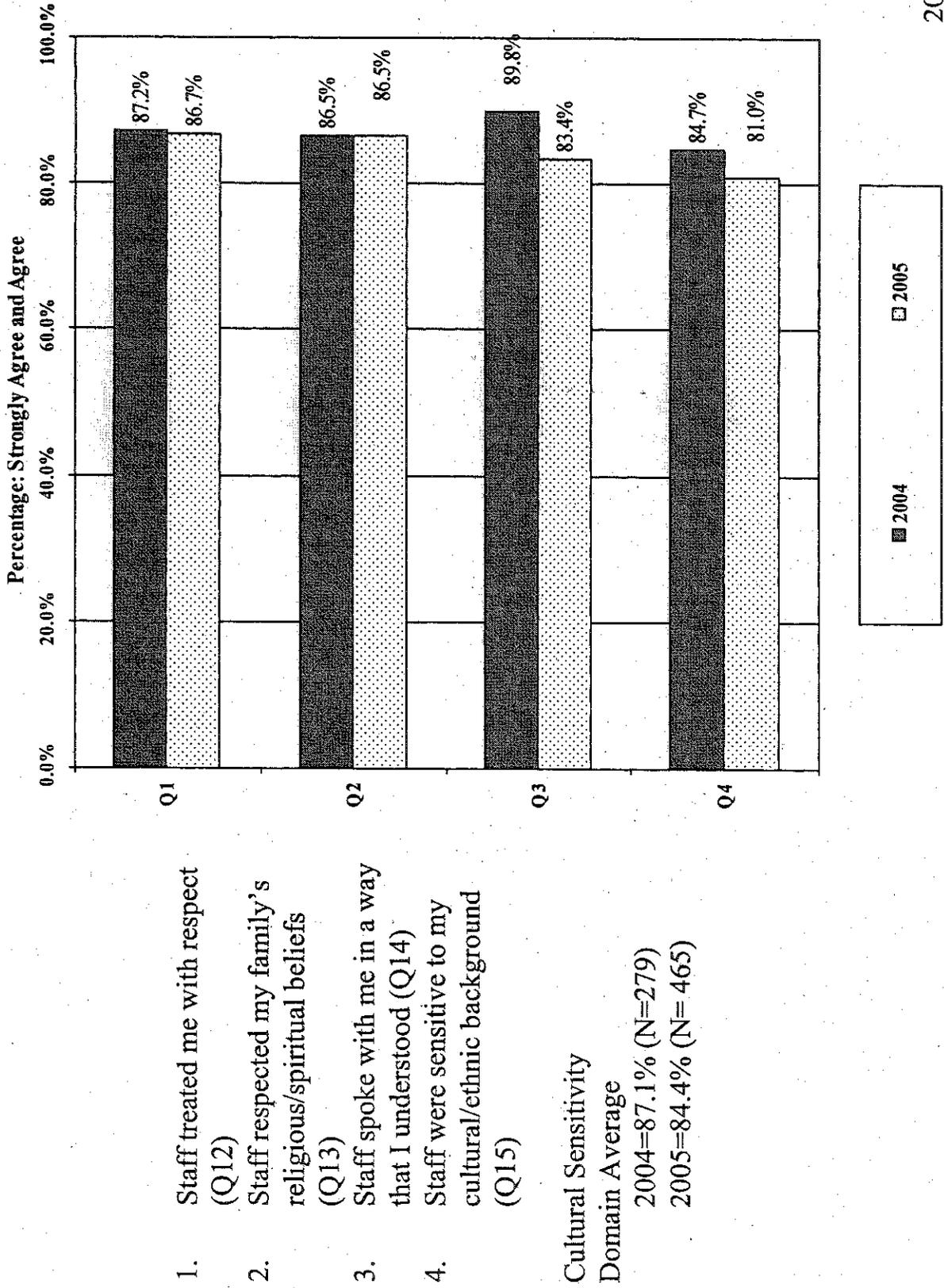
Access Domain Average

2004=79.3.8% (N=279)

2005=76.2% (N=465)



Youth Cultural Sensitivity: 2004 and 2005 Comparison

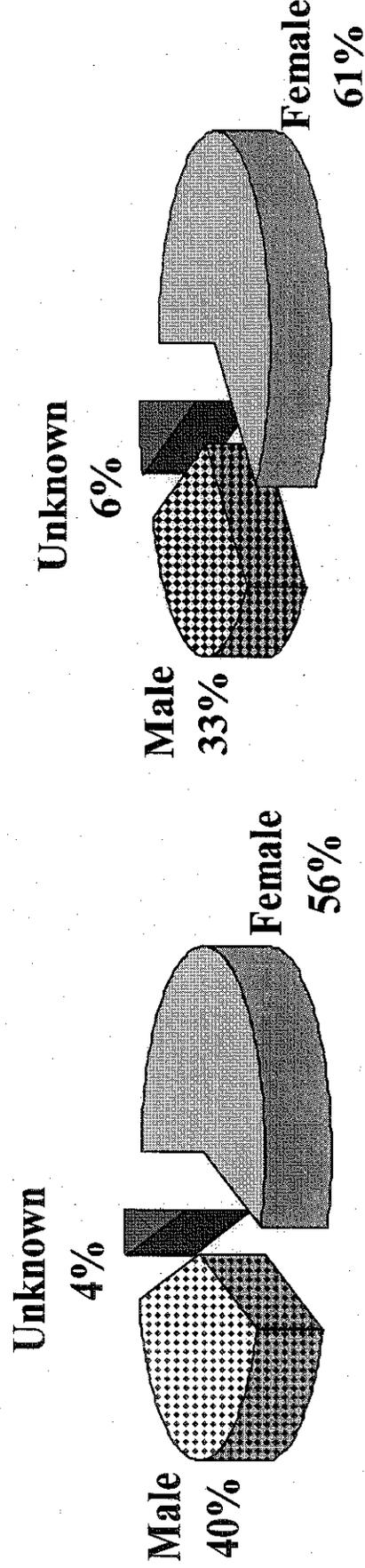


DIG Adult Consumer Survey

2004 and 2005 Comparison

Demographics: Gender

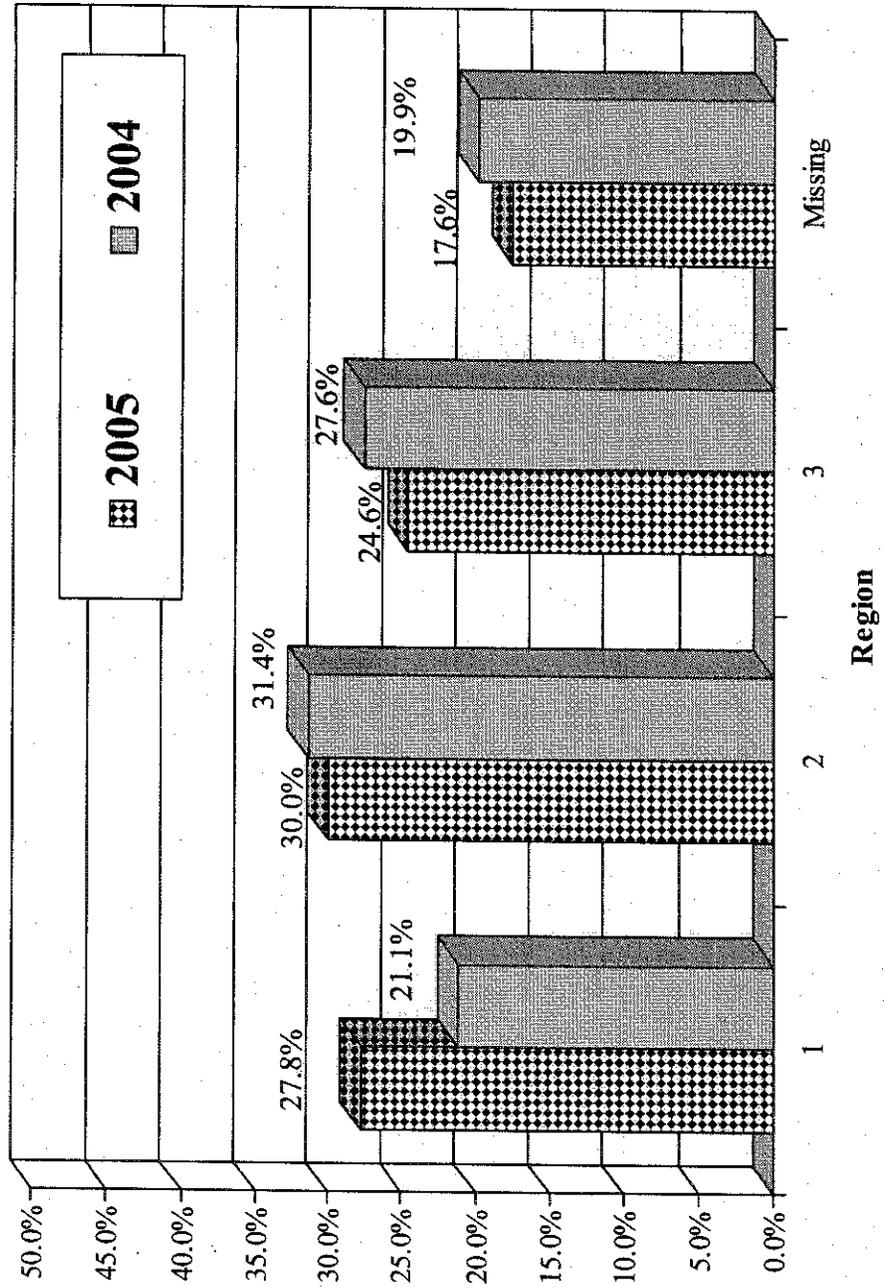
2005 2004



N=1546

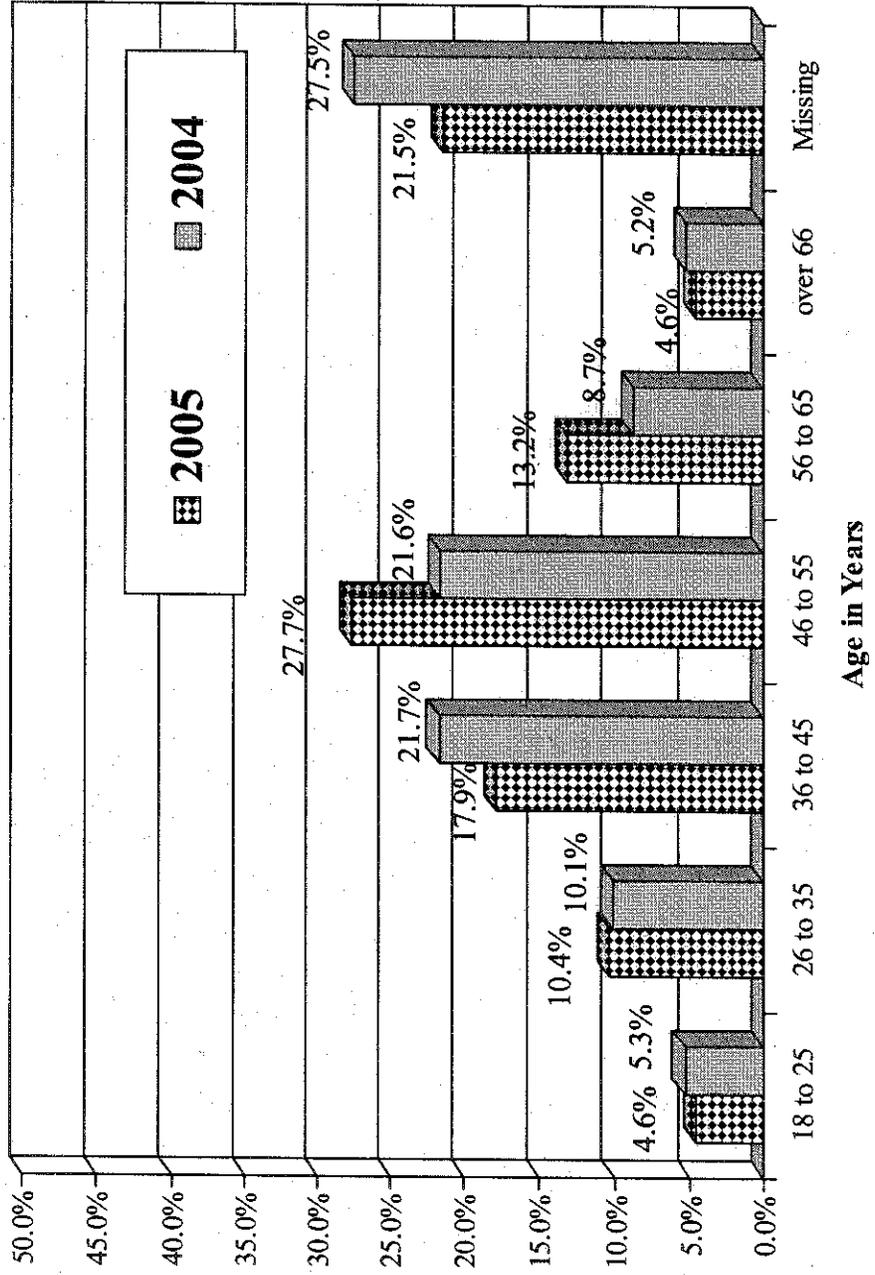
N=758

Demographics: Region



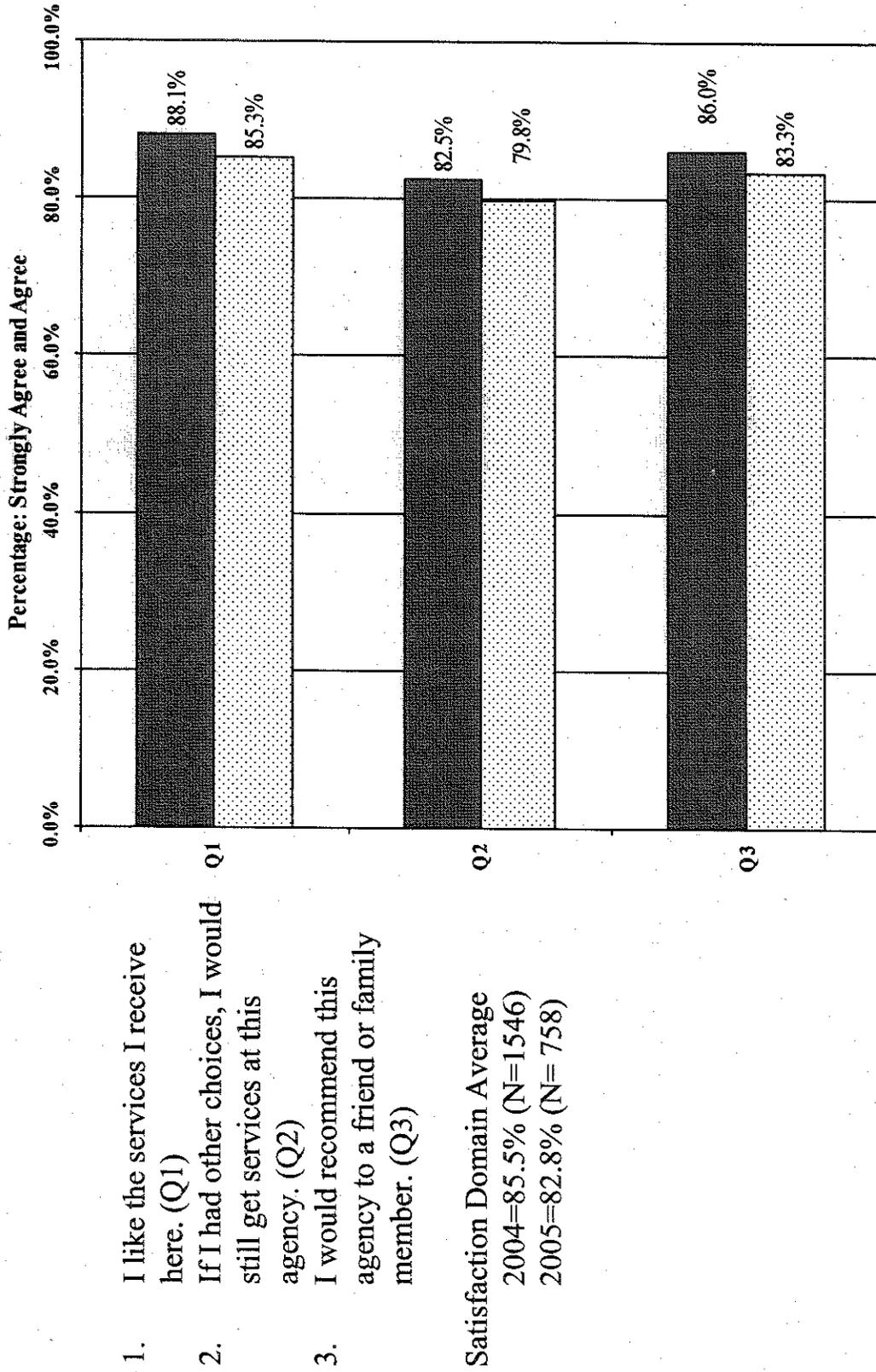
2004 N= 1546
2005 N= 758

Demographics: Age

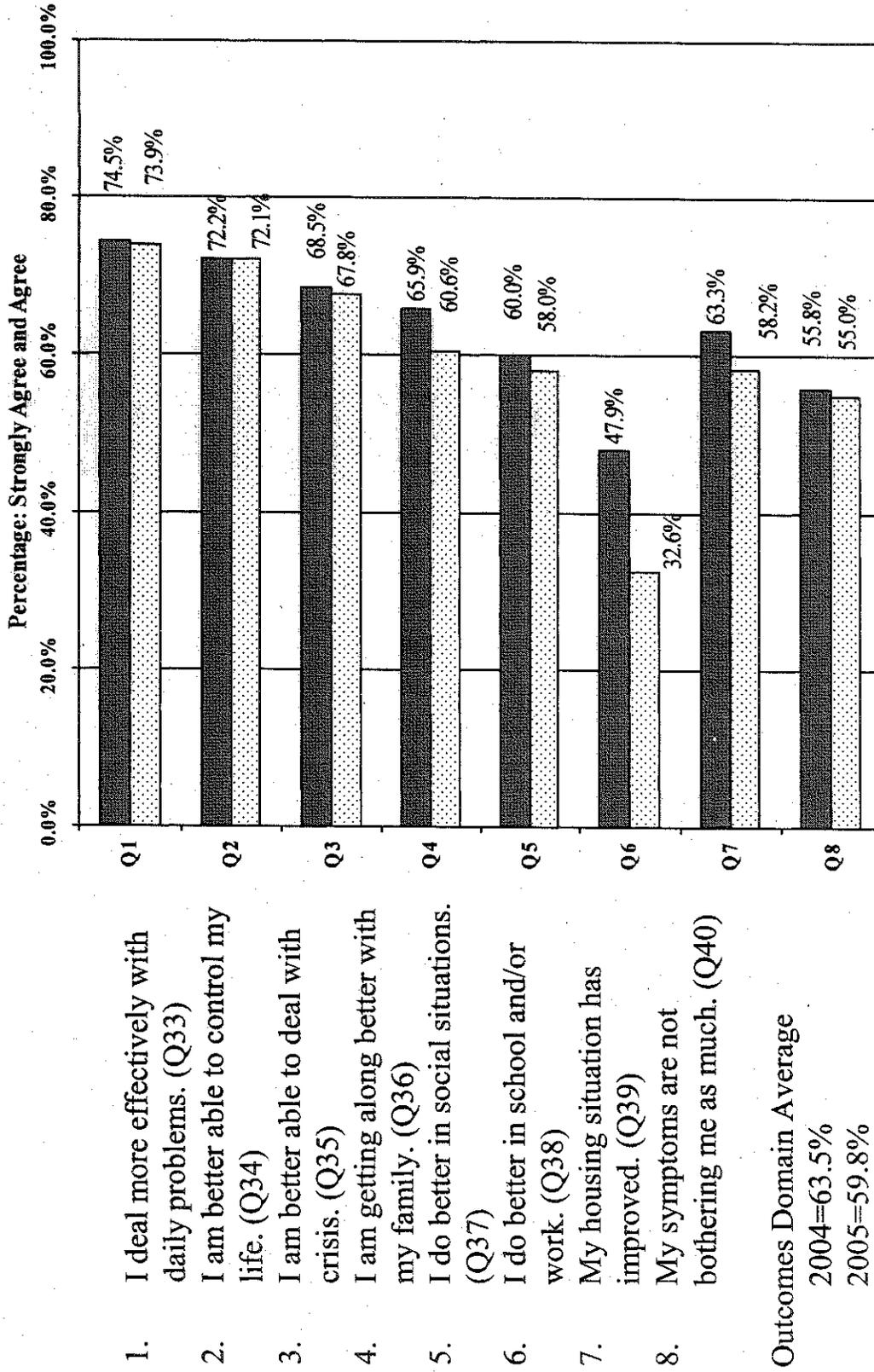


2004 N= 1546
2005 N= 758

DIG Adult Consumer Survey Satisfaction: 2004 and 2005 Comparison



DIG Adult Consumer Survey Outcomes: 2004 and 2005 Comparison



1. I deal more effectively with daily problems. (Q33)
2. I am better able to control my life. (Q34)
3. I am better able to deal with crisis. (Q35)
4. I am getting along better with my family. (Q36)
5. I do better in social situations. (Q37)
6. I do better in school and/or work. (Q38)
7. My housing situation has improved. (Q39)
8. My symptoms are not bothering me as much. (Q40)

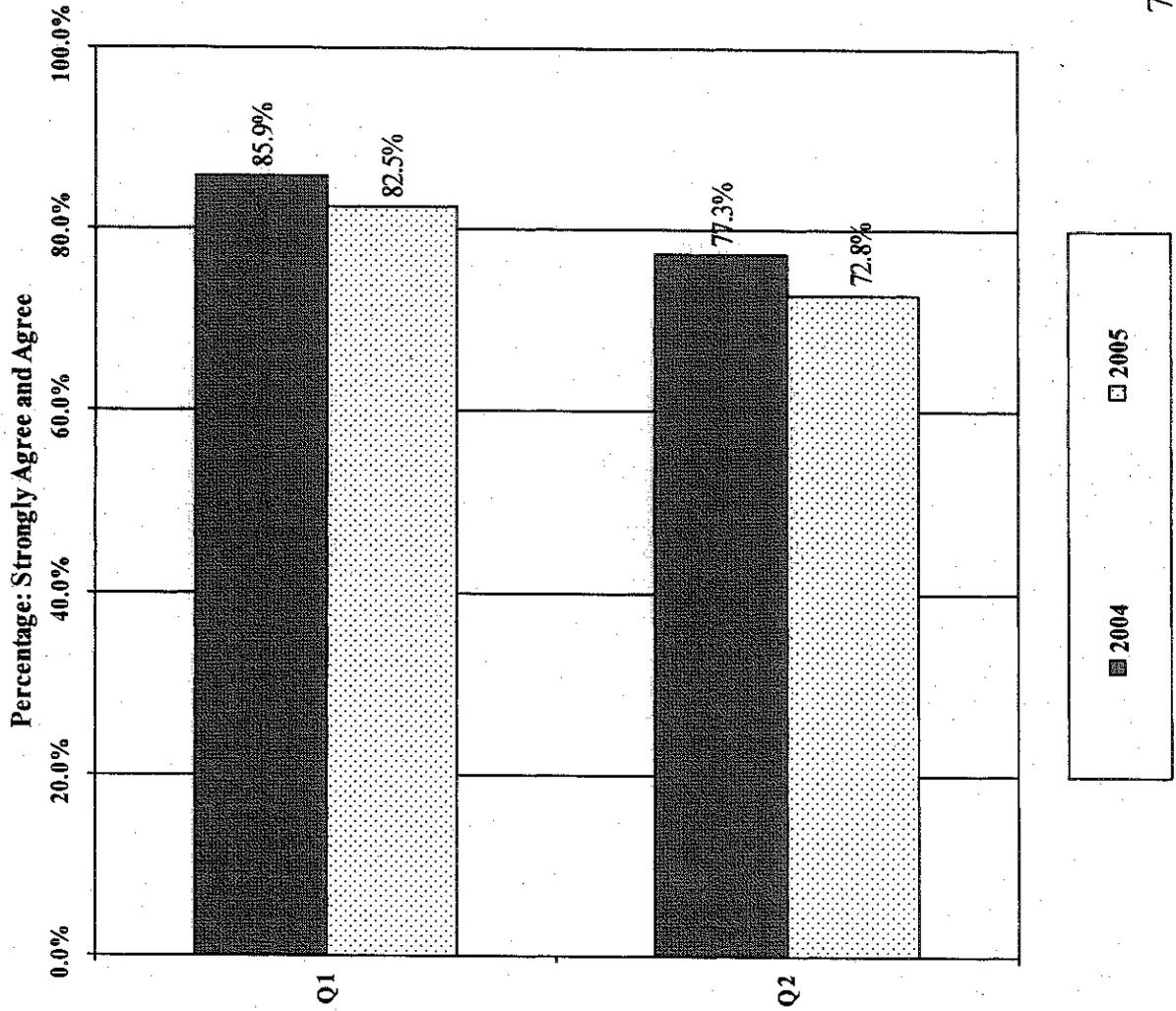
Outcomes Domain Average

2004=63.5%

2005=59.8%



DIG Adult Consumer Survey Treatment: 2004 and 2005 Comparison



1. I felt comfortable asking questions about my treatment medication. (Q12)

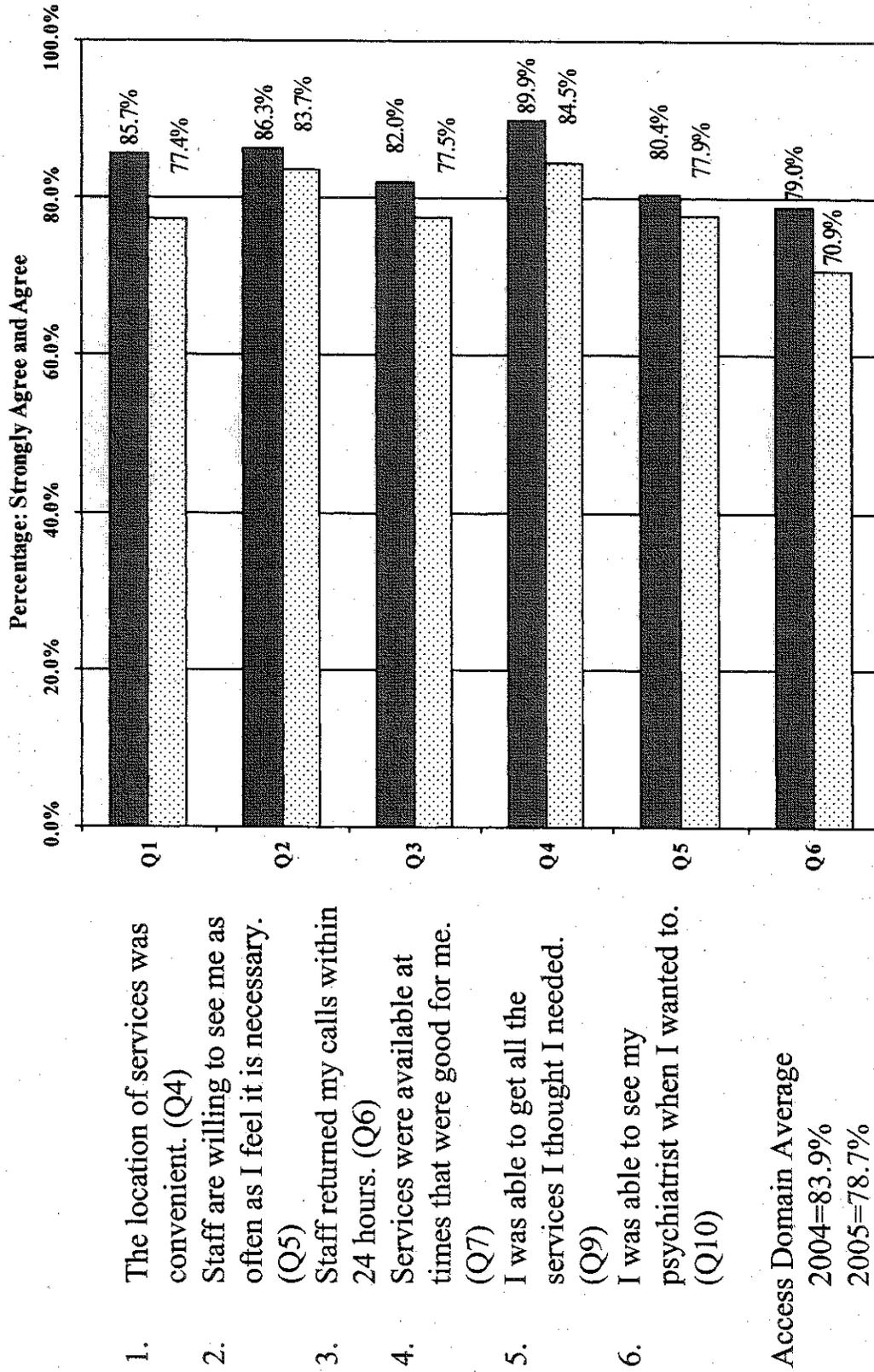
2. I, not staff, decided my treatment goals. (Q18)

Treatment Domain Average

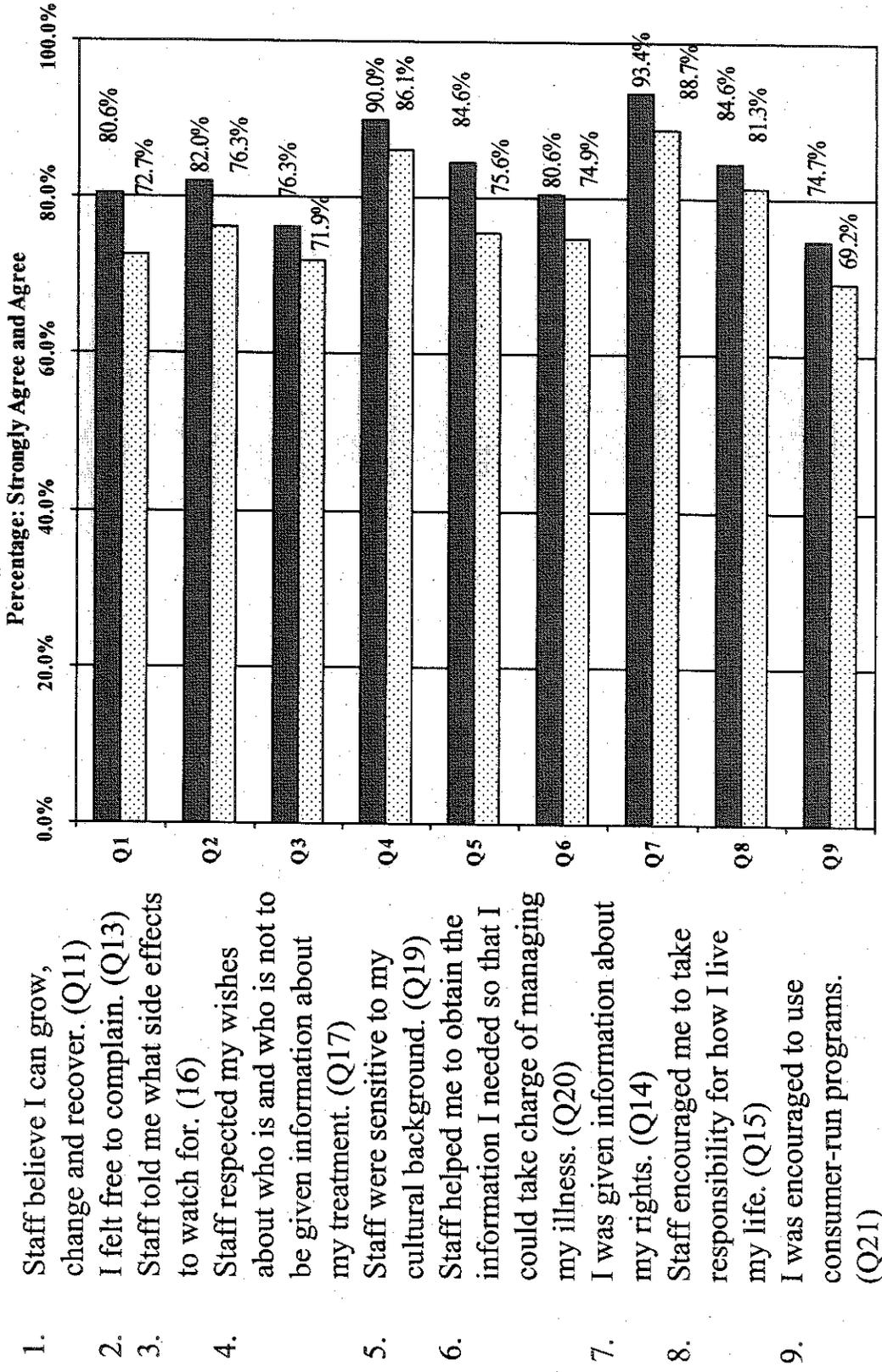
2004=81.6%

2005=77.7%

DIG Adult Consumer Survey Access: 2004 and 2005 Comparison



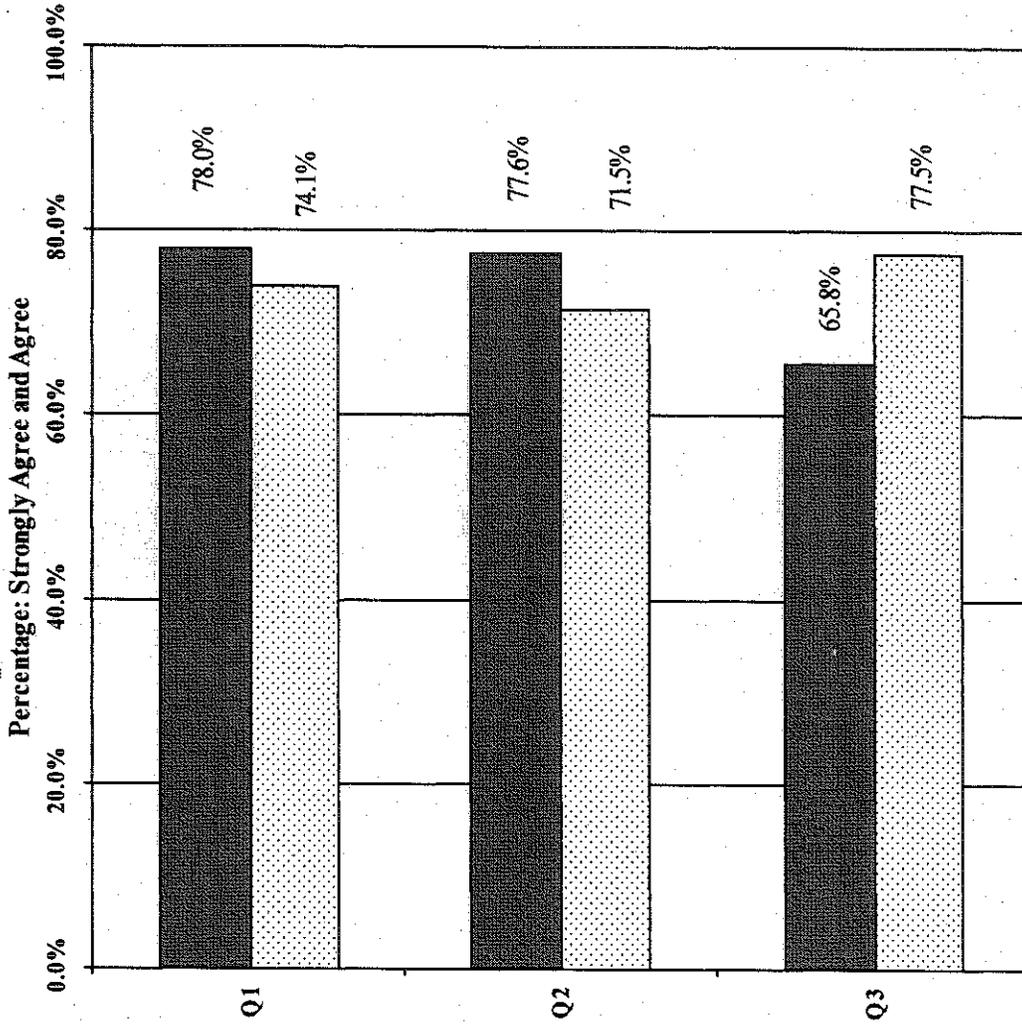
**DIG Adult Consumer Survey Perception of Quality and Appropriateness:
2004 and 2005 Comparison**



Legend:
 2004
 2005

Domain Average
 2004=83.0%
 2005=77.4%

**DIG Adult Consumer Survey Recovery:
2004 and 2005 Comparison**



1. My belief that I can maintain my wellness and recover from mental illness is supported by the services and staff of this agency. (Q22)
2. There are opportunities in this agency to learn skills that allow me to strengthen and maintain my wellness. (Q23)
3. This agency offers mutual support or recovery focus groups that are facilitated by peers. (Q25)

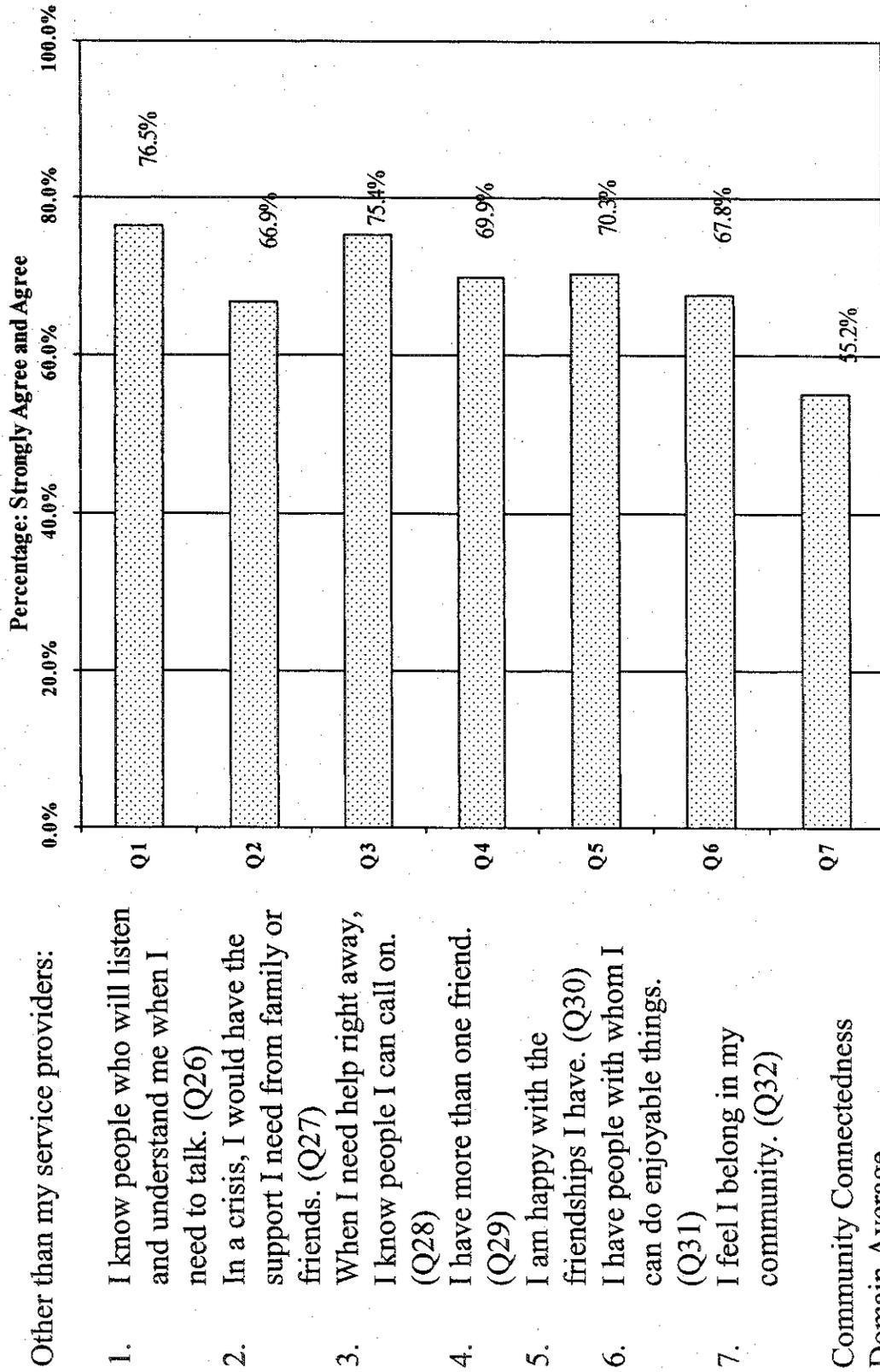
Recovery Domain Average

2004=73.8%

2005=74.4%



**DIG Adult Consumer Survey Community Connectedness:
2005**



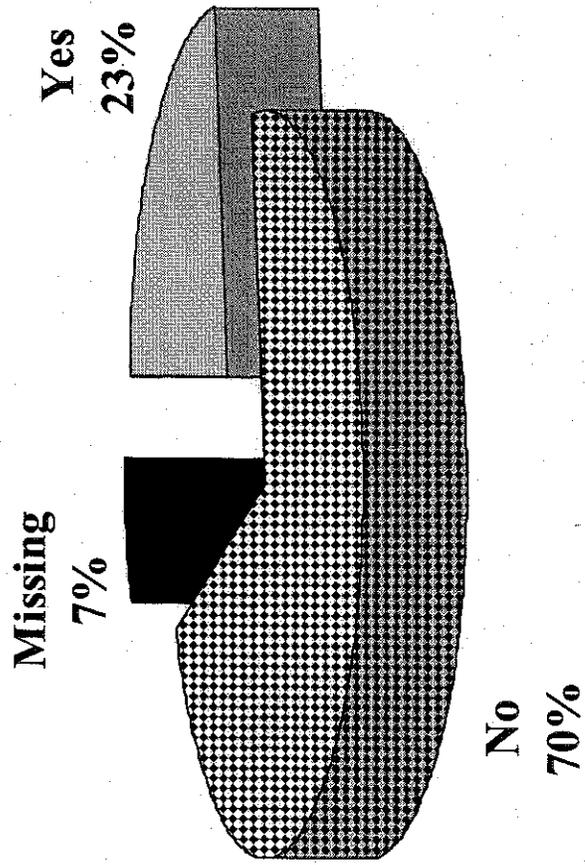
Other than my service providers:

1. I know people who will listen and understand me when I need to talk. (Q26)
2. In a crisis, I would have the support I need from family or friends. (Q27)
3. When I need help right away, I know people I can call on. (Q28)
4. I have more than one friend. (Q29)
5. I am happy with the friendships I have. (Q30)
6. I have people with whom I can do enjoyable things. (Q31)
7. I feel I belong in my community. (Q32)

Community Connectedness
Domain Average

2005=68.9%

Are you aware that Maine has a Mental Health Planning Council that advises the Department of Health and Human Services (BDS) on how it spends 1.8 million dollars a year in Federal Mental Health Block Grant monies?



2005 N=758

AMHI CONSENT DECREE

**The AMHI Consent Decree (Bates v. DHHS)
And The Role of The Statewide QIC**

The AMHI Consent Decree (Bates v. DHHS) was resolved in a Settlement Agreement, signed in August of 1990, between the Superior Court of Maine and The Department of Human Services and The Department of Mental Health and Mental Retardation in response to a class action suit filed on behalf of mental health consumers who were inpatients at Augusta Mental Health Institute from January 1, 1988 to the present. The intent of the Settlement Agreement is to assure the provision of a comprehensive mental health service system that will meet the individualized needs of all consumers. One method of proving compliance with the Settlement Agreement is the submission of a report regarding performance and quality improvement standards. One of the tasks of the Statewide Quality Improvement Council is to stay informed regarding DHHS compliance with the requirements of the Consent Decree Settlement Agreement. The goal of DHHS is to establish a comprehensive mental health system for all consumers, thereby coming into full compliance with the terms of the Settlement Agreement.

The performance standards enclosed in this packet are primarily used in monitoring, evaluation and quality assurance of the areas covered by the Consent Decree pertaining to the community mental health system.

Performance and Quality Improvement Standards ***March 2006***

The attached performance standards are primarily for use in monitoring, evaluation and quality assurance of the areas covered by the Consent Decree pertaining to the community mental health system. The standards are intended to offer the parties and the court master a means of measuring system function and improvement over time, and the Department's work towards compliance.

Definitions:

Standard Title: What the standard is intending to measure.

Measure Method: How the standard is being measured.

Baseline: The baseline represents the level of performance when the standards were first agreed upon at the end of the calendar year 2004

Current Level: The most recent data available for the Standard.

Some of the standards contained in this document continue to be developed and refined.

As a result performance data may not yet be available as the Measurement Methods, Baselines and

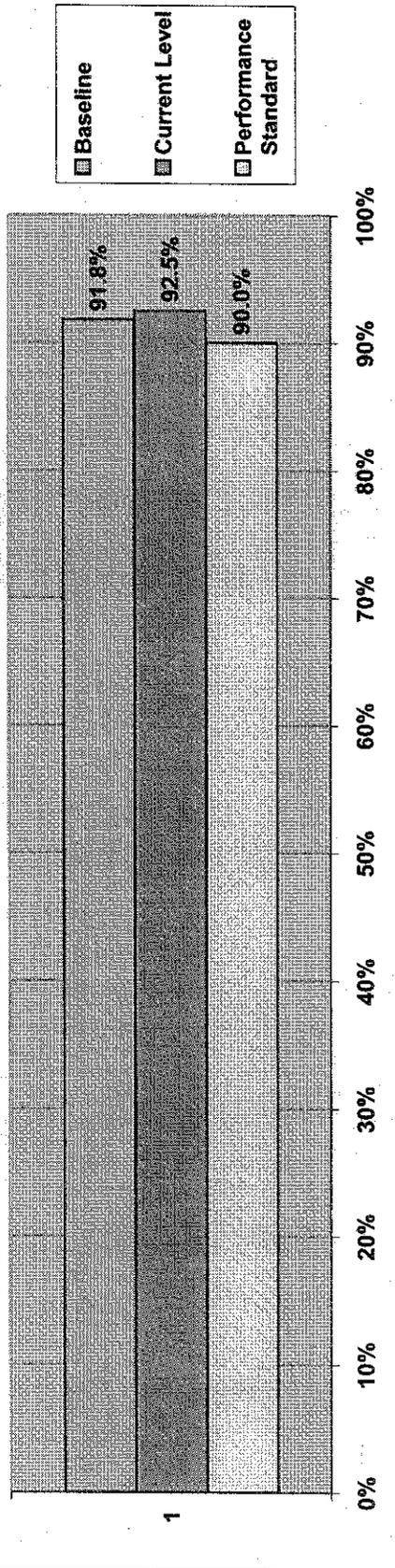
Current Levels continue to be developed. It is intended that with each update of this document, the data will become more complete.

****Low Numbers for some of the Measurement Methods in some instances can have an effect on the variance from quarter to quarter.**

****Some data systems, such as the UR Database, are undergoing continued refinement in terms of definitions and data collection practices. This can have some effect in the percentages from quarter to quarter.**

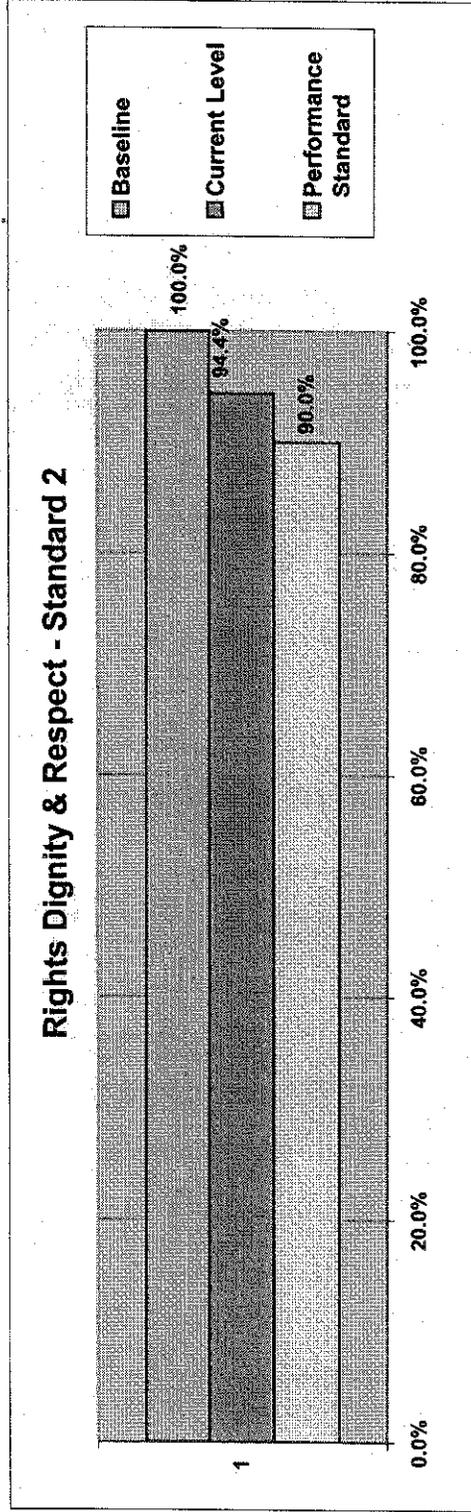
Rights, Dignity and Respect

Rights, Dignity & Respect - Standard 1



Paragraph	Standard 1:	Treated with respect for their individuality
32 a.	Meas. Method	Class Member Survey Q30. % Yes to "Have Service providers treated you with courtesy and respect?"
	Baseline	91.8% 2004 Class Member Survey
	Current Level	92.5% 2005 Class Member Survey
	Performance Standard	90.0%

Rights Dignity and Respect



Paragraph Standard 2:

32a Meas. Method

Baseline

Current Level

Performance Standard

Grievances are addressed in a timely manner

DHHS Grievance Tracking System - Response to Level II Grievances w/in 5 days or agreed upon extension.

100.0%

92.3%

90.0%

2003 Grievance Tracking data (15 out of 15)

2005 Grievance Tracking data (17 out of 18)

Rights, Dignity and Respect-Standard 3

Graph not available for Standard 3.

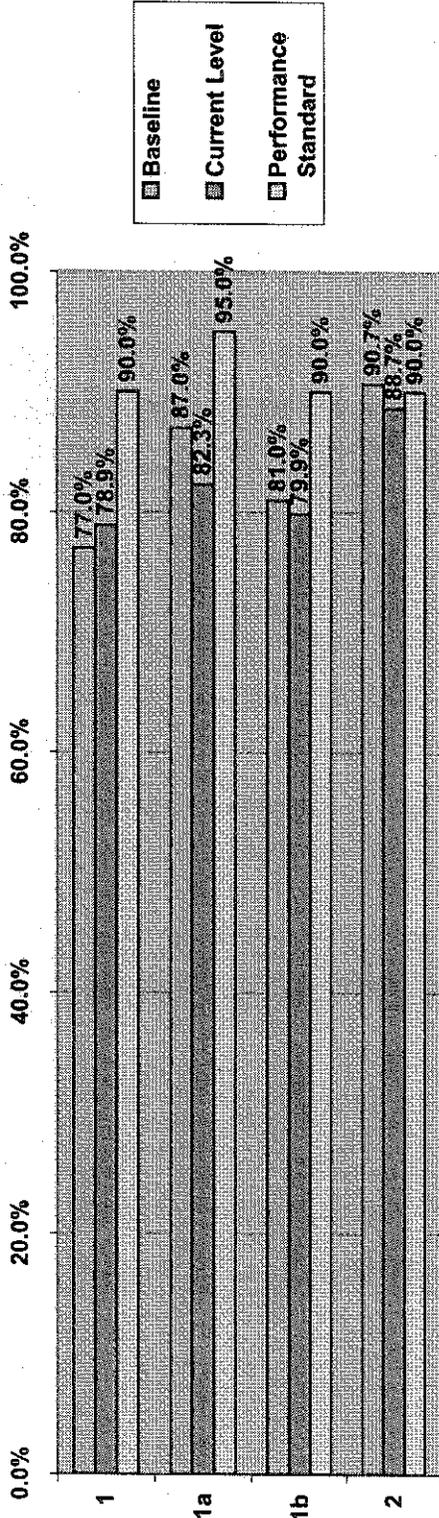
Paragraph Standard 3:
27 Meas Method 1: **Demonstrate rights are respected and maintained**
Baselines DHHS Grievance Tracking System, Number of Level II grievances filed and number unduplicated people
Current Level 11 Grievances, 7 Unduplicated individuals 2004 Calendar Year Grievance Tracking data.
18 Grievances, 14 Unduplicated individuals 2005 Calendar Year Grievance Tracking data.
Performance Standard No numerical standards necessary, ongoing monitoring of grievance trends.

**** Meas Method 2:** DHHS Grievance Tracking System, Number of Level II grievances filed where violation is substantiated.
and remedy applied.
Baselines 2003 Grievance Tracking, 15 grievances filed in 2003, 2 Cases resolved by mediation, 0 required remedies
Current Level 2005 Grievance Tracking, 18 grievances filed in 2003, 4 Cases required remedies/ plan of correction
submitted by the 2 agencies involved
Performance Standard No numerical standards necessary, ongoing monitoring of grievance trends.

Data revised from previous reports.

Rights, Dignity and Respect

Rights Dignity and Respect - Standard 4



Paragraph Standard 4:

57 Meas. Method 1.

Class Members are informed of their rights

Class Member Survey Q29. % class members informed about rights as a MH consumer in way they could understand.

Baseline	77.3%	2004 Class Member Survey (N=538)
Current Level	78.9%	2005 Class Member Survey (N=460)
Performance Standard	90.0%	

Meas. Method 1a.

Class Member Survey. Qs 25 & 29 % class members who have a CIW reporting they were informed about their rights

Baseline	87.0%	2004 Class Member Survey (N=538)
Current Level	82.3%	2005 Class Member Survey (N=460)
Performance Standard	95.0%	

Meas. Method 1b.

Class Member Survey. Qs 29 & 36 % class members who have MaineCare reporting they were informed about their rights.

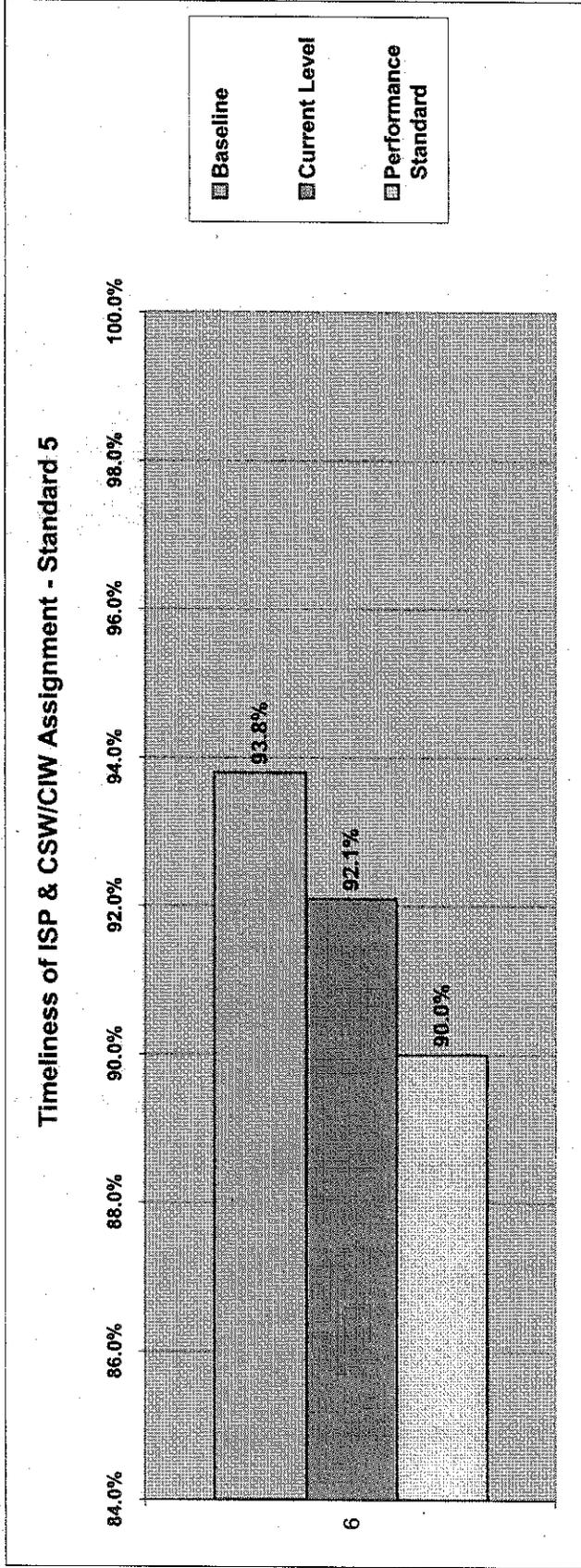
Baseline	81.0%	2004 Class Member Survey (N=538)
Current Level	79.9%	2005 Class Member Survey (N=460)
Performance Standard	90.0%	

Rights, Dignity and Respect

standard 4 cont.

Meas. Method 2.	Data Infrastructure Survey. Percent of consumers reporting they were given information about their rights
Baseline	90.7% 2003 Data Infrastructure Survey-Q14 (N=748)
Current Level	88.7% 2005 Data Infrastructure Survey-Q14 (N=758)
Performance Standard	90.0%

Community Integration/Community Support Services/Individualized Support Planning



Paragraph Standard 5: Prompt Assignment of C/I/CI/CM/ACT Workers, ISP Timeframes/Attendees at ISP Meetings

Percentage of class members requesting a worker who were assigned one.

**Wait List data to be updated to capture this information.

To be established

100.0%

**Wait List data to be updated to capture this information.

Percentage of hospitalized class members who were assigned a worker within 2 days.

**Enrollment data to be updated to capture this information.

To be established

90.0%

Community Integration/Community Support Services/Individualized Support Planning

Standard 5 Continued

Meas. Method 3.
Baseline Percentage of non-hospitalized class members assigned a worker within 3 days.
Current Level **Enrollment data to be updated to capture this information.
Performance Standard To be established
90.0%

Meas. Method 4.
Baseline Percentage of class members in hospital or community not assigned on time but were assigned within 1-7 additional days.
Current Level **Enrollment data to be updated to capture this information.
Performance Standard To be established
100.0%

Meas. Method 5.
Baseline ISP completed within 30 days of service request; Percentage of class members requesting ISP and who received one.
Current Level Forthcoming from the ISP-RDS
Performance Standard To be established
90.0%

This Method is a combination of the original Meas. Method 5 and Meas. Method 1b "Percentage of class members requesting and ISP who received one."

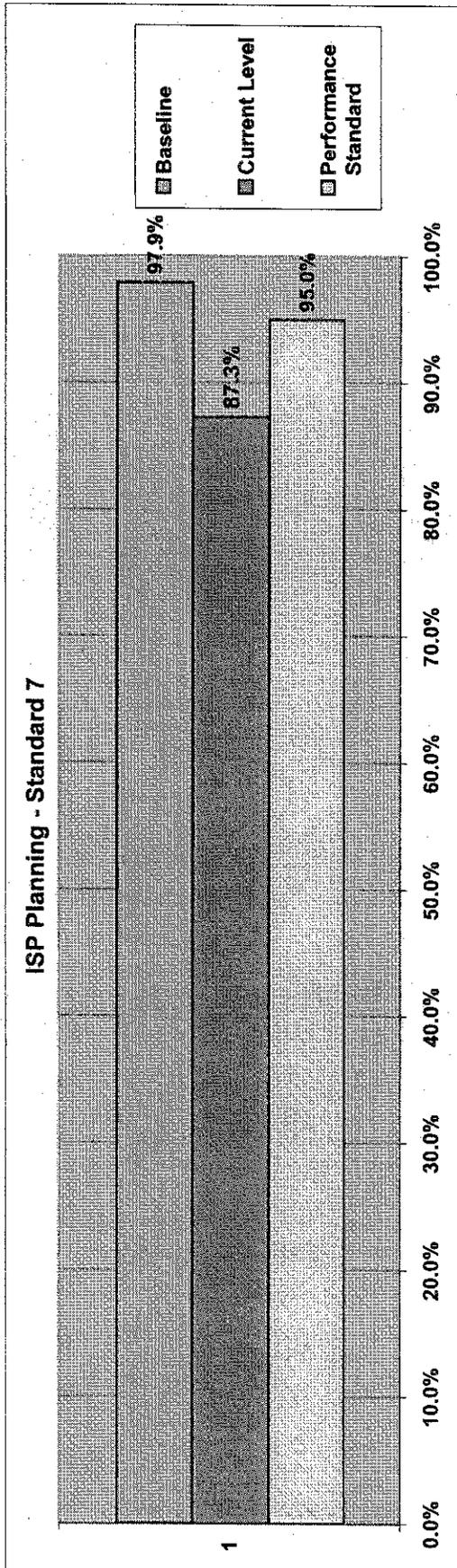
Meas. Method 6.
Baseline 90 day ISP review completed within specified timeframe.
Current Level 93.8% December 2004 ISP Overdue Data
Performance Standard 92.1% January 2006 ISP Overdue Data
90.0%

Meas. Method 7.
Baseline Initial ISPs not developed within 30 days, but were developed within 60 days
Current Level Forthcoming from the ISP-RDS
Performance Standard To be established
100.0%

Meas. Method 8.
Baseline ISPs that were not reviewed within 90 days but were reviewed within 120 days
Current Level Forthcoming from the ISP-RDS
Performance Standard To be established
100.0%

Note: There is no Standard #6 as those aspects are now covered in Standards #5 and #18.

Community Integration/Community Support Services/Individualized Support Planning



Paragraph Standard 7:

61 Meas. Method 1.

Baseline

Current Level

Performance Standard

Demonstrate ISPs are based upon consideration of the class members' strengths & needs

ISPs reviewed with evidence that strengths, needs and potential need for crisis services are considered.

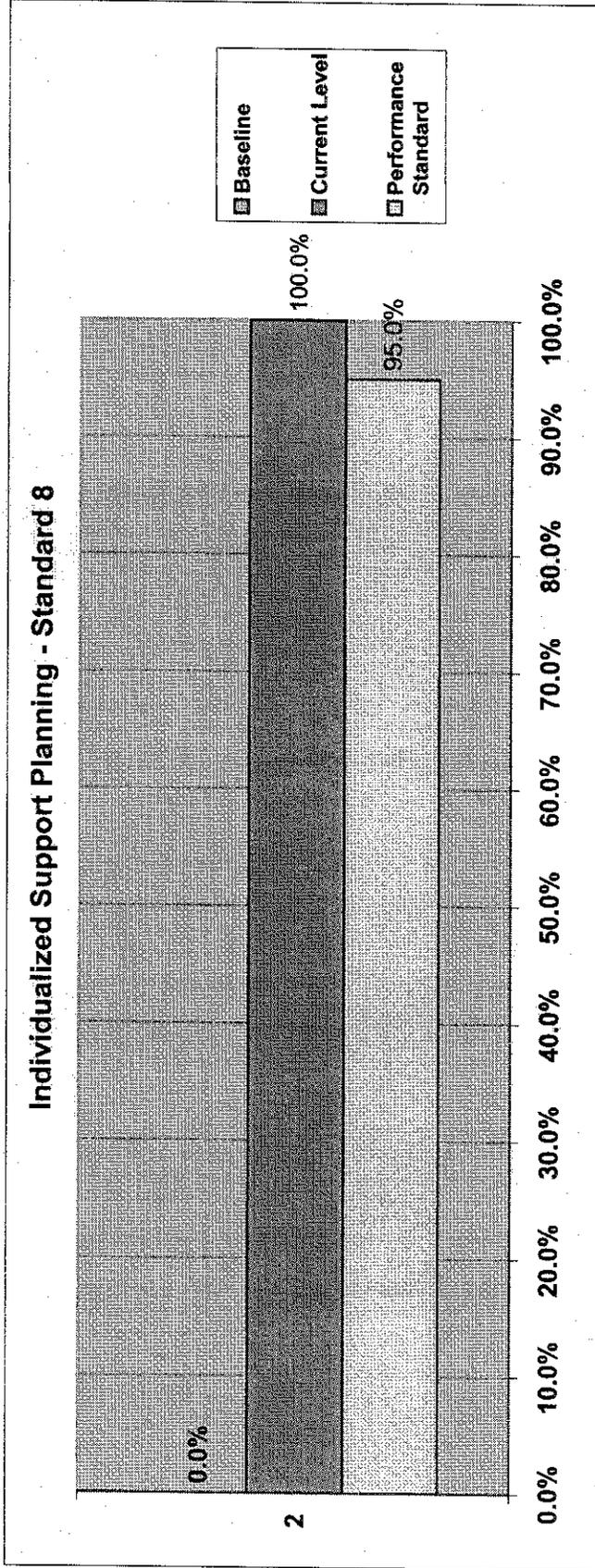
97.9% 2nd Q FY 05 ISP Document Review: Are Strengths and Barriers directly related to the goal (N=53)

87.3% 3rd Q FY 06 ISP Document Review: Are Strengths and Barriers directly related to the goal (N=74)

95.0%

This item to be redefined within the ISP Document Review to incorporate "potential need for crisis services are considered." Document Review process to be refined during the next quarter.

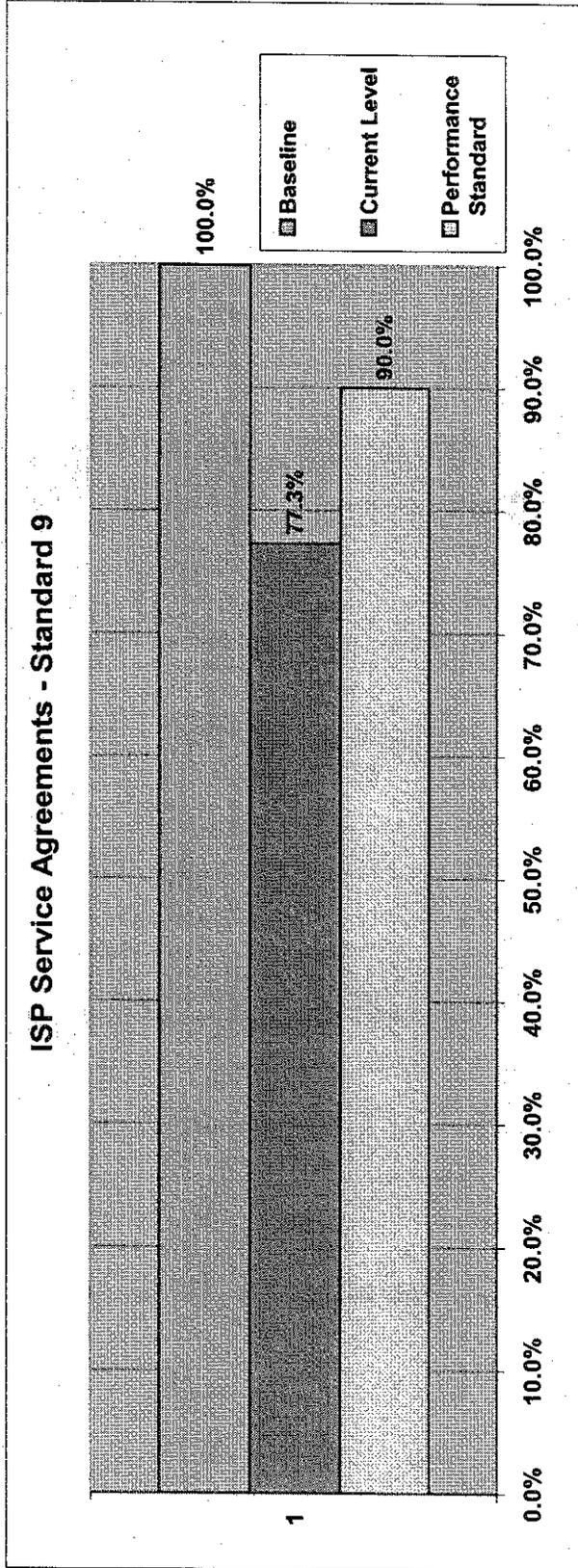
Community Integration/Community Support Services/Individualized Support Planning



Paragraph Standard 8: **Services are based on actual needs of the class member rather than what services are available**
 Meas. Method 1. ISPs reviewed in which there is evidence that the ISP team reconvened after an unmet need was identified.
 Baseline Item to be covered as the *ISP Document Review Process is refined.*
 Current Level 100.0%
 Performance Standard 90.0%

Meas. Method 2. ISPs reviewed with identified unmet needs in which interim plans are established.
 Baseline ** 2nd Q FY 05 ** No Unmet Needs Reported.
 Current Level 100% (1/1) 3rd Q FY 06 ISP Document Review: "Are unmet needs noted?" and "If yes, do the goals reflect interim planning?"
 Performance Standard 95%

Community Integration/Community Support Services/Individualized Support Planning



Paragraph Standard 9:

69 Meas. Method 1.

Baseline

Current Level

Performance Standard

Services to be delivered by an agency funded or licensed by the state.

ISPs with services identified and with a treatment plan signed by each provider.

100% (17/17) 2nd Q FY 05

77.3% (17/22) 3rd Q FY 06

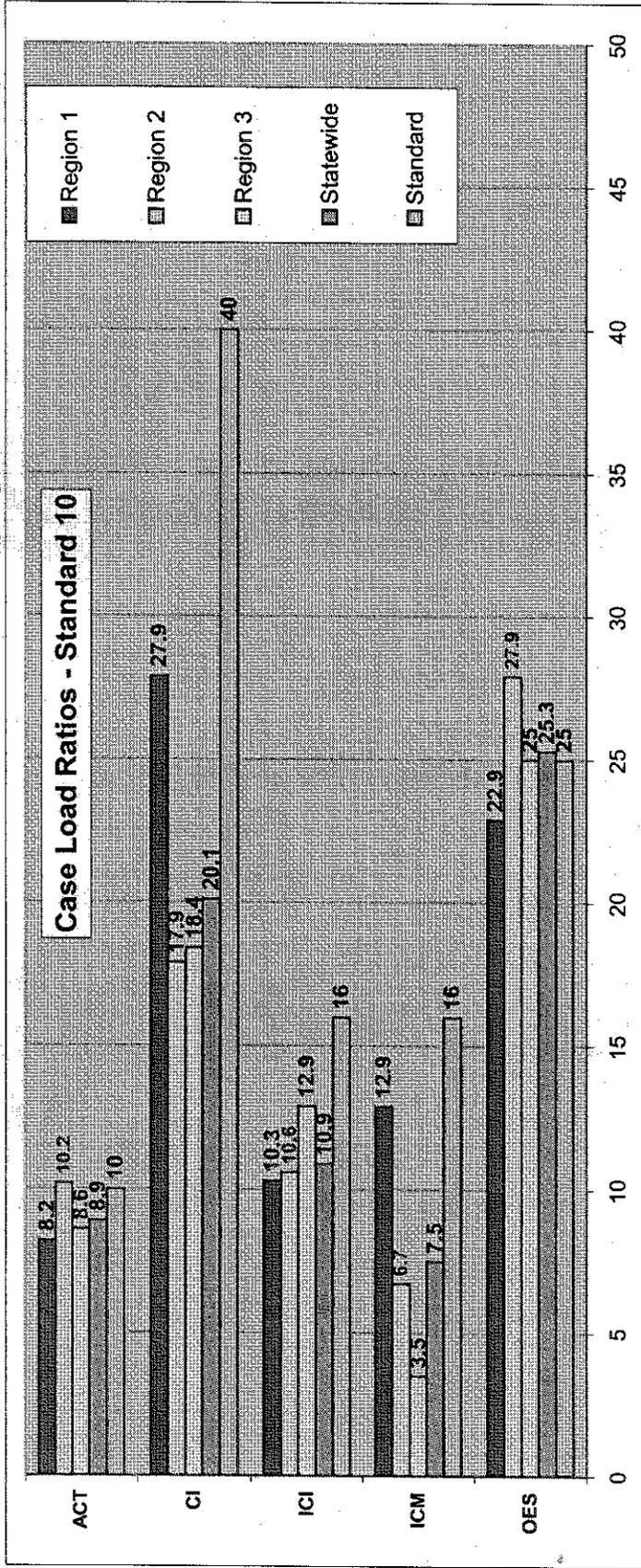
90.0%

"Are Service Agreements/treatment plans required?"

"if yes, have then been acquired?" and "if yes, are they current?"

must be acquired and current

Community Integration/Community Support Services/Individualized Support Planning- Standard 10



Standard 10: March 2006 Case Load Ratio Data Table

	Region 1	Region 2	Region 3	Statewide	Standard
Assertive Community Treatment	8.2	10.2	8.6	8.9	1:10
Community Integration	27.9	17.9	18.4	20.1	1:40
Intensive Community Integration	10.3	10.6	12.9	10.9	1:16
Intensive Case Management**	12.9	6.7	3.5	7.5	1:16
OES Public Ward Case Management	22.9	27.9	25.0	25.3	1:25

**OES Data - 2 workers have caseloads of 26, 1 has 28, 1 has 29 and 3 workers have caseloads of 30.

Standard 10 Cont.

Standard 10:
Ratio of Community Integration/Intensive Case Management ACT Services and OES Services

Paragraph 71	Meas. Method 1.	Community Integration Workers with average caseloads of 40 or fewer.
	Meas. Method 2.	Intensive Case Managers with average caseloads of 16 or fewer.
	Meas. Method 3.	ACT Providers with average caseloads of 10 or fewer.
	Meas. Method 4.	OES Case Managers with average caseload of 25 or fewer.

Community Integration/Community Support Services/Individualized Support Planning-Standard 11

- Paragraph Standard 11:**
74 Meas. Method 1
Performance Standard
Needs of Class Members not in service are considered in system design and services
Class members not in service reporting ISP related needs.
No numerical standard necessary, Trend data from Paragraph 74 will be utilized to guide and inform DHHS service and budget planning.
- Meas. Method 2**
Performance Standard
Class members without community integration workers reporting needs in areas of transportation, crisis services, mental health services, vocational services etc.
No numerical standard necessary, Trend data from Paragraph 74 will be utilized to guide and inform DHHS service and budget planning.

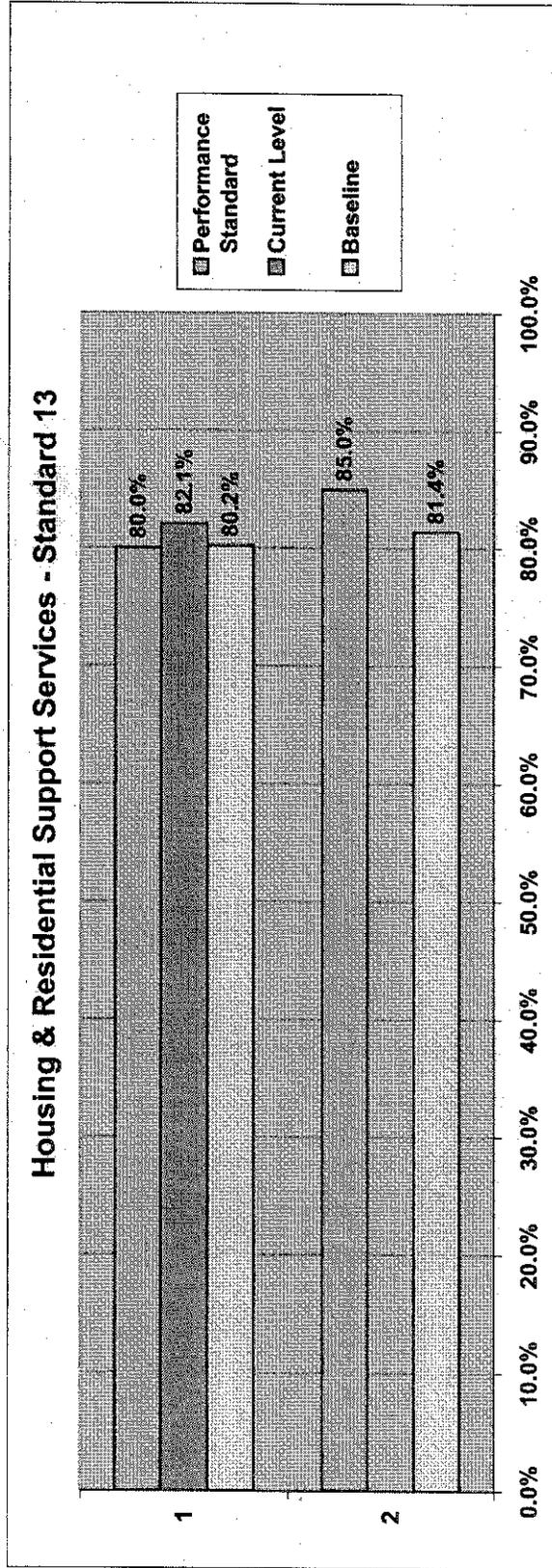
Unnets will be tracked through the ISP-RDS as completed by the CDC.

**Community Resources and Treatment Services
Housing and Residential - Standard 12**

Graph Not Available for Standard 12

- Paragraph 97.98 Standard 12:** A flexible array of residential services adequate to meet ISP identified needs of those ready for discharge
- Meas. Method 1.** Class members in community with ISPs with unmet residential support needs
- Baseline** To be established
- Current Level** To be established
- Performance Standard** 5% or fewer
- Meas. Method 2.** Percentage of class members at Riverview determined to have received maximum benefit from inpatient care, who are discharged within 15 days.
- Baseline** To be established
- Current Level** To be established
- Performance Standard** 75% (within 15 days of that determination.)
- Meas. Method 3.** Of the class members at Riverview determined to have received maximum benefit from inpatient care, lack of residential support services does not impede discharge
- Baseline** To be established
- Current Level** To be established
- Performance Standard** 96%-(within 30 days of that determination.)

**Community Resources and Treatment Services
Housing and Residential**



Paragraph Standard 13: Demonstrate class member satisfaction with access and quality of residential support services

97,98 Meas. Method 1.

Baseline

Current Level

Performance Standard

Annual Class Member Survey Q15, Percent reporting satisfaction with their current living situation.

80.2% 2004 Class Member Survey (N=538)

82.1% 2005 Class Member Survey (N=460)

80.0%

Meas. Method 2.

Annual Class Member Survey Q17, Class members receiving residential/housing supports who report satisfaction with services.

Baseline

Current Level

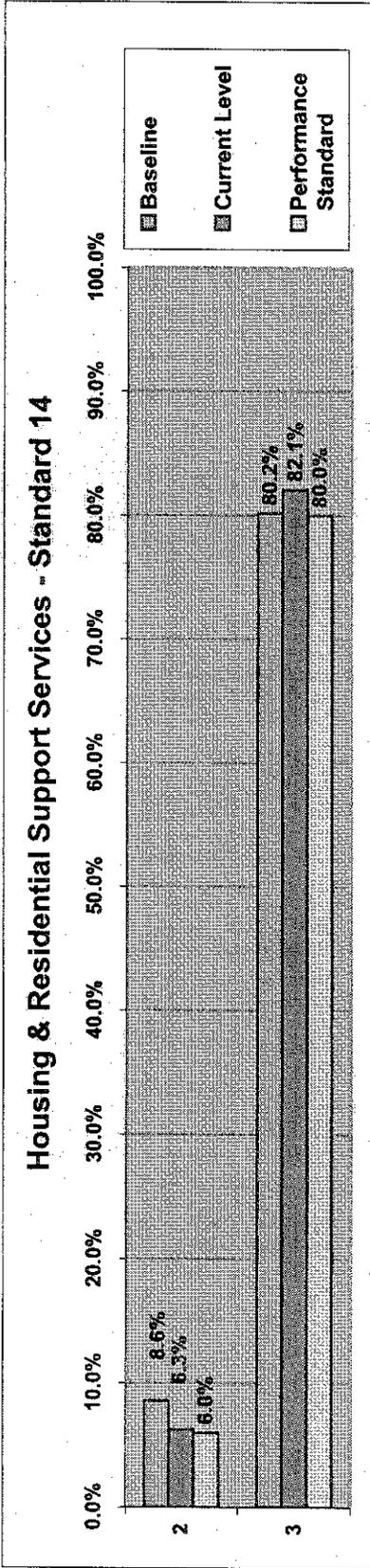
Performance Standard

81.4% 2005 Class Member Survey (N=538)

85.0%

(This question was new for this years' survey.)

**Community Resources and Treatment Services
Housing and Residential**



Paragraph Standard 14: **Demonstrate an array of housing alternatives available to meet class member needs.**

94, 95 Meas. Method 1.

Baseline

Class members with ISPs with unmet housing resource needs.

Current Level

To be established pending availability of data from ISP-RDS

Performance Standard

To be established pending availability of data from ISP-RDS

10.0% or fewer

Meas. Method 2.

Percentage of Class Members who experienced homelessness over 12-month period.

Baselines

8.6% 2004 Class Member Survey (N=538)

Current Levels

6.3% 2005 Class Member Survey (N=460)

Performance Standard

6.0% or fewer

**Stats updated on Meas. Method 2 updated from previous report.

Meas. Method 3.

Annual Class Member Survey Q15, Percent reporting satisfaction with their current living arrangement.

Baseline

80.2% 2004 Class Member Survey (N=538)

Current Level

82.1% 2005 Class Member Survey (N=460)

Performance Standard

80.0%

Meas. Method 4.

Percentage of class members at Riverview determined to be ready for discharge from Riverview who are discharged within 1 week of that determination.

Baseline

To be established

Current Level

To be established

Performance Standard

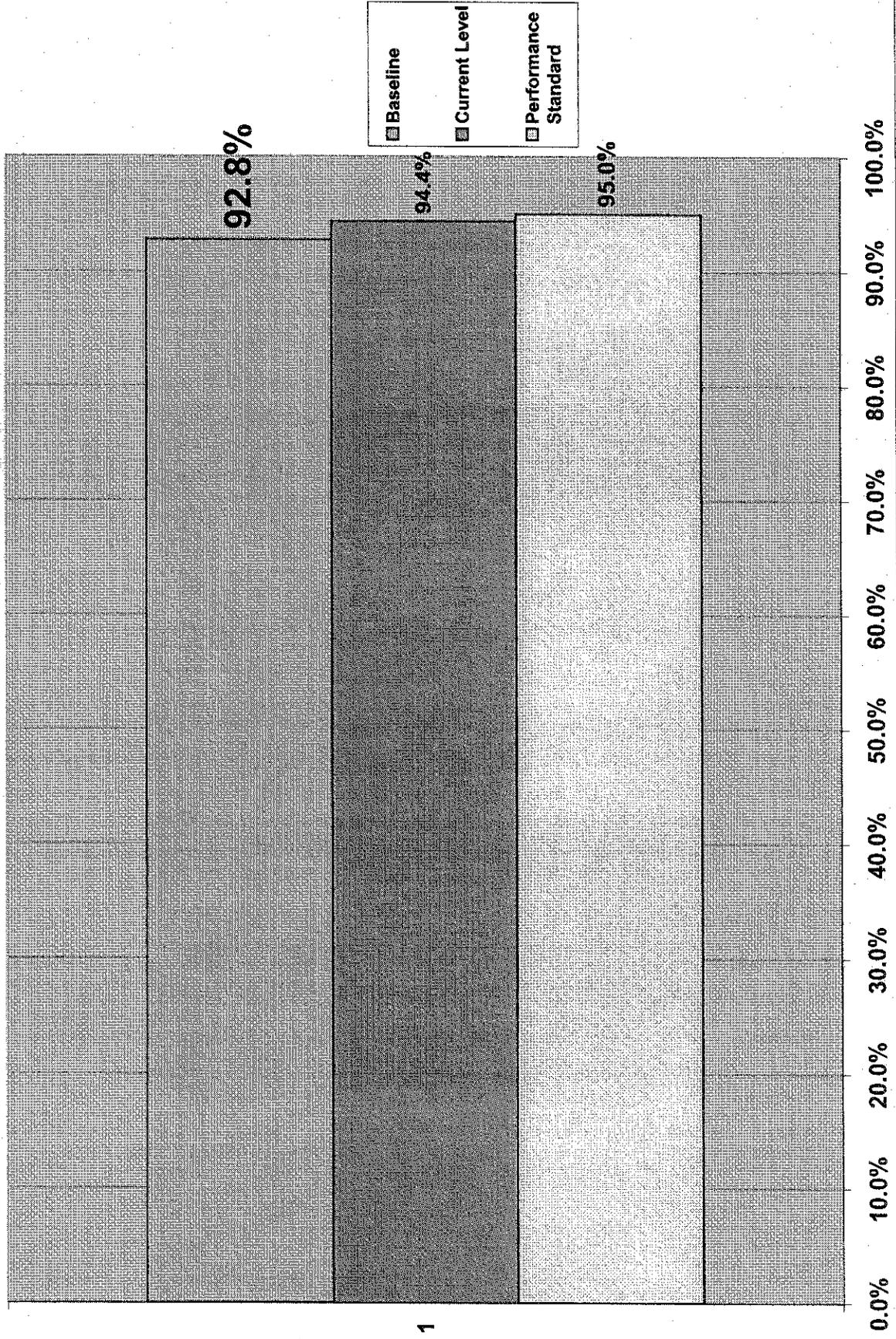
75% (Lack of residential support services does not impede discharge within 15 days of that determination.)

**Community Resources and Treatment Services
Housing and Residential Support Services**

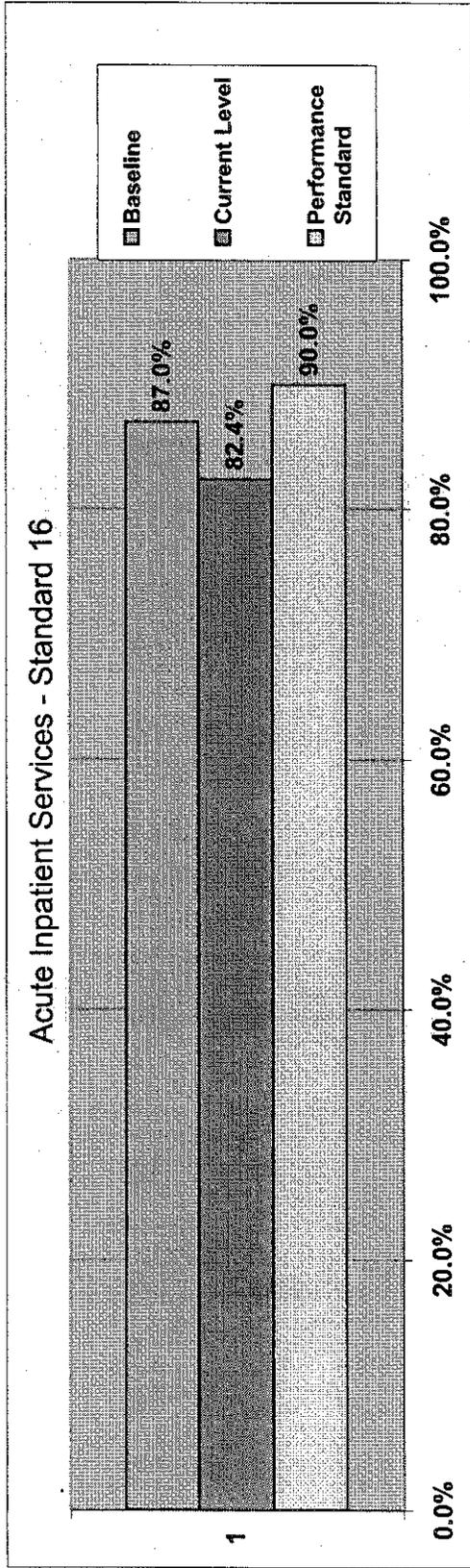
Standard 14 Continued

Meas. Method 5.	Percentage of hospitalized class members determined to be ready for discharge from Riverview who are discharged within 30 days of that determination.
Baseline	To be established
Current Level	To be established
Performance Standard	96%-(Lack of residential support services does not impede discharge within 30 days of that determination.)

Housing/Residential - Standard 15



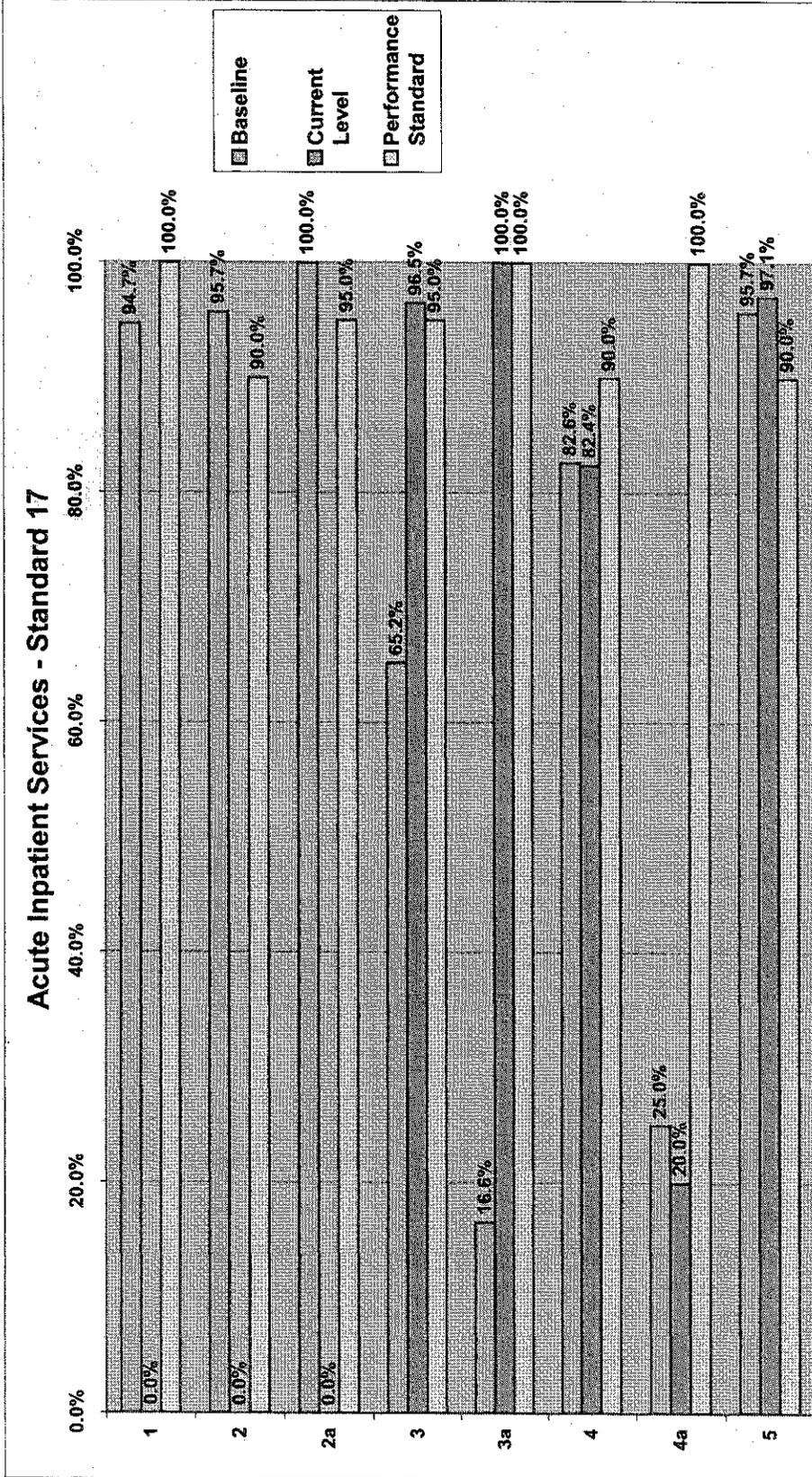
Community Resources and Treatment Services
Acute Inpatient Services



Paragraph 88 Standard 16: *Psychiatric Hospitalization reasonably near an individual's local community.*
Meas. Method 1. Class Member admissions determined to be reasonably near an individual's local community of residence.
Baseline 87.0% UR Database Q1-FY '05 (20 out of 23)
Current Level 82.4% UR Database Q3-FY '06 (28 out of 34)
Performance Standard 90.0%

**Currently defined as a hospitalized in the same county of residence or within a contiguous county.

Community Resources and Treatment Services
Acute Inpatient Services



Paragraph Standard 17: Class member admissions to community involuntary inpatient units are in accordance with law and meet medical necessity criteria

Class member involuntary admissions to community inpatient units have blue paper on file.

89 Meas. Method 1.

Baseline

94.7% UR Database Q4-FY '05

(18 out of 19)

Current Level

97.1 UR Database Q3-FY '06

(33 out of 34)

Performance Standard

100.0%

Performance and Quality Improvement Standards: Settlement Agreement

Indicator 17 continued

Meas. Method 2.

Baseline

Blue paper was completed and in accordance with terms.

95.7% UR Database Q1-FY '05 (22 out of 23)

Current Level

97.1 UR Database Q3-FY '06 (33 out of 34)

Performance Standard

90.0%

Meas. Method 2a.

Baseline

Corrective action taken by UR nurse where blue paper not completed in accordance with terms.

100.0% UR Database Q4-FY '05 (4 out of 4)

Current Level

0.0% UR Database Q3-FY '06 (0 out of 1)

Performance Standard

95.0%

Meas. Method 3.

Baseline

Class member involuntary admissions to community inpatient units in which 24 hour cert completed.

65.2% UR Database Q1-FY '05 (15 out of 23)

Current Level

96.5% UR Database Q3-FY '06 (28 out of 29)

Performance Standard

95.0%

Meas. Method 3a.

Baseline

Corrective action taken by UR nurse where 24 hour recertification was not completed.

16.6% UR Database Q1-FY '05 (1 out of 6)

Current Level

100.0% UR Database Q3-FY '06 (1 out of 1)

Performance Standard

100.0%

Meas. Method 4.

Baseline

Class member involuntary admissions to community inpatient units in which patients' rights were maintained.

82.6% UR Database Q1-FY '05 (19 out of 23)

Current Level

82.4% UR Database Q3-FY '06 (28 out of 34)

Performance Standard

90.0%

Meas. Method 4a.

Baseline

Corrective action taken by UR nurse where documentation showed patients' rights not maintained.

25.0% UR Database Q1-FY '05 (1 out of 4)

Current Level

20.0% UR Database Q3-FY '06 (1 out of 5)

Performance Standard

100.0%

Meas. Method 5.

Baseline

Class member involuntary admissions for which medical necessity has been established.

95.7% UR Database Q1-FY '05 (22 out of 23)

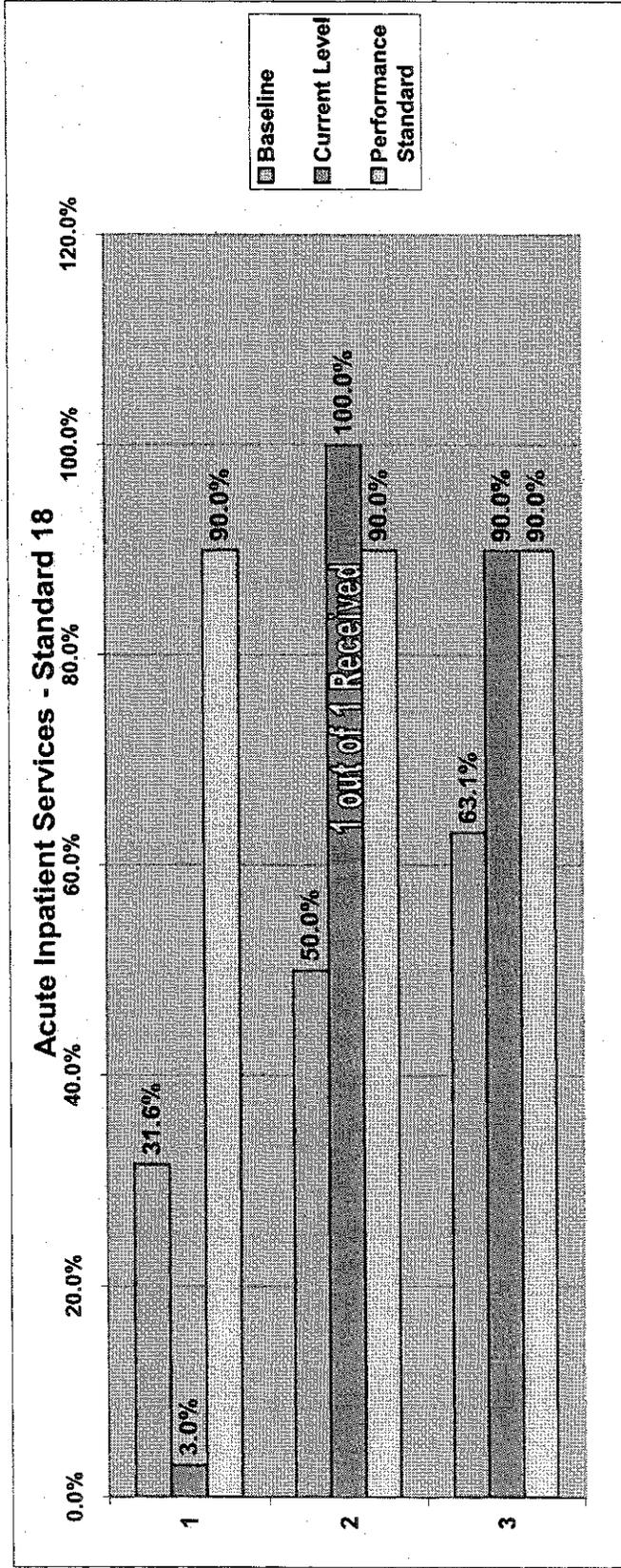
Current Level

97.1% UR Database Q3-FY '06 (33 out of 34)

Performance Standard

90.0%

Community Resources and Treatment Services
Acute Inpatient Services



Paragraph Standard 18: Continuity of Treatment is maintained during hospitalization in community inpatient settings

Class members admitted with ISPs for whom hospital obtained ISP.

31.6% UR Database Q1-FY '05 (6 out of 19)

3.0% UR Database Q3-FY '06 (1 out of 30)

90.0%

Performance Standard

Treatment and discharge plan were determined to be consistent with ISP goals and objectives.

50.0% UR Database Q4-FY '05 (1 out of the 2 received)

100.0% UR Database Q3-FY '06 (1 out of the 1 received)

90.0%

Performance Standard

**Community Resources and Treatment Services
Acute Inpatient Services**

Standard 18 continued

Meas. Method 3.

Baseline

C/I/IC/ICM/ACT worker participated in hospital treatment and discharge planning.

63.1% UR Database Q1-FY '05 (12 out of 19)

Current Level

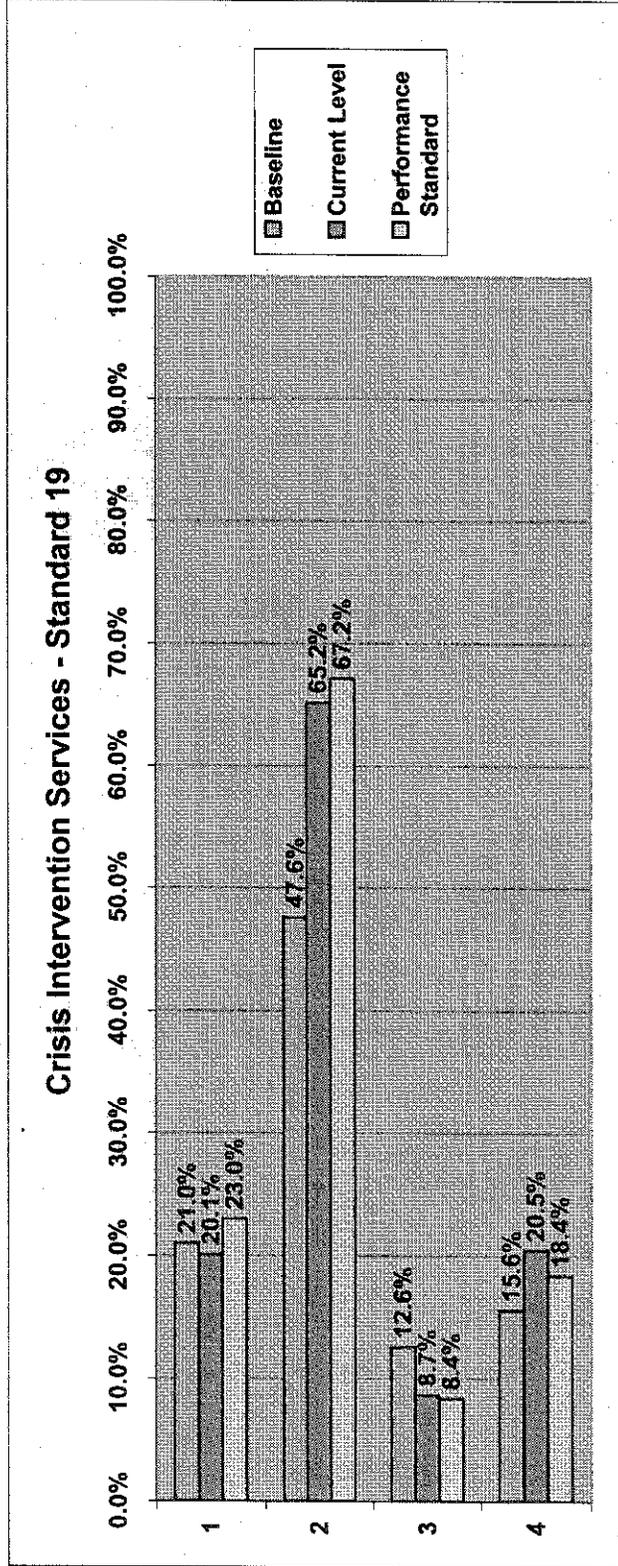
90.0% UR Database Q3-FY '06 (28 out of 30)

Performance Standard

90.0%

****Low Ns for some of the Measurement Methods in some instances can have an effect on the variance from quarter to quarter.
Some data systems, such as the UR Database are undergoing continued refinement in terms of definitions and data collection practices. This can have some effect in the percentages from quarter to t quarter.

**Community Resources and Treatment Services
Crisis Intervention Services**



Paragraph Standard 19: Crisis services are effective and meet Settlement Agreement Standards.
99, 100 Meas. Method 1. Quarterly Contract Performance Data: Face to face crisis contacts that result in hospitalizations.
Baseline 21.0% Performance Indicator Data - Average quarterly % for first three quarters FY 2004
Current Level 20.1% 2nd Qtr FY 2006 (1229 out of 6101)
Performance Standard 20-25% or less

Meas. Method 2. Face to face crisis contacts that result in follow-up and/or referral to community based services.
Baseline 47.6% Performance Indicator Data - Average quarterly % for first three quarters FY 2004
Current Level 65.2% 2nd Qtr FY 2006 (3980 out of 6101)
Performance Standard 67.15%

**Community Resources and Treatment Services
Crisis Intervention Services**

Standard 19 continued

Meas. Method 3. Face to face crisis contacts in which a previously developed crisis plan was available and used.
Baseline 12.6% Performance Indicator Data - 2nd Qtr FY 05
Current Level 8.7% 2nd Qtr FY 2006 (530 out of 6101)
Performance Standard 8.4%

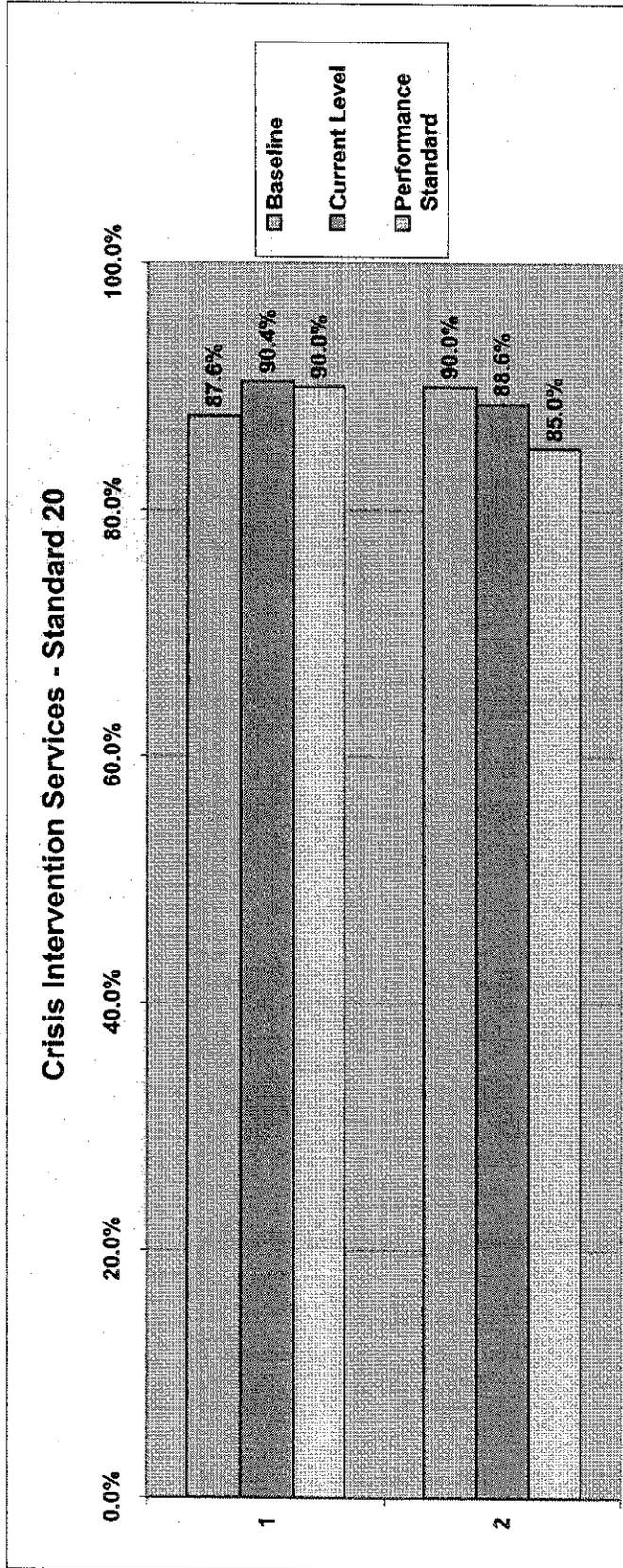
This represents all consumers who received crisis services, it includes individuals for whom this may be the first point of contact with MH services and thus would not have a crisis plan.

Meas. Method 4. Face to face crisis contacts in which client has a CI worker and worker was notified about the crisis.
Baseline 15.6% Performance Indicator Data - 2nd Qtr FY 05
Current Level 20.5% 2nd Qtr FY 2006 (1253 out of 6101)
Performance Standard 18.4%

This represents all consumers who received crisis services, it includes individuals for whom this may be the first point of contact with MH services and thus would not have a case manager.

Performance Standards were developed based on an average of the past year.

Community Resources and Treatment Services
Crisis Intervention Services



Paragraph Standard 20: Class member satisfaction with the availability and quality of crisis intervention services.

99, 100 Meas. Method 1. Class members reporting that they know how to get help in a crisis when they need it-Q2.

Baseline 87.6% 2004 Class Member Survey (N=538)

Current Level 90.4% 2005 Class Member Survey (N=460)

Performance Standard 90.0%

Meas. Method 2. Class members reporting that crisis services were available when needed-Q4.

Baseline 83.3% 2004 Class Member Survey (N=538)

Current Level 88.6% 2005 Class Member Survey (N=460)

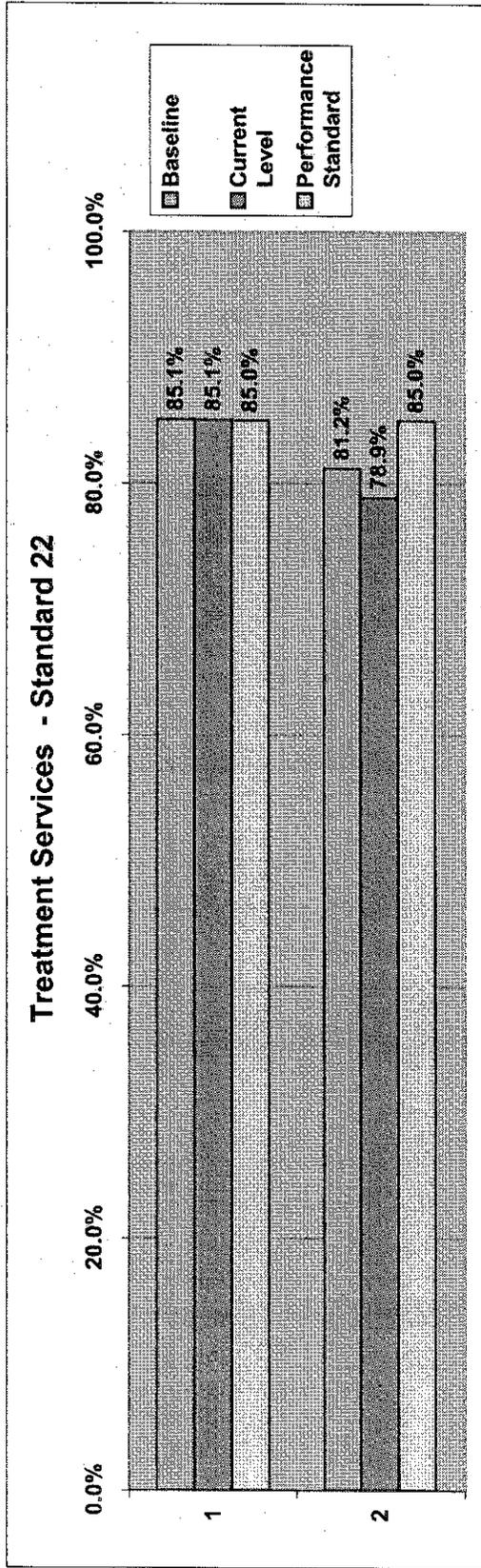
Performance Standard 85.0%

**Community Resources and Treatment Services
Treatment Services - Standard 21**

Graph Not Available for Standard 21

Paragraph Standard 21:	An array of mental health treatment services are available and sufficient to meet ISP needs of class members and the needs of hospitalized class members ready for discharge.
103 Meas. Method 1.	Class members with ISPs with unmet mental health treatment needs
Baseline	To be established pending availability of data from ISP-RDS.
Current Level	To be established
Performance Standard	5% or fewer
Meas. Method 2.	Patients at Riverview, ready for discharge, who are discharged within one week of that determination
Baseline	To be established
Current Level	To be established
Performance Standard	A lack of treatment services does not impede the discharge of 75% of Riverview patients deemed ready for discharge for more than 15 days of that determination.
Meas. Method 3.	Patients at Riverview, ready for discharge, who are discharged within 30 days of that determination
Baseline	To be established
Current Level	To be established
Performance Standard	96%-(Lack of residential support services does not impede discharge within 30 days of that determination.)
Meas. Method 4.	Of the class members at Riverview, determined ready for discharge, lack of housing does not impede discharge within 45 days of that determination
Baseline	To be established
Current Level	To be established
Performance Standard	100%
Meas. Method 5.	MaineCare data demonstrates by mental health service category that class members use an array of mental health treatment services.
Performance Standard	No Numerical Standard Necessary

**Community Resources and Treatment Services
Treatment Services**



Paragraph Standard 22: **Class members are satisfied with access and quality of MH treatment services received.**

103 Meas. Method 1. Annual Class Member Survey Q1, % Yes "Can you get the mental health services and supports you feel you need?"

Baseline	85.1%	2004 Class Member Survey (N=538)
Current Level	85.1%	2005 Class Member Survey (N=460)
Performance Standard	85.0%	

Meas. Method 2. Annual Class Member Survey Q12, % reporting satisfaction with MH services/supports received in past year.

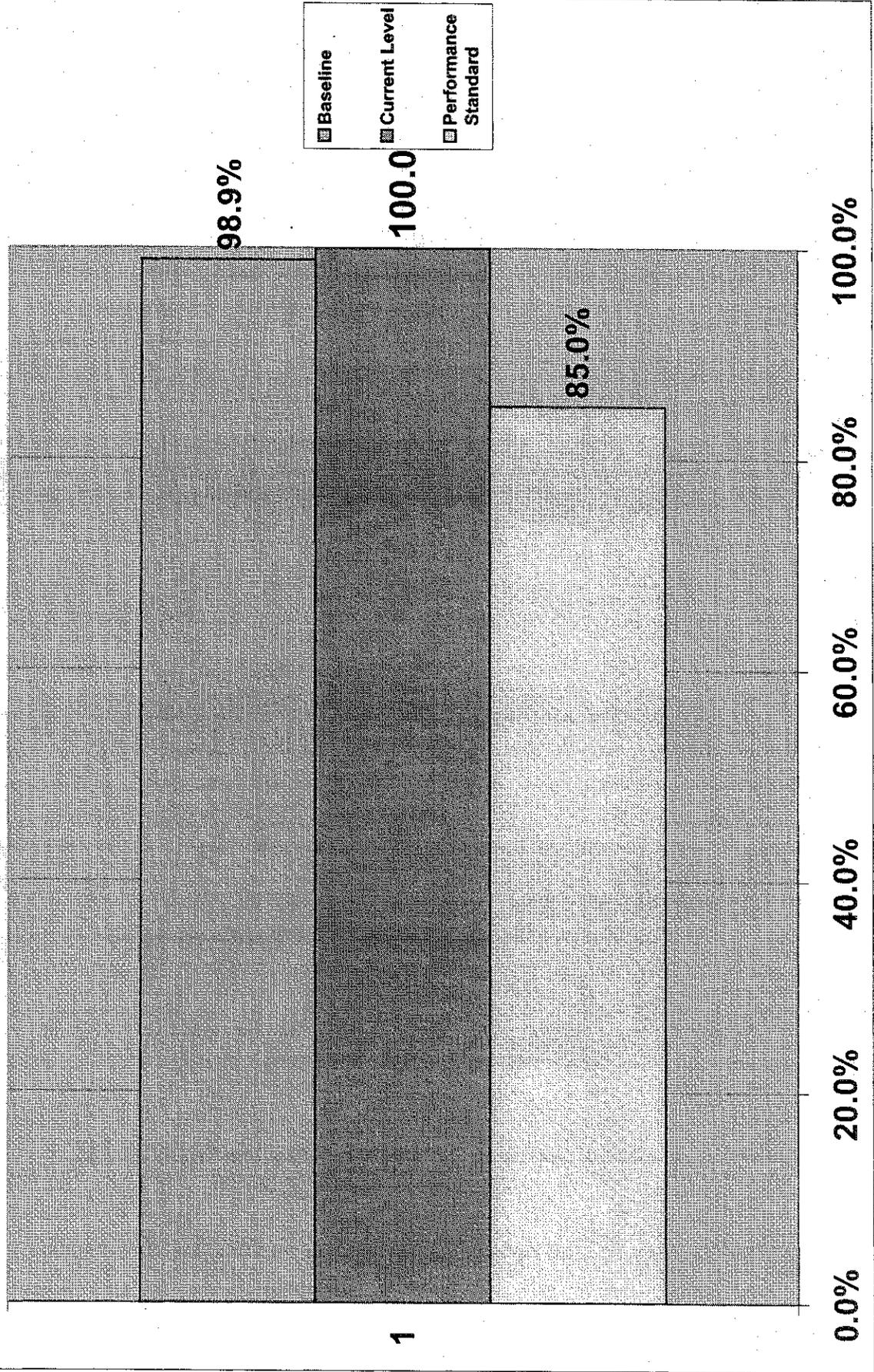
Baseline	81.2%	2004 Class Member Survey (N=538)
Current Level	78.9%	2005 Class Member Survey (N=460)
Performance Standard	85.0%	

**Community Resources and Treatment Services
Family Support Services**

Graph Not Available for Standard 23

Paragraph 109	Standard 23:	Demonstrate provision of an array of family support services as per Settlement Agreement
	Meas. Method 1.	Number of education programs developed and delivered meeting Settlement Agreement requirements
	Baseline	<i>To be established</i>
	Current Level	<i>To be established</i>
	Performance Standard	<i>No standard necessary</i>
	Meas. Method 2.	Number and distribution of family support services provided
	Baseline	<i>To be established</i>
	Current Level	<i>To be established</i>
	Performance Standard	<i>No standard necessary</i>

Family Support Services - Standard 24



APPENDIX

THE EVOLUTION OF FEDERAL MENTAL HEALTH PLANNING LEGISLATION (2005)

By ©: Joseph N. de Raismes, III

Beginning with the passage of Public Law 99-660 in 1986, and continuing through Public Law 101-639 (1990), Public Law 102-321 (1992), and Public Law 106-310 (2000), the federal government has mandated mental health planning as a condition for receipt of federal mental health block grant funds and has mandated participation by stakeholder groups, including people living with mental illness and their families, in the planning process. The nature of the federal mandates and the state response have evolved over time, and states and advocates find themselves in a very different situation now than in 1986, when the mandates began. This paper will trace that evolution and reflect on the enhanced role of state planning and advisory councils.

The original concept was to condition part of the mental health block grant on compliance with federal mandates concerning deinstitutionalization, case management and outreach to the homeless. These were ill-defined from the beginning and became more so when a separate children's plan and outreach to rural areas were added to the federal mandates. And the whole legislation was flawed from the start by its effort to mandate state spending to improve mental health services, coupled with an express prohibition of any such requirement, known in the original legislation as the "Quayle Amendment," one of the few legislative monuments to the former Vice President. The statute as a whole can be accurately described as an unfunded mandate coupled with a denial that that is what is intended.

But it is also a revolutionary exercise in mental health planning and stakeholder and federal review of state plans. As such, it responds directly to the World Health Organization's central recommendation in its *Mental Health Policy, Plans and Programs* (Revised 2004). It is a quintessentially American process for the development of state mental health policy under limited federal oversight. The federal government has taken on a collaborative rather than a regulatory role, and the states have responded with real systems change initiatives, beginning with closing state hospitals and continuing with development of community-based treatment. At the same time, recent loss of state and federal funding and lack of linkage to Medicaid (social welfare) policy have limited the leverage of state mental health planning.

The core mandate for the states to plan and to review "comprehensive" plans with the federal government was the only part of the original idea that survived the 2000 amendments, although all of the original goals remain in a vestigial form, as plan components. The one remaining point of contention is the plan implementation requirement. A plan is not a promise, not a contract. The plan

IJD Harvard (1970). Retired City Attorney, Boulder Colorado (1979-2003), City Manager (1990-1991), First Assistant Attorney General, State of Colorado (1975-1979). Chair of NAMHPAC (1994-2002).

implementation/sanction component of federal mental health planning legislation is thus an anomaly at best, left over from the original mandate concept.

This part of the mental health planning law, and the related "maintenance of state effort" requirement have been controversial, more or less skillfully ignored in practice, and remain to be worked out in the next Congress. This issue will need to be resolved in the next iteration of the "performance partnerships" that the 2000 legislation directed to be developed, although the terminology is shifting from "partnership" to "transformation," since President Bush's New Freedom Commission called for new energy and resources to deal with mental illness in America. The "transformation" work plan is hung up in the federal bureaucracy and seems not to be a priority in Congress so far. Since the word has little content, advocates cannot be faulted for hoping that the promise of systems change may imply, to facilitate recovery, consideration of paying for comprehensive psychosocial rehabilitation to make community-based mental health care work. Unfortunately, it appears thusfar that the Bush human services budgets will shatter that dream.

The federal agency now in charge of the block grant is SAMHSA, the Substance Abuse and Mental Health Services Administration, and the Center for Mental Health Services within it ("CMHS"). Since the 1992 transfer of the block grant from the National Institutes of Mental Health, the successor agency SAMHSA has advocated increased funding of the mental health block grant, and, in a productive alliance with advocacy groups, has had some success in Congress. CMHS has supported the block grant review functions by recruiting grass roots reviewers, drawn from planning and advisory councils and mental health advocacy groups, and has convened annual conferences to discuss mental health planning issues and empower the planning and advisory councils ("pacs"). An association has been formed that provides planning and advisory council training and promotes federally supported evidence based practices that include, but are broader, than the original goals of children's systems of care, deinstitutionalization, case management and homeless and rural response. The pacs' organization, NAMHPAC, is discussed at the end of this history.

The federal block grant legislation tries to use the block grant to drive systems change in states emerging gradually from the discredited past of sometimes brutal and negligent state hospitals and inadequate community support systems. Although the deinstitutionalization and case management mandates that drove the legislation in 1986 are now gone, restrictions on block grant funding of mental health centers that do not provide full transition services is still in the statute. And since 2000, the plan has been the driver, not the old mandates. One of the immutable features of the legislation has been the directive to the states to develop (or at least to describe how they might develop) a comprehensive system of care for adults with serious mental illness and for children with serious emotional disturbance. Comprehensiveness is the one remaining mandate.

The legislation has also mandated the involvement of certain state agencies as members of planning and advisory councils, which are an important innovation of federal mental health planning law. Medicaid administrators and others, especially education and criminal justice agencies, have,

however, not given priority to listening to or interacting with the pacs. The current law with regard to the pacs is as follows:

42 USC Sec. 300x-3. - State mental health planning council

(a) In general

A funding agreement for a grant under section 300x of this title is that the State involved will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) Duties

A condition under subsection (a) of this section for a Council is that the duties of the Council are -

(1) to review plans provided to the Council pursuant to section 300x-4(a) of this title by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;

(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems; and

(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c) Membership

(1) In general

A condition under subsection (a) of this section for a Council is that the Council be composed of residents of the State, including representatives of-

(A) the principal State agencies with respect to -

(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and

(ii) the development of the plan submitted pursuant to title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) [Medicaid];

(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) the families of such adults or families of children with emotional disturbance.

(2) Certain requirements

A condition under subsection (a) of this section for a Council is that -

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to

provide adequate representation of such children in the deliberations of the Council;
and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

42 USC Section 300x-3

Although this model assures real grass-roots participation, and the last paragraph gives control to non-providers of service, many terms, like "provider," need definition: For example, does a peer-to-peer service make a peer into a provider, and does it matter for how much time or for how much money? The parental participation language is also ambiguous in light of the prevalence of children's advocates whose children are no longer young. And the dearth of cultural competence and diversity and the difficulty of maintaining geographical representation make membership a tough issue for all pacs.

Pacs have had to become active in membership vetting and recruitment to maintain energy and diversity. State agency participation is often a problem. In particular, Medicaid administrations have not been closely linked with planning councils in practice. This needs to change, and pacs are working hard to advocate for Medicaid services for people with mental illnesses. The pacs are asking: How comprehensive can a plan or system of care be if it does not take into account the majority of the spending?

With Medicaid accounting for well over 50% of community-based service provision by itself and the child welfare, juvenile justice and education departments in most states purchasing three to four times the amount of mental health services for kids than the mental health system, plus related jobs and vocational rehabilitation programs, how comprehensive is the block grant perspective? The block grant averages under three percent of state mental health funding. One is compelled to ask: Isn't the block grant legislation ultimately the tail trying to wag the dog? But the answer is more complex. Between Medicaid, Medicare, and other sources of federal funding, the federal government has an enormous stake in the effectiveness of state mental health programs. And the federal mental health planning legislation is how Congress has chosen to pursue those interests. The issue for the pacs is how to make this planning process work in practice.

THE FOUR STATUTES

The focus of this paper is on understanding the evolution of the mental health block grant regulatory process under four successive statutes:

PL 99-660 (1986)

Beginning with PL 99-660, the general goal was enunciated of: "the establishment and . . . implementation of an organized community-based system of care for chronically mentally ill individuals." This goal statement focused on three planning elements: (1) organization of a system, that is, state-wide assurance of continuity of care and state-wide assurance of availability of a full spectrum of needed services; (2) a community-based system, that is, a system in which community-based care is generally preferred over institutional care; and (3) focus on people with chronic mental illness, as opposed to what some advocates have inappropriately but effectively referred to as the "walking worried," or other populations less in need of mental health services. The federal mandate covers only the most needy.

This goal statement was to be implemented by state-by-state development of plans to meet "quantitative targets" which would include: (4) a census of people with chronic mental illness in need of service, (5) services to enable such individuals to "gain access to mental health services," (6) "rehabilitation services, employment services, housing services, medical and dental care, and other support services to be provided to [people with chronic mental illness] in order to enable such individuals to function outside of inpatient institutions to the maximum extent of their capabilities," (7) "activities to reduce the rate of hospitalization of [people with chronic mental illness]" and, (8) most specifically of all, "the provision of case management services to each chronically mentally ill individual in the [s]tate who receives substantial amounts of public funds or services," limited only by express permission for each state to define the term "chronically mentally ill individual" under its own state laws and regulations and implicit permission to define "receiving substantial amounts of public funds or services," in the absence of a federal definition. PL 99-660 also provided for (9) consultation with employees of state institutions and public and private nursing homes in order to facilitate the deinstitutionalization mandate and (10) the establishment and implementation of "a program of outreach to, and services for, chronically mentally ill individuals who are homeless." (11) The Quayle Amendment further provided that all of the above-described mandates were subject to "existing state resources." (12) Advisory "state mental health planning councils" (usually called planning and advisory councils to better reflect the federal mandate) were charged with assisting in the development of the state plans, to assure broad stakeholder consultation and direct communication with each state governor and the federal government about unmet stakeholder concerns. The councils also were mandated to advocate for improved mental health services and to evaluate public and private mental health services within the state. That part of the statute has never changed.

PL 101-639 (1990)

(1) While PL 101-639 essentially carried forward the mandates of PL 99-660, it added a plan component to deal with the needs of "children with serious emotional and mental disorders," specifying a related plan development requirement for: "a system of integrated social services, educational services, juvenile services, substance abuse services. . . [and] health and mental

health services." (2) The 1990 statute also broadened the adult target group from "chronically" to "**seriously**" mentally ill individuals. (3) The term "health and mental health services" was also added to the original general services list (paragraph 6 under PL 99-660, above). (4) Although a **reference to "available treatment options" and "available resources" appeared to continue the intent of the Quayle Amendment in avoiding an unfunded mandate**, the reference was only to resources required to gain access to needed services. And the 1990 statute specifically required, for the first time, that the plan: "describe the financial resources and staffing necessary to implement the requirements of such plan," thus indicating at least the possibility that new resources might be required. (4) The special **outreach requirement for homeless mentally ill persons was temporarily dropped** in favor of a more **general outreach mandate**.

PL 102-321 (1992)

The enactment of PL 102-321 in 1992 represented a major change, corresponding to the change of responsibility for administration of the law from the National Institute of Mental Health to the newly formed Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration of the Public Health Service ("SAMHSA"), in the Department of Health and Human Services. (1) PL 102-321 continued the basic deinstitutionalization focus, changing the targeted population to the current formulation: "**adults with a serious mental illness or children with a serious emotional disturbance**," with provision for a federal definition, but continuing the targeting system and insisting upon "quantitative targets" as a part of the planning process. (2) Although the language of the Quayle amendment was removed, the legislation continued to refer to a "description" of: "**available services, available treatment options, and available resources. . . to be provided such individuals,**" thus **ruling out a federal mandate** that increased resources be developed. The language of the 1990 statute that limited the reach of the "available resources" language to the resources necessary for targeted individuals to gain access to needed services was removed, reinforcing this conclusion. (3) In the process, **the outreach goal of helping unserved or underserved people to gain access to treatment resources fell by the wayside.** (4) On the other hand, the 1992 statute continued the requirement for a plan description of "the financial resources and staffing necessary to implement the requirements of such plan, including. . . training." Thus, development of resources remained an implied goal as well, and the training language represented a new mandate.

(5) The key change in 1992 was the provision that the **definition of "adults with a serious mental illness and children with a serious emotional disturbance" be established by the Secretary of the Department of Health and Human Services, rather than the states.** With definitional flexibility removed as a method of avoiding strict compliance, the 1992 statute went on to require that the plan "describe health and mental health services, rehabilitation services, employment services, housing services, educational services, medical and dental care, and other support services to be provided to such individuals. . . to enable such individuals to function outside

of inpatient or residential institutions to the maximum extent of their capabilities. . . ." The only change from PL 99-660 was in the addition of the term "health services," which may not be very significant since the term "medical care" was present from the beginning, and the addition of the term in the 1990 statute appeared to make little difference. But the important change was the application of the mandate to a broader population, defined by the federal definition. Interestingly, no federal definition was proposed for the equally important qualifying term, "receiving substantial amounts of public funds or services."

(6) With regard to **case management**, the mandate of provision of **services to each targeted individual "receiving substantial amounts of public funds or services"** remained intact, with another new phase-in date. **While the general outreach requirement was dropped, the requirement of a program of outreach to homeless individuals was reinstated, and the 1992 statute tacked on a requirement for outreach to individuals residing in rural areas.** (7) The only substantial deletion in the 1992 statute was the requirement of participation of employees of state institutions and nursing homes in the planning process.

(8) The 1992 statute specifically mandated "an **estimate of the incidence and prevalence** in the [s]tate of serious mental illness among adults and serious emotional disturbance among children," using, of course, the new federal definition and a census methodology to be developed. The census methodology for an unduplicated count of individuals in the mental health system is being developed and incidence and prevalence data have been developed for all states and territories. (9) The 1992 statute also clarified the requirement of **sanctions** of ten percent if the Secretary determines that a state has not "substantially implemented the plan," in accordance with the timetables set forth in the plan, subject to a five percent reduction in the penalty if the Secretary determines that the state is "making a **good faith effort** to implement the plan." New maintenance of effort provisions were added as well. SAMHSA was expected to tighten up enforcement as it took over the regulatory role.

PL 106-310 (2000)

Just before the 2000 election, the federal Congress passed an act reauthorizing SAMHSA, which had been in suspense for four years pending Congressional review. The new law substantially changed the mental health planning and advisory council legislation and suggested further changes to substitute a "performance partnership" for the grant sanctions specified in the law for failure to implement block grant-required plans.

(1) The formal change was made to specify **five plan elements** instead of the twelve elements outlined in the prior legislation. This change conformed the statute to SAMHSA's guidelines, which had sought to avoid duplication through consolidation of plan elements. However, the very first element of a "**comprehensive community-based mental health system**" still says it all, and the **data, children's system, rural and homeless and management, finance and training** elements are drafted as elements of the plan rather than as separate plans. (2) The last sentence under

42 USC Section 300x-1(b) resolves the drafting problem that came from treating the children's plan as an element while requiring that it contain all of the other elements. It's not pretty, but it works. The entire new **plan criteria** are as follows:

(1) Comprehensive community-based mental health systems

The plan provides for an organized community-based system of care for individuals with mental illness and describes available services and resources in a comprehensive system of care, including services for dually diagnosed individuals. The description of the system of care shall include health and mental health services, rehabilitation services, employment services, housing services, educational services, substance abuse services, medical and dental care, and other support services to be provided to individuals with Federal, State and local public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities, including services to be provided by local school systems under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.). The plan shall include a separate description of case management services and provide for activities leading to reduction of hospitalization.

(2) Mental health system data and epidemiology

The plan contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children and presents quantitative targets to be achieved in the implementation of the system described in paragraph (1).

(3) Children's services

In the case of children with serious emotional disturbance, the plan -

(A) subject to subparagraph (B), provides for a system of integrated social services, educational services, juvenile services, and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (such system to include services provided under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.));

(B) provides that the grant under section 300x of this title for the fiscal year involved will not be expended to provide any service under such system other than comprehensive community mental health services; and

(C) provides for the establishment of a defined geographic area for the provision of the services of such system.

(4) Targeted services to rural and homeless populations

The plan describes the State's outreach to and services for individuals who are homeless and how community-based services will be provided to individuals residing in rural areas.

(5) Management systems

The plan describes the financial resources, staffing and training for mental health providers that is necessary to implement the plan, and provides for the training of providers of

emergency health services regarding mental health. The plan further describes the manner in which the State intends to expend the grant under section 300x of this title for the fiscal year involved.

Except as provided for in paragraph (3), the State plan shall contain the information required under this subsection with respect to both adults with serious mental illness and children with serious emotional disturbance.

42 USC Section 300x-1(a)

(3) The new statute kept the reference to “available resources” but specifically required a “system of care” and “quantitative targets,” which could be read to reinforce the “comprehensiveness” mandate. But the mandate was changed to include “Federal, State and local public **and private** resources,” confirming that **no state resources mandate is intended**. It should be noted in passing that this may imply a scope of planning that no state does, or could do. Like the ongoing statutory mandate for the planning and advisory council to evaluate at least annually the private as well as the public mental health system – a mandate that no state has yet undertaken.

(4) References to **the case management and deinstitutionalization goals of the original legislation were watered down** by eliminating the requirement that all persons in need be covered by the plan – rather than just those being served by that state mental health system. The old goal was reduced to a “separate” plan element. Thus, the mental health block grant plan now only must:

- ...provide...for an organized community-based system of care for individuals with mental illness, and describe...**available services and resources** in a comprehensive system of care, including services for dually-diagnosed individuals. The description of the system of care shall include health and mental health services, rehabilitation services, employment services, housing services, educational services, substance abuse services, medical and dental care, and other support services to be provided to individuals with Federal, State and local public **and private** resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities, including services to be provided by local school systems under the Individuals with Disabilities Act (20 U.S.C. [Section] 1400 *et seq.*). **The plan shall include a separate description of case management services and provide for activities leading to reduction of hospitalization.** 42 USC Section 300x-1(a)(1) (emphasis supplied).

(5) The other prior mandates, **for homeless and rural outreach, were also watered down**, so that the plan is merely required to “describe the State’s outreach to and services for individuals who are homeless,” whomever they may be and whatever it may be, and “how

community-based services will be provided” in rural areas. Only descriptions remained, without a goal.

(6) The implementation requirements of Section 300x-1(d) remained unchanged, but council comment was required on the state implementation report as well as the plan (Section 300x-4(1)(a)). And the “maintenance of effort” provisions of Section 300x-4 were changed slightly to allow (but not require) exclusion of “non-recurring” program initiatives from the base. But the penalty for failure of “material compliance,” such as by a general fund budget cut, was still set at one hundred percent of the cut, unless the Secretary of HHS found that “extraordinary economic conditions in the state” justified a waiver. And with budget cutbacks around the country, maintaining funding is rarely possible in fact.

(7) As part of the federal government’s effort to change federal block grants into performance-based systems, PL 106-310 required the Secretary to submit a report to Congress on the legislative and other steps required to implement a performance partnership model. This plan would grow out of the MHSIP and data infrastructure grant projects, and would specify what performance measures would be imposed under a performance partnership.

The report was never submitted to Congress, and Congress has not acted to enact any form of performance partnership. Instead, SAMHSA has required core data elements as part of its annual instructions which have phased in *de facto* uniform performance criteria, based on the following chart:²

² SAMHSA/CMHS Block Grant Application Form (2004). Criteria references track the statute (See pages 7-8 above).

PPG Core Performance Indicators*		Relevant Criterion	DIG Tables Basic & Developmental	PART
INDICATORS EXPECTED IN 2005 OR COMPLETE STATE LEVEL DATA REPORTING CAPACITY CHECKLIST				
1. Increased Access to Services	Number of Persons Served by Age, Gender, and Race/Ethnicity	Criteria 2 and 3	Basic Tables 2A and 2B	Yes
2. Reduced Utilization of Psychiatric Inpatient Beds	Decreased Rate of Readmission to State Psychiatric Hospitals within 30 days and 180 days	Criteria 1 and 3	Developmental Table 20A	Yes
3. Evidence-Based Practices*	Number of Evidence-based Practices Provided by State	Criteria 1 and 3	Developmental Tables 16 and 17	Yes
	Number of Persons Receiving Evidence-based Practice Services	Criteria 1 and 3	Developmental Tables 16 and 17	Yes
4. Client Perception of Care	Clients Reporting Positively About Outcomes	Criteria 1 and 3	Basic Table 11	Yes
INDICATORS ENCOURAGED TO BE INCLUDED IN THE STATE PLAN IF STATE HAS CAPACITY TO REPORT				
5. Increase in Employment or Return to School	Profile of Adult Clients by Employment Status	Criterion 1	Basic Table 4	No
	Increased school attendance	Criteria 1 and 3	Developmental Table 19C	No
6. Decreased Criminal Justice Involvement	Profile of Client Involvement in Criminal and Juvenile Justice Systems	Criteria 1 and 3	Developmental Table 19A and 19B	No
7. Service Capacity	Number of Persons with SMI/SED Served by Age, Gender, and Race/Ethnicity	Criterion 2	Developmental Table 14A	No
INDICATORS IN DEVELOPMENT				
8. Increased Social Supports	TO BE DETERMINED (initial indicators and measures have not yet been identified)	Criteria 1 and 3	Developmental TBD	No
9. Increase in Family Stabilization and Living Conditions	TO BE DETERMINED Profile of Clients' Change in Living Situation (including homeless status)	Criteria 1, 3, and 4	Developmental TBD	No
10. People with Co-Occurring Substance Use Disorders	TO BE DETERMINED In conjunction with SAMHSA/CSAT/CSAP and the State's proposed measure are to be detailed and pilot tested	Criteria 1 and 3	Developmental TBD	No

Summary: It looks more like it does now than it did then

To summarize, then, the evolution of the federal mental health planning legislation has been toward:

- (1) inclusion of **seriously emotionally disturbed children** and broadening the adult target to **adults with serious mental illness**, even if not (yet) chronic;
- (2) development of a **uniform federal definition** of the target group, to avoid state-by-state exclusions from the definition (particularly in light of some states' limitation of the definition to individuals actually receiving mental health services, thus essentially avoiding the outreach functions contemplated by the earlier forms of the statute, although the equally important qualifying term "receiving substantial amounts of public funds of services" remains undefined);
- (3) addition of persons residing in **rural areas** to the original special targeted population of **homeless** persons – however watered down in 2000;
- (4) delays in enforcement leading to abandonment in 2000 of the **case management** mandate in the earlier forms of the law-- the single clear service mandate contained in the original legislation – only to be reduced to a goalless plan element in 2000.
- (5) Early deletion of the **general outreach requirement** and the requirement of dedication of resources to help the target group to **gain access to needed services**;
- (6) on-going fuzziness in the extent of the support services required to be developed to fulfill the "maximum extent of their capabilities" **deinstitutionalization** mandate – only to be dropped as a goal in 2000 with the rest.
- (7) deletion of required representation of employees of state institutions and nursing homes; and
- (8) addition of specific **data** and **training** components.

ANALYSIS

The increased **focus on determinations of compliance and potential sanctions** for non-compliance, and the administrative changes reinforcing that focus, were perhaps the most significant administrative change for states as they began to deal with SAMHSA rather than NIMH. This definitely changed the role of state advisory councils in reviewing state plans, realizing that sanctions can ultimately result in a decrease of services to the population for which they are advocating. However, no one really wanted to impose sanctions, which would cause trouble in Congress and

could be a career-ending move. So a complicity developed between state planners and pacs, block grant reviewers and federal officials to avoid findings of non-compliance that would jeopardize block grant funds. The sanction (and, to a lesser extent, the continuation of effort) provisions of the statute were not ignored, but they were avoided.

As a component of federal mental health planning legislation, **the creation of planning advisory councils has had perhaps the most significant lasting effect**, as the councils have taken up the challenge to advocate for chronically mentally ill people in a multi-disciplinary setting, in which they have been, for the first time in many states, empowered to do more than simply react as stakeholder groups to initiatives from state bureaucracies. They have unevenly but on the whole effectively: "monitored, reviewed, and evaluated the allocation and adequacy of [public] mental health services," as specified in the legislation, reviewing (rather than rubber-stamping, as in the early years) the federally required mental health plans and also advocating for modifications of services, securing of funds, and restructuring service delivery, particularly between state and local options for provision of service. **The planning councils have acted as effective proxies for the federal goal of transformation of state mental health systems from the custodial model of the past to a future of recovery and community integration for people with serious mental illness.**

It is appropriate for planning and advisory councils to reflect with the federal administration and the Congress on **the pros and cons of increased regulation**. As regulations have been developed for the mental health block grant program, the planning councils have consistently opposed them. Such regulation could hurt, further reducing state discretion and promoting more "paper compliance" rather than strategic planning. In particular, the federal government needs to recognize the differences in state constitutional and organizational structures, fiscal options, especially as mental health budgets have declined with state revenues around the country, and stages of deinstitutionalization and development of community resources. The states and the federal government need to deal together constructively with the instability which exists as a result of broader state and federal health care initiatives as well as changes in the individual states reflecting fiscal pressures which are unique to each state.

On the other hand, federal requirements such as the statutory mandate of uniform definitions of "serious mental illness" and "serious emotional disturbance" seem eminently reasonable in a program of federal financial assistance – even under a "block grant" format, affording flexibility to the states. The common data elements are also reasonable, when coupled with the data infrastructure grants that made the data manipulation feasible. The states are still burdened with the data collection and systems maintenance costs, of course. But accountability is a fair trade-off for funding.

The federal government has attempted for over five years to persuade the states to develop **Olmstead plans** in response to the United States Supreme Court's invitation in *Olmstead v. L.C.*, 527 U.S. 581 (1999), with identifiable targets for reducing unnecessary institutionalization that may otherwise violate federal law, the Americans with Disabilities Act. This is reinforced by the one clear

indicator we have of the road ahead: the mandate by the New Freedom Commission for comprehensive state mental health plans.

Why the need to keep re-inventing the wheel? How many mandates for comprehensive planning are needed? Why not identify the barriers within the statute that inhibit comprehensive planning and call for changes? Why not reach out to the states with more help for data development, collection and maintenance and more funding of training and organizational development?

One wonders, for example, whether it is truly productive to have federal mental health planning legislation dictate a new planning process every year, when often the best goal that can be enunciated is to simply avoid losing ground any further. Wouldn't it be more productive to consider a longer time horizon? And if so, mustn't the federal government recognize that states cannot commit funds three to five years out?

The original PL 99-660 assurance that the obligation of implementation would be qualified by "existing resources" certainly needs to be emphasized if an implementation/sanctions component is to continue. And the maintenance of effort clause needs to be enforced against a diversion of state resources, while respecting the reality of budget cutbacks. Mental health will suffer -- but it should not suffer disproportionately. That is simply the reality as budgets are cut around the country. And given that reality, what is the point of sanctions for failure to fully implement the block grant plan?

Perhaps most saliently, the federal government needs to examine the original five mandates: a comprehensive system of community-based care for the most seriously mentally ill adults and children; maximum feasible deinstitutionalization; comprehensive outreach (especially to homeless and rural populations) and case management. Is mental health planning the best way to achieve these aims, and if so, under what structure of federal oversight?

It is my thesis that while mental health planning is indeed an appropriate way to accomplish all of these aims, mandatory plan implementation is a constraint upon true strategic planning and compromises the actual effectiveness of the planning process. Regulations which further constrain states by imposing restrictive federal interpretations of the statutory mandate could make this situation worse, rather than better. Some ambiguity is helpful. This is a planning process, not a regulatory process.

For example, do we really need a federal definition of the extent of required outreach to provide case management services? Do we need to define "case management," define what it means to receive "substantial public funds or services," define required outreach activities, define exclusions for treatment resistance or refusal, set due process protections, etc? I hope not, and happily PL 106-310 (2000) seems to make such formerly proposed regulations even more inappropriate and unneeded. Rather, in my view, we need to work together to develop strategies to make case management a better and more comprehensive vehicle for addressing people in need of

mental health care and allow the states to work out the details in true strategic planning processes. That would best fulfill the promise of federal mental health planning legislation, as it continues to evolve.

Most importantly, at a time when the New Freedom Commission has staked out a federal goal of "**transformation**" of state mental health systems, **the planning and advisory councils have pride of place in making that goal a reality through the planning process**, however flawed it may be. It is incumbent on advocates to make it as much as it can be.

The Planning Councils' Organization: NAMHPAC

The planning and advisory councils (pacs) have united in forming NAMHPAC, the national association of pacs, which has tried to activate the pacs to engage their administrative and political prerogatives and relationships more creatively and enthusiastically. NAMHPAC was founded in 1992, when a group of chairs of mental health planning and advisory councils got together at a conference convened by the new SAMHSA block grant administration, the Center for Mental Health Services (CMHS), which took over administration of the mental health block grant from the National Institutes of Mental Health. The idea that the chairs embraced was to band together, to share insights, and to strengthen state planning and advisory councils.

State pacs were originally created by the federal government to ensure grassroots input in the planning processes of state mental health programs. Thus, they were intended as an indirect federal accountability system for state mental health agencies, focused on federal block grant funds, but ultimately also, in concept, driving federal funds, including Medicaid, and state general funds. However, despite this ambitious mandate, pacs were not equipped with the tools and resources necessary to fulfill their mission. They were left to fend for themselves in figuring out how to partner with and influence the states and CMHS. NAMHPAC was created to address this problem.

The author of this article, Joseph de Raismes, then-Chair of the Colorado Planning and Advisory Council, drew up the NAMHPAC bylaws and got them adopted, with some debate, at the annual conference held in 1994, when he was elected as the first Chair of the Board of Directors of NAMHPAC, a position in which he served for eight years. As such, he is sometimes referred to as the founder of NAMHPAC. He remains in a non-voting position on the NAMHPAC Board of Directors.

NAMHPAC first became visible at the annual conference given by CMHS in San Diego in 1995, when few people at the meeting had heard of NAMHPAC, few states had sent in a letter to join the newly-formed organization, and a long debate was required before a vote was taken to start the meeting over to allow states to vote that had not yet joined. But the time of trial soon passed. NAMHPAC now has a track record to recommend it, and all states and territories have now joined.

NAMHPAC achieved its initial funding by becoming a contractor for CMHS. Beginning with basic organizational development training, NAMHPAC eventually was asked to help train planning and advisory councils in evidence-based practices and advocate for their use, to carry out the federal government's new mandate to develop evidence-based practices and persuade the states to adopt them. This program, originally called the Knowledge Development and Application Program, was the successor to the demonstration grants program that had given the states temporary funding for new programs. Thus far, NAMHPAC has published eleven brochures and toolkits, on supported employment, co-occurring mental health and substance abuse disorders, homelessness, managed care, children's systems of care, evidence-based herbal and omega-3 and sam-e treatments, and assertive community treatment. New brochures on jail diversion and evidence-based practices have received content clearance and should receive final approval soon. A brochure concerning mental health treatment for older adults is being finalized, and one on rural issues is in the early drafting process. Thus, NAMHPAC has been charged with two primary jobs: peer-to-peer training of planning councils and the creation and marketing to planning and advisory councils of CMHS-approved brochures to advertise the evidence-based practices that CMHS is trying to promote.

In addition to conducting trainings with pacs and distributing brochures, NAMHPAC adopts policy statements for consideration by pacs. There are six current policy statements, including advocacy of maximum diversion from the criminal justice system, advocacy of integrated mental health and substance abuse treatment, advocacy of planning to avoid unnecessary institutionalization that violates federal antidiscrimination laws under the *Olmstead* case, advocacy of a broad form of insanity defense, advocacy of broad access to medications, and advocacy of a non-coercive model for mental health courts.

All of these materials are available (or will be available, upon approval) on the NAMHPAC website: www.namhpac.org.

In 1996, NAMHPAC appointed its first Executive Director. The organization is currently served by its third Executive Director, Judy Stange. Since its creation, NAMHPAC has bid on and won various other contracts, including technical assistance trainings implementing the New Freedom Commission Report. In addition, the organization has also been funded by pharmaceutical companies to do brochures and technical assistance about access to medications. However, due to the controversial nature of pharmaceutical funding, NAMHPAC has discontinued this practice. The organization has been trying to diversify its funding and has also acquired a few foundation grants. However, as creatures of federal statute, foundations properly insist that the pacs and NAMHPAC look primarily to the block grant for base funding.

At present, NAMHPAC employs two staff (an Executive Director and a Project Coordinator), each $\frac{3}{4}$ time. NAMHPAC contracts with the National Mental Health Association (NMHA) as a host organization, and NMHA provides space, equipment and allocation of staff to meet the needs of NAMHPAC. NAMHPAC originally approached NAMI (The National Alliance for

the Mentally Ill) and NASMHPD (The National Association of State Mental Health Program Directors) as well, but only NMHA was able to help. It has been a productive alliance, under which NAMHPAC has guaranteed its autonomy. NAMHPAC maintains close relationships with NAMI and NAMHPD to keep its advocacy balanced. The NMHA relationship had given NAMHPAC access to the Washington mental health advocacy community and policy information and influence, but NAMHPAC has maintained a separate voice through the process.

NAMHPAC employees divide their labor between the two organizations with .75 of each employee's time being devoted to NAMHPAC work and .25 being devoted to NMHA. The NAMHPAC Board is composed of 7 voting members and 2 non-voting members. Board members are spread all over the United States, and the board's composition is a good representation of geographical areas and mental health constituencies. Due to the difficulty of convening members spread all over the United States, the NAMHPAC Board only meets in person two times a year. Conference calls are used for interim business.

The scope of NAMHPAC continues to grow, and its budget reached \$250,000 in 2005. With this expansion in budget, NAMHPAC has more than doubled the number of technical assistance trainings that it offers each year. The original contract with CMHS called for 8 to 10 technical assistance trainings a year. NAMHPAC is expecting to do about 25 technical assistance trainings in 2005, including an intensive technical assistance with one state. Since 1994, when NAMHPAC was formed, it has held over sixty retreats with state pacs, two regional conferences on Medicaid policies affecting mental health, and a conference with pac chairs to train them and help them to work with each other to do their jobs better. Running a meeting with such a diverse membership is sometimes a tough job, and fairness and balance are essential. But fortunately, conducting pac meetings is a learnable skill. It mainly takes patience and good listening and mediation skills.

Annual "train the trainers" sessions train advocates willing to volunteer to conduct team facilitations and network among the pacs. The technical assistance trainings in the states help pacs with basic organizational development and specific pac issues. A good understanding of the block grant law and its evolution and examples from other states collected by NAMHPAC are blended with new personal connections among the pac members and a simplified work plan model. This leads in most cases to development of a realistic agenda for the pac.

One goal of the planning and advisory councils, through NAMHPAC, is to achieve a set-aside of dedicated federal funds from the block grant funding pac staff and expenses. This would free the pacs from competing in the state appropriations process, where they might well be disadvantaged because of the very leadership that the federal government is trying to encourage. If the federal government is serious about its desire for a partnership to replace the implementation sanctions of the current federal mental health block grant legislation, it should support dedicated pac funding. It is the only way to assure ongoing excellence in the planning and advisory councils.

The planning and advisory councils are the federal government's direct links with the grass roots in every state, its statutory way of sifting all of the competing threads of mental health advocacy in each state. The pacs are, at base, the way that the federal government assures state consideration of evidence-based practices. Absent new dollars for demonstration projects, the federal strategy now focuses on knowledge development through basic and applied science and knowledge application, through state-by-state and agency-by-agency consideration of the state of the art of mental health practice. This is the real meaning of the current federal mantra, "transformation."

The pacs, as planners of improvement and change, are the federal government's natural allies in trying to improve state mental health systems and in maximizing the impact of federal resources, including Medicaid as well as block grant dollars. Federal mental health planning legislation is a natural component of a performance partnership based on recognition that federal mental health block grant dollars cannot drive the outcome of state planning and are best focused on the integrity and the intelligence of the process at the state level. Based on that final conclusion, the federal mental health planning statutes have been a resounding success, and have shown how to get transformation gradually, and in spite of setbacks, through ongoing planning, with the pacs serving as federal proxies to force the states to deal with issues they otherwise might avoid. And the states too have bought in, embracing their own planning and advisory councils and effectively partnering with them, for the most part. This is a work in progress. But the progress so far is good.