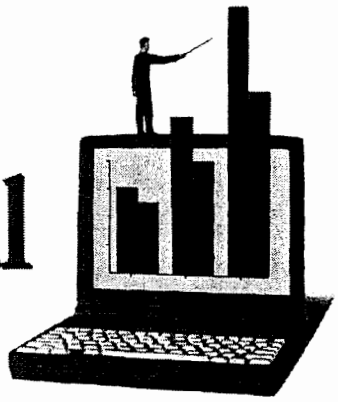
Behavioral Healthcare Tomorrow

FEATURE

Children's Mental Health Benchmarking:

Progress and Potential



Comparing state, county systems proves challenging

By Sylvia B. Perlman, Ph.D., Sara L. Nechasek and Richard H. Dougherty, Ph.D.

Despite extensive, long-term and ongoing discussions in the field about the value of developing benchmarks, a recent report finds that it continues to be a challenge for states and counties to provide timely data that enable cross-site comparisons.

At the end of last year, Dougherty Management Associates Inc. (DMA) released the first report on its Children's Mental Health Benchmarking Project. Funded by the Annie E. Casey Foundation, the project has begun to review and compare data on public mental health systems for children.

The long-term goal of the benchmarking effort is to begin offering state and county systems the ability to compare their performance with one another. This exploratory work points to the value of the process, the potential significance of the results, the benefits to participants and, not least, the substantial challenges involved.

Benefits of participation for states and counties

States and counties that participate in this benchmarking project are realizing a variety of benefits. These include:

- For many states, this may be the first time they have had a comprehensive population-based review of their children's mental health system, combining Medicaid and non-Medicaid cost and utilization of mental health services to children.
- States and counties can compare themselves to others on a more or less comparable playing field. While there are certainly differences among systems, review of the differences will help identify key funding and service questions.
- The data may be useful for advocacy purposes within the agencies, within the state and with external entities. This has already helped at least one state.
- Participation in the project over several years will permit the review of useful trend information in comparison to trends in other states.
- Review of the data is likely to prompt useful quality-improvement related questions that can inform state and county policy- and decision-making.

Methods

The researchers originally approached 38 state and county mental health agencies. Of those, 22 expressed interest and a willingness to participate, but only 13 ulti-

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mately provided data. The 13 jurisdictions were able to provide fewer than 40 percent of the data elements that they had initially thought they could. The agencies that did submit data confronted many obstacles as they attempted to comply with the request.

The challenges they faced included:

- Experiencing changes in the political and personnel contexts of their own agencies.
- Having difficulties in coordinating data production and reporting between states' departments of mental health and their Medicaid agencies when the two were separate.
- Dealing with personnel shortages.
- Generating these measures specifically for children and adolescents for the first time.
- Competing with special report requests not pertaining to day-to-day needs.
- Experiencing difficulty in meeting this project's time frames.

Preliminary findings

The report includes preliminary findings from nine states, three counties and the District of Columbia regarding indicators such as penetration rate, expenditures per capita, inpatient utilization and out-of-home placement rate. Although DMA selected only indicators that had been identified and defined by significant national groups, no more than eight jurisdictions were able to provide data for each indicator. Here are some of the results.

Penetration rate, the percentage of covered individuals who have received at least one mental health service during a specified period of time, is a global indicator of access to healthcare. This report includes data on Medicaid penetration rate from five states and three counties. For seven of the eight sites, rates range from 5.6 percent to 11.7 percent, and average 9 percent. For the other state, the calculated rate was significantly below the expected range (see Figure 1).

The study also gathered data on both **Medicaid and total (Medicaid and non-Medicaid) direct service expenditures** per child served. While six jurisdictions provided data for *each* indicator, only three of them provided data for *both* indicators. Average Medicaid expenditures ranged from $1,230 to $6,563 (see Figure 2), and average total expenditures ranged from $2,524 to over $9,000 per child.

The magnitude of the variation relates both to differences in mental health benefit packages and to differences in overall funding levels. In future work on this project, DMA will seek a clearer understanding of the variations.

While only three jurisdictions were able to provide data that enabled calculation of **average length of stay in acute-care inpatient treatment** (at non-state hospitals), their numbers clustered closely together. Average lengths of stay ranged from 12 to 15 days.

Because high-quality mental healthcare for children often requires the involvement of numerous other public systems (e.g., child welfare, juvenile justice and education), DMA attempted to find out what information mental health agencies had about their clients' relationships to those systems.

Six jurisdictions were able to provide data on the number of children receiving mental healthcare who were in **out-of-home placements** at any time during the year. Their rates ranged from 5.8 percent to 40.3 percent. This indicator clearly requires further investigation.

The 13 jurisdictions were able to provide fewer than 40 percent of the data elements that they had initially thought they could.

Only four jurisdictions were able to indicate how many children receiving mental health services also had an encounter with the **juvenile-justice system**, and virtually no state or county even expected to be able to provide data on **school absenteeism** among children in the mental health system.

Limitations of the analysis

DMA researchers acknowledge the need for caution in interpreting the project's findings and in drawing conclusions. They note several important considerations in this regard: Only a small number of jurisdictions provided data, and some of them are reporting on small numbers of cases; the systems that offered data are very different from one another; many key pieces of data are missing; and there are one or two extreme outliers, or wide dispersions of data, on most indicators.

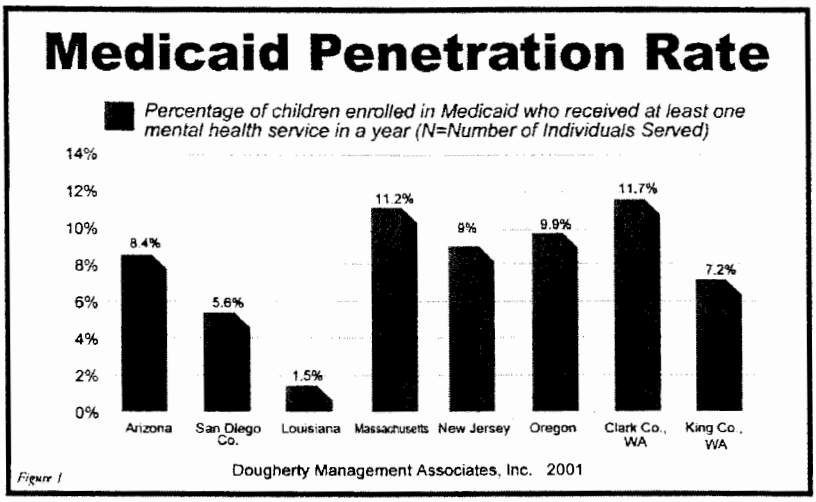

Figure 1

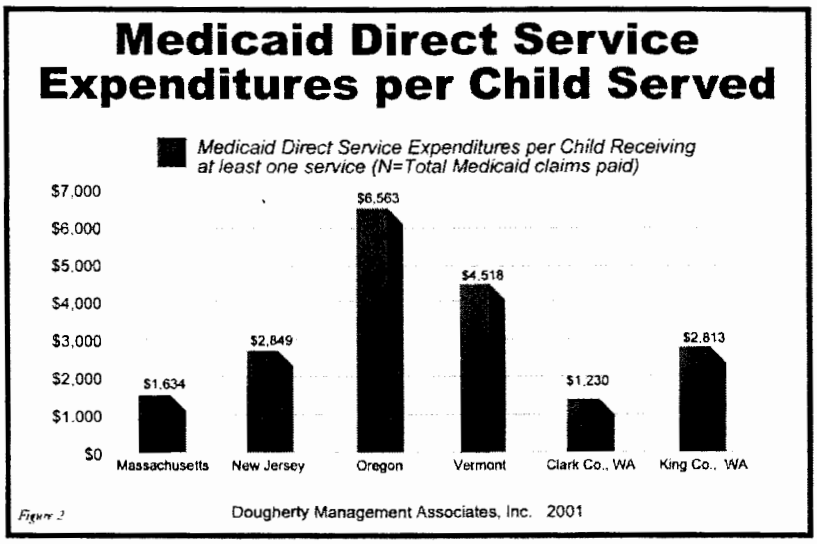

Figure 2

Future steps

With further support from the Annie E. Casey Foundation, DMA is now in the process of gathering data from the same states and counties for another year, and will be adding new jurisdictions as well. In the fall of 2001 DMA hopes to sponsor a meeting of respondents for the purpose of discussing the project's findings and sharing information on the data-gathering process and how it might be improved.

The project's goal will continue to be developing meaningful benchmarks related to mental healthcare for children served in the public sector, and to increase their utility to stakeholders.

Sylvia B. Perlman, Ph.D., Sara L. Nechasek and Richard H. Dougherty, Ph.D., are associate, Senior Associate and president, respectively, of Dougherty Management Associates, Inc. *The report narrative and the data collection instrument are available online at www.doughertymanagement.com. Call (800) 814-7802 for more information on the project, to express interest in participating or to request a copy of the complete report.*

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